PULMONARY CRITICAL CARE AND SLEEP SPECIALISTS, P.A.

Assignment of Insurance

I hereby authorize direct payment of medical benefits to **Pulmonary Critical Care and Sleep Specialists, P.A.** for services provided to me. I understand that I am financially responsible for any co-pay or deductibles as determined by my medical insurance or health plan.

Authorization to Release Protected Health Information

I hereby authorize **Pulmonary Critical Care and Sleep Specialists, P.A.** to release any medical or incidental information that may be necessary for either my medical care or in processing claims for medical services rendered.

Personal Assurance

You will be considered personally financially responsible for the serviced provided to you by **Pulmonary Critical Care and Sleep Specialists, P.A.** if: (1) your medical insurance coverage is terminated voluntarily or involuntarily prior to the performance of the procedure or treatment or (2) your medical insurance carrier has changed prior to the performance of the procedure or treatment and **Pulmonary Critical Care and Sleep Specialists, P.A.** was not informed, (3) your primary insurance company determines that the procedure or treatment you are scheduled for is not considered "reasonable or necessary" for your diagnosis.

Out-of-Network Benefits

I understand that by exercising my health plan's Out-of-Network benefits, **Pulmonary Critical Care and Sleep Specialists, P.A.** agrees to accept as payment in full my health plan's In-Network payment amount plus any applicable In-Network co-payments and deductibles.

Consent for Testing-Treatment

I understand that I am agreeing to the test(s), treatment(s) and or procedure(s) to be performed on me or a minor member of my family as directed by the ordering physician or specialists.

By signing below I understand and acknowledge the above subjects and I also acknowledge receipt of Pulmonary Critical Care and Sleep Specialists, P.A. Notice of Privacy Practices hand-out.

____ ________________

Signature of Patient or Guardian Date

____

Printed Name

RIGHT TO REFUSE DIAGNOSTIC-THERAPEUTIC PROCDURE, TREATMENT

(Sign only if you elect to exercise this option)

I understand that I have the right to refuse the disorder and/or therapeutic procedure to be conducted by **Pulmonary Critical Care and Sleep Specialists, P.A.** If I exercise this right, I fully understand that I am exercising this right against medical advice (AMA) from my primary care physician and/or ordering physician, and I will hold harmless **Pulmonary Critical Care and Sleep Specialists, P.A.** and it's employees of any detrimental consequences related to an undiagnosed and/or untreated sleep and/or pulmonary disorder.

I willfully elect to exercise the "Right to Refuse Disorders/Therapeutic Procedure, Treatment" option.

____ ________________

Signature of Patient/Guardian Date

PCCSS Representative: ________________________________ Date: ____________

A photocopy of these assignments shall be valid as the original.

PULMONARY CRITICAL CARE AND SLEEP SPECIALISTS, P.A.

Patient Consent/Medical Release/Receipt of Privacy Practices Form

Patient Consent

By signing this document, I am requesting Pulmonary Critical Care and Sleep Specialists (PCCSS) and the doctors in the practice to treat me for pulmonary and or sleep disorders. I understand that as a patient, I am required to authorize PCCSS for such services and am hereby authorizing such treatment. I understand that PCCSS will retain ownership rights to the records of my treatment, but I will be allowed access to view or obtain copies of them. I understand that these records will be stored in a secure manner that will protect my privacy. I also acknowledge that I have consulted my physicians and understand the nature of the treatments that I am about to receive at PCCSS. By signing this document, I consent to the treatments that will be provided for me by the staff of PCCSS.

Patient's Authorization for Release of Medical Information:

I give Pulmonary Critical Care and Sleep Specialists (PCCSS) my permission to release to the following family members/friends information from my medical record in my absence. This release will apply to PCCSS, doctors and their staff who provide services at PCCSS. Unless otherwise noted this release allows the above entities to leave messages on my answering machine/voicemail, with whomever answers my home phone, and contact me at work.

____ ________________

____ ________________

____ ________________

Name Relationship

Exceptions: ____

Receipt of Notice of Privacy Practices Written Acknowledgement

I, _______________________________, have received a copy of the Privacy Practices of Pulmonary Critical Care and Sleep Specialists, P.A.

____ ________________

Signature of Patient or Guardian Date

____ ________________

Witness Date