SMYRNA PULMONARY & SLEEP ASSOCIATES, PLLC

Prakash Patel, M.D.

13181 Old Nashville Hwy.
Suite 150
Smyrna, TN 37167
(615) 355-5105

635 North Main Street
Suite F
Shelbyville, TN 37160
(931) 536-4149

Fax (615) 355-5195

Name _____
First Middle Initial Last

Address _____
Street City State Zip

Home Phone # _____ **Cell Phone #** _____

Email _____

Employer _____ **Work Phone #** _____

Date of Birth _____ **Social Security Number** _____

Race: ☐African American ☐Asian ☐Caucasian ☐Hispanic ☐Other: _____

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Refuse to Report

Language: ☐English ☐Spanish ☐Other: _____

Marital Status S M W D **Spouse or Legal Guardian** _____

Primary Care Physician _____ **Phone #** _____

How did you hear about us? Dr. _____ **Radio** **Family/Friend** **Insurance**

Emergency Contact _____ **Relationship** _____ **Phone #** _____

Pharmacy Name _____ **Phone #** _____

Primary Insurance Company Name _____

Subscriber Name _____ **Relationship to Patient** _____

Policy Holder's SSN _____ **Policy Holder's DOB** _____

Secondary Insurance Company Name _____

Subscriber Name _____ **Relationship to Patient** _____

Policy Holder's SSN _____ **Policy Holder's DOB** _____y

PLEASE COMPLETE REVERSE SIDE

SMYRNA PULMONARY AND SLEEP ASSOCIATES
Dr. Prakash Patel

Disability Paperwork

Please be aware that Dr. Patel does not complete Disability or FMLA paperwork. He requests that you contact your family care physcian to complete this paperwork.

Referrals

If my insurance carrier requires a referral and one is not obtained, I understand I am responsible for payment of services rendered.

Authorization to Release Information

I hereby authorize any holder of medical information about me to release to my insurance carrier (s) or sponsoring agency or the Social Security Administration or its intermediaries of carriers, DME (durable medical equipment), or medical/dental care providers when relevant information requested by them for processing of benefit claims or management of healthcare.

Physicians that SPSA can specifically release records to: _____

HIPPA

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. Unless otherwise indicated with a written request for a restriction of your protected health information, Smyrna Pulmonary and Sleep Associates, PLLC will follow HIPPA Privacy Practices when discussing your medical or billing information.

Telephone Messages

I authorize Smyrna Pulmonary and Sleep Associates to leave messages on my answering machine or cell.

YES **NO**

Permission to Speak to other parties

I authorize Smyrna Pulmonary and Sleep Associates to discuss my medical condition with:

Living Will or Durable Power of Attorney

Do you have a Living Will? **YES** **NO**

Do you have a Durable Power of Attorney? **YES** **NO**

If yes, please provide our office with a copy.

Collection Fees

In the event, that your account is turned over to an outside collection agency the patient or responsible party will be held responsible for all costs related to collecting the balance.

Assignment of Benefits

I certify that the information given by me is correct. I hereby authorize payment to Smyrna Pulmonary and Sleep Associates, PLLC of the insurance benefits payable to me. In applying for payment under the Title XVIII or Title XIX of the Social Security Act, I request payment for authorized benefits be made on my behalf to those who accept assignment. I futher understand that I am responsible for any charges not covered or payable by this agreement.

Signature _____ **Date** _____

Print Name _____

Patient Portal gives you access to your records online, ability to request an appointment online, ability to view your appointment history online, ability to view your statement online and the ability to manage your personal contact information online. **Are you interested in being activated for Patient Portal? YES NO**