Children's Lung Specialists, Ltd.
3006 S. Maryland Pkwy., Suite 315
Las Vegas, NV 89109

PATIENT REGISTRATION FORM

Patient Information:

Last Name_____ First _____ Middle_____

○Male or◉Female DOB_____/_____/_____ Social Security # _____

Language Spoken _____ Ethnicity _____

Address_____

City/State/Zip_____Home Phone #_____

If applicable for ADULT patients:

Employer_____Occupation_____

Address_____Work Phone #_____

If patient is a minor, please complete the following:

Mother's Name_____ DOB_____/_____/_____ SS#_____

Home Phone #_____Work Phone #_____

Occupation_____Employer_____

Father's Name_____ DOB_____/_____/_____ SS#_____

Home Phone #_____Work Phone #_____

Occupation_____Employer_____

Authority to Obtain Medical Treatment

Additional adults aged 18 and over who are authorized to obtain medical treatment for patient. (If none, please write NONE.) *Please note that payment is still due at time of service even if child is brought in by an authorized person.

Full Name of Adult:	Relationship:	Phone Number:	Does Patient Reside with?
_____	_____	_____	☐ Yes / No ☐
_____	_____	_____	☐ Yes / No ☐
_____	_____	_____	☐ Yes / No ☐
_____	_____	_____	☐ Yes / No ☐

Primary Insured Information

Primary Guarantor Name_____Relationship_____

Insurance Company Name_____

Policy Effective Date_____/_____/_____ ID# _____

Secondary Insured Information

Secondary Guarantor Name_____Relationship_____

Insurance Company Name_____

Policy Effective Date_____/_____/_____ ID# _____

*Primary Care Physician or Specialist _____

I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits to be paid to Children's Lung Specialists, Ltd., and I understand that I am financially responsible for charges for medical services rendered to the above named patient, regardless of insurance coverage, including amount not limited to any and all immunizations. In the event of collection proceedings due to lack of payment on my part, I agree to pay any and all collection fees that may be added to my account in order to recover monies due.

Patient or Guarantor's Signature _____ Date_____

CHILDREN'S LUNG SPECIALISTS, LTD.

A Professional Medical Corporation

ACKNOWLEDGEMENT AND AUTHORITY

All professional services rendered are charged to the patient. Necessary forms will be completed and signed by the patient to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services as they are rendered unless other arrangements have been made in advance. Therefore, copays are due at the time services are provided. If unable to fulfill your copay/coinsurance, please let the front desk know and we will have to reschedule your appointment for a later date.

Children's Lung Specialists, Ltd., cares for ill children. Therefore, if you are unable to keep your appointment, please have the courtesy of calling and canceling. By doing this, we will have the opportunity to fit in another person's ill child. You understand that you are financially liable for a **$50.00** non-cancellation fee if your appointment is not cancelled **24 hours prior to your scheduled appointment time.**

Should this account become delinquent, you understand that you are responsible for any and all legal fees, court costs, and collection charges involved as a result of any collection activity, plus interest, at two percent above prime rate.

The undersigned authorizes the release of any medical or related information to process insurance claims, and authorizes payment of insurance benefits to Children's Lung Specialists, Ltd.

_____ _____

Patient's Name **Patient's DOB**

_____ _____

Signature of Patient, Agent, or Parent (if minor) **Date**

Phone (702)598-4411 ® Fax (702)598-1988
3006 S. Maryland Pkwy., Suite 315
Las Vegas, NV 89109

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my/my child's healthcare, Children's Lung Specialists originates and maintains paper and/or electronic records describing my/my child's health history, symptoms examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my/my child's care and treatment
- A means of communication among the many health professionals who contribute to my/my child's care
- A source of information for applying my/my child's diagnosis and surgical information to my/my child's bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Privacy Policies* brochure that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use my health information for director purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that Children's Lung Specialists is not required to agree to the restrictions requested I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent, or revoking this consent, this organization may refuse to treat me/my child as permitted by Section 164.506 of the Code of Federal Regulation.

I further understand that Children's Lung Specialists reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Children's Lung Specialists change their notice, they will send a copy of any revised notice to the address I've provided (whether US mail or, if I agree, e-mail).

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

By signing below, I acknowledge that I fully understand and accept the terms of this consent.

_____ _____

Patient's Name Patient's DOB

_____ _____

Signature of Patient, Agent, or Parent (if minor) Date