



# Registration Form

Please complete this form entirely. You will also need to bring your photo ID and insurance card with you to your appointment.

How did you hear about us? \_\_\_\_\_

## Patient Information

Patient's Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Marital Status:  Single  Married  Widowed  Divorced

Employer: \_\_\_\_\_ Status:  Part-Time  Full-Time  Not Employed  
 Student

Email: \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Primary Care Doctor: \_\_\_\_\_

Emergency Contact: Name \_\_\_\_\_ Phone#: \_\_\_\_\_

## Insurance Information

Primary Insurance: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Subscriber's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ID/Member/Subscriber #: \_\_\_\_\_

Subscriber's Employer (if different than above): \_\_\_\_\_

Subscriber's Address (if different than above): \_\_\_\_\_  
State Zip Address City

Subscriber's Home Phone: \_\_\_\_\_ Work or Cell Phone: \_\_\_\_\_

## Responsible Billing Party (if other than patient)

Name: \_\_\_\_\_ Home Phone #: \_\_\_\_\_

Address \_\_\_\_\_  
Street/P.O. Box City State Zip

**YOUR PERMISSION IS REQUIRED TO RELEASE YOUR MEDICAL INFORMATION (lab results, appointment information, etc.) TO ANOTHER PERSON.** If you are 18 yrs of age or older, we must have your written permission to release any medical information to ANY person other than yourself. If you would like to give consent for us to speak to someone else (spouse, significant other, family member, etc.) concerning you, please fill in their names below. Please check the box and WRITE THEIR NAME in the blank space. This authorization shall remain valid until revoked in writing. By signing at the bottom of this page, you give consent to release your medical information to the person(s) listed below.

Spouse \_\_\_\_\_  Parent \_\_\_\_\_  Other (name/relationship) \_\_\_\_\_

**FINANCIAL RESPONSIBILITY:** You will be billed for any charges not paid by your insurance company within 180 days. You agree to pay for such charges within 30 days. You will be responsible for a 35% collection fee if payment is not received within a timely manner. Charges for office services are payable at the time of service. Copayments, deductibles, and co-insurance amounts are payable at the time of service. Texas Sleep Medicine does not accept payment from third party payors such as PIP (Personal Injury Protection or from attorneys for accidents). You are financially responsible for all charges not covered under your health insurance benefits. Your insurance policy is a contract between you and your insurance company. Your doctor is not involved. Any checks returned by the bank will be subject to a \$35.00 handling fee and that future visits will be on cash/credit basis. **You may be billed \$35.00 for a Late Cancellation/No Show fee for office visits, and a \$250 Late Cancellation/No Show fee for sleep studies.**

**I understand that I have the right to received/review a written description of how Texas Sleep Medicine will handle health information about me.** I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. This authorization shall remain valid until revoked by me in writing. I have read all the information provided to be by Texas Sleep Medicine. By signing this document I agree to and understand all the information listed above.

X \_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Relationship Date