Welcome to
Longmont Pulmonary and Critical Care Associates, PC
1551 Professional Lane, Suite 235 Longmont, Colorado 80501

**PATIENT INFORMATION FORM:**

Date: _____
Legal First Name: _____ Legal Last Name: _____
Preferred Name:_____
Address: _____ City, State, ZIP: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____ Date of Birth: _____
Social Security #:_____Gender: _____
Marital Status: _____Primary Language: _____
Race: _____ Ethnicity: _____
Primary Care Provider: _____ Referred by:_____
Emergency Contact: _____ Emergency Contact Phone Number:_____
Relationship to the patient: _____
PROXY decision maker:_____ Phone Number: _____

I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes to the above information.

X_____ Date: _____
Patient/Responsible Party

AGREEMENT TO PAY FOR TREATMENT

I, the responsible party listed below, hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed-care organization with whom this office has a contractual agreement, I agree to pay ALL applicable co-payments, deductibles, and co-insurance which arise during the course of treatment for the patient. The responsible party also agrees to pay for treatment rendered to the patient which is not considered to be a covered service by third party insurers and payors.

X _____ Date: _____
Patient/ Responsible Party

RELEASE AND STATEMENT TO PERMIT PAYMENT OF PRIVATE INSURANCE BENEFITS TO THE PROVIDER

- I, the undersigned responsible party, hereby authorize this office/its employees to release and disclose all or any part of the patients medical records to any entity which is or may be liable for all or part of the provider changes.
- I authorize the release and disclosure of any and all of my or my child's medical records to any other entity including, but not limited to, specialty physicians, hospitals, or other healthcare providers which may be of assistance in the opinion of this office in providing treatment for the patient.
- I authorize the release of records necessary to assist in reimbursement of benefits to which I may be entitled.
- I authorize this office and/or its employees to release via fax machine medical records which are needed in order to provide the patient with the most appropriate medical care.
- I authorize and request that payment of any third- party insurance company benefits be made directly to this office for any service furnished to the patient. The signature furnished below shall suffice for all insurance forms on a continuing basis.

X _____ Date: _____
Patient/Responsible Party