Ventura Pulmonary and Critical Care Medical Group

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□ Amir Arfaei, M.D. FCCP
□ Gordon Pelegrin, M.D. FCCP
□ Jerome De Vera, D.O

Patient Information Form

Date_____

Name _____Birth Date_____

Address_____ Home Phone_____

City_____ Zip_____Work Phone_____

Social Security Number_____Age_____Sex M ( ) F ( )

Employer_____Name of Spouse_____

Emergency Contact_____Phone Number_____

Signature_____ Date_____

Name of Referring Physician_____Phone #_____

I hereby authorize payment directly to above named Physician for his services as described on attached claim and to release information to the referring M.D and my insurance company.

Turn this page over and complete the second page

Financial Policy and Agreement

I hereby authorize treatment by the physicians of the Ventura Pulmonary and Critical Care Medical Group.

I understand that I am financially responsible for all the fees and charges for such treatment regardless of my medical insurance coverage.

It is my responsibility to understand the terms and limitations of my medical insurance coverage. I must provide accurate, complete, timely and updated medical insurance information to Ventura Pulmonary. Failure to provide this information constitutes a breach and I remain responsible for all relevant medical charges. It is my responsibility to see that benefits are paid.

I authorize Ventura Pulmonary to furnish to my medical insurance carrier(s) any medical information necessary to process my claim.

I irrevocably assign to the physician/Ventura pulmonary payment for all medical services and unpaid balances. I authorize copies of this authorization to be used in lieu of the original.

If my account is referred to an attorney or collection agency, I agree to pay all reasonable fees and collection expenses. This authorization remains in effect until revoked by me in writing.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received the Notice of Privacy Practices. This document explains the policies of Ventura Pulmonary and Critical Care Medical Group Pertaining to the use and disclosure of medical information.

_____

Print Name

_____ _____

Signature Date