Klamath Pulmonary & Critical Care Medicine ~ Klamath Sleep Medicine Center
David Panossian, M.D., P.C., FACP, FCCP, DABSM
Linda Tesman PA-C
2614 Almond Street, Klamath Falls, Oregon 97601
(541)-885-2201. FAX (541) 883-1400

Patient Information:

Name: _____ Date of Birth: _____/_____/_____ Sex: (M/F)_____

Address: _____ Soc. Sec. # _____-_____-_____ Marital Status: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (_____)_____Work Phone: (_____)_____ Occupation: _____

e-mail Address: _____ Spouse's Name: _____

Emergency Contact: _____ Relationship to patient: _____

Emergency Contact Phone: (_____)_____ Primary Care Doctor: _____

Referring Doctor: _____

Primary Insurance: _____ Insured Party's Name: _____

Address: _____ Phone #: (_____)_____ Group#: _____

ID & SSN #: _____ Insured's DOB: _____

Secondary Insurance: _____ Insured Party's Name:_____

Address: _____ Phone #: (_____)_____ Group#: _____

ID & SSN #: _____Insured's DOB: _____

Consent for Treatment / Care:

By signing below I consent to treatment and care by David H. Panossian, MD, PC and their physicians and health care providers involved in my care to administer and or order diagnostic procedures and treatment as they may consider advisable to maintain my health and to assess, evaluate, and treat my illness.

By signing below I also understand I have a choice when referred to a facility for diagnostic testing or health care treatment where to receive those tests or treatment and it may be at a facility other than the one recommended by the health care provider.

Patient's Signature _____ Date _____

MEDICAL RECORDS RELEASE:
I hereby authorize my medical records to be released to another physician or myself if necessary. I consent to release my medical information during the next 180 days from the date of signing or for the period reasonably needed to complete my on going treatment.

_____ _____

DATE **PATIENT'S OR RESPONSIBLE PARTY SIGNATURE**

FINANCIAL AGREEMENT:

By signing below I acknowledge I have been given, have read, and agree to the terms and conditions of the Financial Policy.

_____ _____

DATE **PATIENT'S OR RESPONSIBLE PARTY SIGNATURE**

INSURANCE:
I request payment of authorized benefits be made on my behalf to **David Panossian, MD, PC**

I authorize any holder of medical information about me to be released to my insurance company needed to determine benefits for related services.

If payment is made directly to me from the insurance company I will either endorse the check and send to the doctor or write a personal check for said amount and send within five days of receipt of such a check.

I understand that I am also responsible for any balance not paid by the insurance company and this balance is subject to the financial agreement noted and signed above.

_____ _____

DATE **PATIENT'S OR RESPONSIBLE PARTY SIGNATURE**

MEDICARE INSURED:
In order to submit a claim for payment to us for services covered under your policy, we must have your authorization to release medical information to your insurance carrier.

I request that payment of Medicare benefits be made to **David Panossian, MD, PC** for any services provided for this office.

I authorize any holder of medical information about me to be released to the health care financing administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

_____ _____

DATE **PATIENT'S OR RESPONSIBLE PARTY SIGNATURE**