Klamath Pulmonary & Critical Care Medicine
David Panossian, M.D., P.C., FACP, FCCP, DABSM
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: _____

Protected Health Information Release:

Can confidential messages (ie. Appointment reminders) be left on your home answering machine or voice mail?
YES _____ NO _____

If you do not have voice mail, can a confidential message be left at your place of employment?
YES _____ NO _____

Please print the telephone number, if any, where you want to receive calls about your appointments, lab and x-ray results, or other health care information if other than your home phone number.

(_____)_____

Patient's Signature _____ Date _____

(NOTE;PLEASE TURN FORM OVER TO COMPLETE)

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 any request.

_____ _____

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

FINANCIAL AGREEMENT:
My balance or the balance of the bill that is not paid by my insurance will be paid within 60 days of the billing for that balance. Balances outstanding over 60 days are considered delinquent and are subject to being sent to a collection agency. Payment arrangements need to be set up in advance with the billing manager and scheduled monthly amounts must be received on time to maintain a current account.
I understand and will comply with this agreement.

_____ _____

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

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

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**, 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**