Midwest Respiratory, Ltd.

Pulmonary Diseases, Critical Care Medicine, Internal Medicine, and Sleep Medicine

2012 Patient Registration Update

Name: _____ Birthdate: _____

Age: _____ Gender: M / F Social Security Number: _____-_____-_____

Address: _____ City: _____ Zip: _____

Home Phone: ( ) _____ Cell Phone: ( ) _____

Work Phone: ( ) _____ Employer: _____

Race: _____ Preferred Language: _____ *(now required by most insurances)*

Spouse's Name: _____ Birthdate: _____ SSN (if guarantor): _____-_____-_____

Primary/Referring Physician: _____

Emergency Contacts:

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

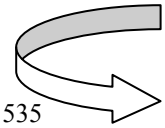
Pharmacy Name & Location:

_____

_____

I hereby give my consent for medical treatment rendered to me by the physicians and associates at Midwest Respiratory, Ltd. I hereby authorize the release of medical information to parties involved in my treatment, payment, or healthcare operations. I am aware of the new "HIPAA" guidelines and have read, "The notice of privacy practices" given to me by Midwest Respiratory, Ltd., and associates. I may have a copy if I so request. I hereby assign Midwest Respiratory, Ltd., and associates all payments for medical services rendered unless paid for at the time of service. I am responsible for all charges not covered by my insurance company. I am responsible for all co-pays due at time of service rendered.

☒ PLEASE SIGN: _____ Date: _____



Midwest Respiratory, Ltd.

903 129th Infantry Drive, Suite 400
Joliet, Illinois 60435
Phone: 815-725-2653 Fax: 815-744-3232

1890 Silver Cross Boulevard, Suite 535
New Lenox, IL 60451
Phone: 815-740-1301 Fax: 815-723-6778

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2012 Personal Health Information Disclosure Update

I authorize Midwest Respiratory, Ltd. and Associates to disclose my medical information pertaining to my diagnosis and/or treatment, lab results, medical history, or any other such related information to those listed below:

NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP
NAME	RELATIONSHIP

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize the release of this information to other health care providers associated with my care to facilitate further health care treatment. I further understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of my medical information.

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Please read each policy and ***sign the bottom*** to accept the terms and conditions and to agree to abide by them.

1. Consent for Treatment:
   a. I hereby authorize and acknowledge to work with Midwest Respiratory, Ltd. to administer such medications and treatments as may be deemed necessary for the interest and care of me/the patient described on this form.

2. Pre-Authorization for Benefits:
   a. I hereby acknowledge that I am required to call my insurance company to verify my benefits and insurance coverage for services rendered.

3. Payment Guarantee:
   a. Full payment is due at time of each appointment, unless managed care insurance covers authorized services.
   b. Co-payments are due in full at time of each visit.
   c. Checks written and returned will be charged an additional $35.00.
   d. If you do not have insurance, payment is due in full at each visit.
   e. Responsibility of an account balance is that of the patient and NOT the insurance company.

4. 24-Hour Cancellation:
   a. Appointments must be cancelled 24-hours in advance; otherwise the patient will be responsible for the minimum charge of $30 for the reserved time. Insurance Companies do not cover this fee.
   b. Please do not rely upon our phone confirmations to remind you of your appointment, it is a courtesy.

5. Release of Insurance-Related Information:
   a. I authorize insurance payment(s) to be made directly to providers of Midwest Respiratory, Ltd.
   b. I authorize Midwest Respiratory, Ltd. to release any information about me to insurance carriers needed to process claims.

6. Medical Records Charge:
   a. We take the time and consideration to ensure your records are kept confidential. There is a standard processing fee for any medical records that are released. Also, all patient responsibility balances must be paid in full before any medical records are released.

7. Completion of Forms/Letters:
   a. The charge for the completion of forms/letters typically can range between $30-$150 depending upon the length of the letter/documentation.
   b. Completion of forms/letters can take a couple of days to fill out so please allow a sufficient amount of time when dropping them off.

I, the patient signed below, acknowledge and agree to the information provided above by Midwest Respiratory, Ltd. and understand each of the aforementioned documents.

☒ PATIENT SIGNATURE: _____

Date: _____

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