



The Institute for Respiratory and Sleep Medicine

PATIENT INFORMATION

Date: ____/____/____

Name: _____ Date of birth: ____/____/____

☐ Male ☐ Female Marital Status: _____ Social Security #: _____

Address: _____ City: _____ State: ____ Zip code: _____

Home phone (____) _____ Cell phone (____) _____ Work phone (____) _____

Employer: **SELF:** Part time/Full Time/Retired/Student **SPOUSE:** Part time/Full Time/Retired/Student

Employer name and address: _____

Emergency contact: _____ Relationship to patient: _____

Address: _____ Phone: (____) _____

Pharmacy name: _____ Phone: (____) _____

Primary care physician: _____

Name

Address

Phone

Referring physician: _____

Name

Address

Phone

Primary Health Insurance

Effective date (if known) : ____/____/____

Insurance name: _____ Policy # _____ Group # _____

Address: _____ Phone: (____) _____

Policy holder information for primary health insurance Relationship to patient: _____

Name: _____ Date of birth: ____/____/____ Social Security #: _____

Address: _____ City: _____ State: ____ Zip code: _____

Home phone (____) _____ Cell phone (____) _____ Work phone (____) _____

Employer name and address: _____

Secondary Health Insurance

Effective date (if known) : ____/____/____

Insurance name: _____ Policy # _____ Group # _____

Address: _____ Phone: (____) _____

Policy holder information for secondary health insurance Relationship to patient: _____

Name: _____ Date of birth: ____/____/____ Social Security #: _____

Address: _____ City: _____ State: ____ Zip code: _____

Home phone (____) _____ Cell phone (____) _____ Work phone (____) _____

Employer name and address: _____

- I have completed this form, and I certify that I am the patient, or duly authorized general agent of the patient, authorized to furnish the information requested.
- I authorize any holder of medical or other information about me to release this information to any insurance company, its intermediaries or carriers or another physician's office
- I hereby authorize direct payment of medical benefits to include major medical benefits to which I am entitled, Medicare, Private Insurance, and any other health plan to Alliance Cancer Specialists, P.C.
- I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.
- I understand that, as these services were performed for me or my legal dependent, I am financially responsible for all personal balances.
- I realize that if the claim goes to collection, I am responsible for interest as well as collection fees.

Financial Charges:

A \$10.00 fee will be assessed if co-payment is not received at the time of service

A \$20.00 fee will be assessed for any bounced check or returned check

A \$75.00 fee will be assessed for any no-show appointments

A 30% collection fee will be assessed for any account that is sent to a collection agency

Signature

____/____/_____
Date

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