Lung Associates & Sleep Disorder Clinic, P.A.

M.P. Rampertaap, M.D.

Patient Consent Form

Our Privacy Practice notice provides information about how we may use and disclose protected health information about you. This notice contains a Patients' Rights section describing your rights under the law. The terms of our notice may change upon office discretion. You may obtain a revised copy by contacting our office.

You may request that we restrict how protected health information about you is used or shared. This information is used for treatment, payment and healthcare operation. You have the right to revoke this consent, in writing, signed by you. The form is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The patient has the right to change the Notice of Privacy Practices upon a written request.
- The patient has the right to restrict the use of their information but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all further disclosure will then cease.
- I understand that if I have no insurance or no out of network benefits, all office charges are to be paid at the time of service.

I authorize treatment rendered to me by Lung Associates & Sleep Disorders Clinic, P.A.

I authorize payment of medical services directly to Lung Associates & Sleep Disorder Clinic P.A.

Patients who have changed insurance, mailing address, or phone number need to make the office aware of the change at the time of service or sooner.

If this is not done, the entire insurance and account balance then becomes the patients responsibility.

I hereby give my consent to Lung Associates & Sleep Disorder Clinic, P.A., to release medical records to any requesting physician's office with appropriate signed medical records request.

I understand that if I decide to walk out of any scheduled appointment which includes any testing that I give all liability to Lung Associates & Sleep Disorder Clinic, P.A. I also understand that my insurance company will be billed for any uncompleted visits.

I understand that my copay will be collected at time of service. I also understand that my copay is subject to change based on the type of services rendered.

I understand that all current balances on my account are to be paid in full at time of service.

Please Be Aware that beginning April 15th, 2019, there will be a $50 charge for no-show appointments and/or for appointments that are not canceled within 24 hrs without prior approval that your insurance will not cover*

Patient Signature: _____ Date: _____

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