Lung Associates P.A.
Sleep Disorders Clinic P.A.
M.P Rampertaap, MD, FCCP
Board Certified: Internal Medicine, Critical Care Medicine,
Pulmonary Medicine, Sleep Medicine

ACCREDITED MEMBER CENTER

Patient Information / Please Print

First Name: _____ Last: _____ MI: ___ Age: _____

Address: _____ City: _____ ST: ___ Zip: _____

Home #: _____ Work/Cell #: _____ Marital Status: S M W D

Date of Birth (MM/DD/YYYY): ____/____/_____ Social Sec. #: _____

Email: _____

Spouse First name: _____ Last: _____ MI: ___

Work/Cell#: _____ Date of Birth (MM/DD/YYYY): ____/_____/_____

Emergency Contact Name: _____ Phone #: _____

Relationship: _____ Alternate Phone #: _____

If not Permanent Florida Resident, Enter Alternate Address:

Address: _____ City: _____ ST: ___ Zip: _____

Home #: _____ Work/Cell #: _____

Commercial Insurance/Medicare Supplement

Name: _____

Address: _____

Plan ID#: _____ Phone #: _____

1. I understand that if I have no insurance or I am a Canadian resident, all office charges are to be pad at the time of service.
2. I authorize treatment rendered to me by Lung Associates, P.A. Sleep Disorders Clinic
3. I authorize release of medical records services directly to Lung Associates Sleep Disorder Clinic
4. I authorize payment of medical services directly to Lung Associates Sleep Disorders Clinic.
5. Copies of charts will be done for a fee to attorneys and insurance companies. If the fee is denied by the requesting agency, this fee then becomes the responsibility of the patient if they still wish to have records released.
6. Patients who have changed insurance companies or their mailing address, need to make office aware of the change at the time of service or sooner. ***IF THIS IS NOT DONE, THE ENTIRE BALANCE THEN BECOMES THE PATIENTS RESPONSIBILITY.***

Signature: _____ Date: _____

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