SOUTH ATLANTA PULMONARY & CRITICAL CARE ASSOCIATES, L.L.C.
AND
CENTER FOR SLEEP MEDICINE

483 Upper Riverdale Road, Suite A • Riverdale, Georgia 30274
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PULMONARY DISEASES
SLEEP MEDICINE
PULMONARY REHAB

RAO S. MIKKILINENI, M.D., F.C.C.P., F.A.C.P.
Board Certified in Pulmonary Diseases
Board Certified in Sleep Medicine
Board Certified in Internal Medicine

Confidential Patient Information Sheet

Name: _____ **Age:** _____ **DOB:** _____
Sex:_____
Street:_____ **Apt/Unit:**_____
SS#_____
City: _____ **State:** _____
Zip: _____
Home Phone #: _____ **Work #:** _____
Pager/Cell #:_____
Emergency contact: _____
Phone #: _____
Referring Physician: _____
Primary Care Physician:_____

Employment information

Employer's Name:_____ **Occupation:**
_____
Employer's Address: _____ **City:** _____
State : _____
Employed: Full Time:_____ **Part Time:**_____ **Retired:**_____
Spouse's name: _____ **Work Tel#:** _____
Ext: _____
Spouse's Employer: _____ **City:** _____
State :_____
Employed: Full Time: _____ **Part Time:** _____ **Retired:** _____
*** Insurance Information- Please present all insurance cards and picture ID to Front Desk for Copying***
Primary Insurance: _____**Policy#:** _____
Group#:_____
Insured's Name: _____ **SS#:** _____
DOB: _____
(Policy Holder) Secondary Insurance:_____
Policy#:_____ **Group#:**_____
Insured's Name:_____ **SS#:** _____ **DOB:**
_____

I hereby undersigned authorize the physicians and staff of **South Atlanta Pulmonary and Critical Care Associates L.L.C. and Center for Sleep**

Medicine to provide medical care for the above named patient. I hereby authorize **South Atlanta Pulmonary and Critical Care Associates L.L.C. and Center for Sleep Medicine** to release any information in my examination or treatment to any insurance, government agency providing benefits or other policies to process any claims on my behalf for payment.

I hereby with signature assign and authorize my insurance carrier(s) to make payment directly to **South Atlanta Pulmonary and Critical Care Associates L. L.C. and Center for Sleep Medicine** for all service rendered. I hereby with my signature understand that I will be charged an additional fee of **$30.00** for any check or draft dishonored by any financial institution. In the event of collections placement of my account, I understand that I will be charged a placement fee of **$25.00** in addition to the balance subject to collection. I hereby with my signature understand that I am ultimately responsible for payment in full of all **co-payments and or deductibles.** all non-covered services and supplies obtained during the course of my medical care.

_____

_____

Signature Date

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize South Atlanta Pulmonary and Critical Care Associates, L.L.C., and Center for Sleep Medicine to use and/or disclose certain protected health information(PHI) about me to the party or parties listed below.

1) I give my permission for South Atlanta Pulmonary and Critical Care Associates L.L.C., and Center for Sleep Medicine to leave detailed messages on my answering machine.

Patient Signature:_____

Date_____

2) I give my permission for South Atlanta Pulmonary and Critical Care Associates L.L.C., and Center for Sleep Medicine to discuss my medical information with

my_____

Whose name is _____

Patient Signature:_____ **Date:**_____

3) I give my permission for South Atlanta Pulmonary and Critical Care Associates L.L.C ,and Center for Sleep Medicine to discuss my financial information with

my_____

Whose name is_____

Patient Signature_____

Date:_____

When my information is used or disclosed pursuant to this authorization, it may

be subject to re-disclosure by the recipient and may no longer be protected by the Federal HIPPA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that **South Atlanta Pulmonary and Critical Care Associates, L.L.C., and Center for Sleep Medicine** has acted in reliance upon this authorization. My written revocation must be submitted to **South Atlanta Pulmonary and Critical care Associates, L.L.C., and Center for Sleep Medicine** at **483 Upper Riverdale Road, Suite A, Riverdale , GA 30274 .**
Signed By:

_____

Signature of Patient or Legal Guardian Relationship to Patient

_____

Patient's Name Date

_____

Print Name of Parent or Legal Guardian