Tri-State
PULMONARY ASSOCIATES, INC.
Pulmonary and Critical Care Medicine
www.tspapulmonary.com

The Christ Hospital MOB
2123 Auburn Ave, Suite 401
Cincinnati, OH 45219
Ph: 513-241-5489 Fax: 513-241-5490

Patient Registration

Date of Visit: _____ Provider: (Circle) Scott Orabella Schmitt Weinstein Lanka Jivan Becca

Patient Legal Name: _____ Patient Preferred Name: _____

Date of Birth: _____ SSN: _____

Primary Phone: _____ Alternate Phone: _____

Home Street Address: _____

City: _____ State: _____ Zip: _____

Emergency Contact (please list at least one):

Emergency Contact:_____ Phone:_____ Relationship: _____

Emergency Contact:_____ Phone:_____ Relationship: _____

Emergency Contact:_____ Phone:_____ Relationship: _____

Insurance Information

Primary Insurance:_____ Member/Subscriber ID: _____

Group #:_____ Effective Date:_____ Patient's Relationship to Subscriber: _____

Subscriber Name:_____ Subscriber Sex:_____

Subscriber Date of Birth: _____ Subscriber SSN:_____

Subscriber Employer:_____

Secondary Insurance:_____ Member/Subscriber ID: _____

Group #:_____ Effective Date:_____ Patient's Relationship to Subscriber: _____

Subscriber Name:_____ Subscriber Sex:_____

Subscriber Date of Birth: _____ Subscriber SSN:_____

Subscriber Employer:_____

Authorizations

Authorizations: I hereby assign all medical/surgical benefits to which I am entitled, including Medicare, private insurance and any other plan to **Tri-State Pulmonary Associates, Inc.** The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original. I understand that I am responsible for co-insurance/deductibles not payable by insurance. I hereby authorize **Tri-State Pulmonary** to release information requested by my insurance company to secure payment. I authorize payment directly to Tri-State Pulmonary Associates. I further authorize Tri-State Pulmonary Associates, Inc. to render treatment and/or medical advice for myself and/or my dependent.

Notice of Privacy practices for Protect Health Information and Acknowledgement of Receipt of Notice: I acknowledge that I have received/declined a copy of Tri-State Pulmonary Associates, Inc. HIPAA Notice of Privacy Practices and understand that my protected health information may be used by the practice as stated in the notice.

I have read and understand the office policy statement above and agree to accept responsibility as described.

Patient Signature or Responsible Party: _____ Date: _____

Printed Name: _____