



# HOWARD COUNTY CENTER for LUNG AND SLEEP MEDICINE

## PATIENT REGISTRATION FORM

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_  Male  Female

Preferred Phone # (home/cell/work) \_\_\_\_\_ Other Phone # (home/cell/work) \_\_\_\_\_

E-Mail Address \_\_\_\_\_ (for appointment reminders and office contact)

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Preferred language \_\_\_\_\_

Employer \_\_\_\_\_ Address \_\_\_\_\_

Spouse or Parent's Name \_\_\_\_\_ Phone # (home/cell/work) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone # \_\_\_\_\_

Referring Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Pharmacy Name\* \_\_\_\_\_ Pharm. Address \_\_\_\_\_

**Primary Insurance Company** \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

*If not self:* Policyholder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Employer \_\_\_\_\_

**Secondary Insurance Company** \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

*If not self:* Policyholder \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Employer \_\_\_\_\_

On occasions when our office is unable to contact you, our staff may wish to leave you messages with personal health information. Healthcare information that we may possibly disclose on your home, work, or cell phone would include, but is not limited to: test/ lab results, prescription/ pharmacy information, appointment reminders, and instructions for appointments for office visits and procedures.

\_\_\_\_ (Initial) **YES**, I agree to allow Howard County Center for Lung & Sleep Medicine, LLC to leave messages and/or send letters that include Protected Healthcare Information on the following: (*Circle the allowed means of communication*)

Telephone: Home / Cell / Work      E-Mail      Home address

\_\_\_\_ (Initial) **NO**, I do not agree to allow Howard County Center for Lung & Sleep Medicine, LLC. to leave messages that include Protected Healthcare Information. If checking "NO" to this statement, a follow up appointment must be made to obtain your Protected Healthcare Information.

### Main Office

10910 Little Patuxent Pkwy  
Suite 100  
Columbia, MD 21044

Phone: 410 - 740 - 3635  
Fax: 410 - 740 -1253

### Diagnostic Sleep Lab

8600 Snowden River Parkway  
Suite 202  
Columbia, MD 21044

Please refer to the "Patient Policy" documents that contain our office policies, for which you have read and acknowledge:

- I have read and understand the **Patient Financial Responsibility Policy** of Howard County Center for Lung and Sleep Medicine, LLC (HCCLSM) and I agree to be bound by its terms. I agree to pay any finance charges incurred by failure to pay the balance due on my account in full within ninety (90) days of the bill date.
- I hereby assign any and all insurance benefits due and payable to me by any insurance policy to Howard County Center for Lung and Sleep Medicine, LLC for services rendered. I authorize any insurance company to pay benefits due directly to HCCLSM to release to my insurance carrier any medical records or other documents requested by the carrier which are deemed necessary by the carrier to process payments of the claim.
- I understand that I am financially responsible to pay HCCLSM for any and all fees incurred by the practice in collecting all outstanding debts sent to the collection agency or lawyer.
- I have read and understand Howard County Center for Lung and Sleep Medicine, LLC's **Appointment Scheduling Policy** and I agree to be bound by its terms. I have received a copy of my signed policy. I also understand that such terms may be amended periodically by the practice with notice.
- I hereby acknowledge that I have received a copy of Howard County Center for Lung and Sleep Medicine, LLC's **Notice of Privacy Practices** upon my request. I understand that my health information and records are confidential and will not be used or disclosed without my written authorization. I understand that I have the right to refuse to sign this acknowledgement if I so choose.
- I understand and have received a copy of the **Medication Refills and Medical Records policies**.

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Patient or Legal Representative**

\_\_\_\_\_  
**Guarantor's Signature**

\_\_\_\_\_  
**Printed Name of Patient's Representative (if applicable)**

**Relationship to Patient (if applicable)**

- Parent or guardian of un-emancipated minor
- Court appointed guardian
- Executor or administrator of decedent's estate
- Power of Attorney

\_\_\_\_\_  
**Witness**

## ADVANCE DIRECTIVES STATEMENT

This statement is provided by Howard County Center for Lung and Sleep Medicine, LLC, in accordance with a federal law called the Patient Self-Determination Act of 1990. This law requires that Howard County Center for Lung and Sleep Medicine, LLC, provide each patient with written information concerning our policies for implementing a patient's rights to make health care decisions and to formulate advance directives.

Howard County Center for Lung and Sleep Medicine, LLC respects the right of each adult to participate in health care decision-making to the maximum extent of his or her ability, and respects the right consistent with the requirements of the laws of Maryland. To this end, Howard County Center for Lung and Sleep Medicine, LLC has instituted specific policies and procedures to ensure that a patient's wishes with respect to his or her individual health care decisions are respected.

To ensure your ability to participate in your care, the Howard County Center for Lung and Sleep Medicine, LLC policy requires that we:

1. Comply with the applicable Maryland laws, including statutes and court decisions regarding your right to make health care decisions and to formulate advance directives.
2. Provide you with written information to inform you that you have the right under Maryland law to accept or refuse medical or surgical care or treatment and to formulate advance directives.
3. Document in your medical record whether you have executed an advance directive.
4. Make you aware that Howard County Center for Lung and Sleep Medicine, LLC shall not condition the provision of your care or otherwise discriminate against you in any way based upon whether or not you have executed an advance directive.

Separate forms for both a durable power of attorney for health care decisions and a living will that are recognized as valid under Maryland law are available. If you wish to obtain copies of these forms you may contact:

Library and Information Services Division  
Department of Legislative Reference  
90 State Circle  
Annapolis, MD 21401  
Baltimore/Annapolis: 410-841-3810/3886  
Washington, DC: 301-858-3810/3886  
All other areas: 1-800-492-7122, ext. 3810/3886

This form has been discussed with me and received by me. I have also received an information packet explaining advance directives.

\_\_\_\_\_ At present, I do not have an Advance Directive.

\_\_\_\_\_ At present, I do have an Advance Directive, and I will forward a copy to Howard County Center for Lung and Sleep Medicine, LLC to be placed with my record.

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**Patient Signature Date**

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**Responsible Party Relationship Date**