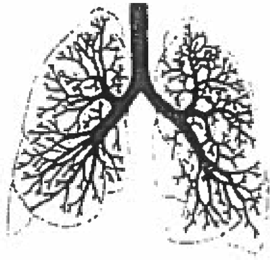
Co-pays are due at the time service is provided. If you can't pay your co-pay/co-insurance amount, please let the receptionist know and we can reschedule your appointment.

Thank you!

Parent's Initials: ________



CHILDRENS LUNG SPECIALISTS, LTD.

A Professional Medical Corporation

ACKNOWLEDGEMENT AND AUTHORITY

All professional services rendered are charged to the patient. Necessary forms will be completed and signed by the patient to expedite insurance carrier payments. The patient is responsible for all fees, regardless of insurance coverage. It is customary to pay for services as they are rendered, unless other arrangements have been made in advance.

Childrens Lung Specialists, Ltd. cares for ill children. If you are unable to keep your appointment, please have the courtesy of calling and canceling. By doing this we will have the opportunity to fit in another person's ill child. You understand that you are financially liable for a **$50.00** non-cancellation fee if your appointment is not cancelled 12 hours prior to the scheduled time.

Should this account become delinquent, you understand that you are responsible for any and all legal fees, court costs and collection charges involved as a result of any collection activity, plus interest at two percent above prime rate.

The undersigned authorized the release of any medical or related information to process my insurance claim.

Patient Name:______________________________ DOB_____________

______________________________________ _______________
Signature of Patient, Agent, or Parent (if minor) Date

I authorize payment of my insurance benefits to Childrens Lung Specialists, Ltd.

______________________________________ _______________
Signature of Patient, Agent, or Parent (if minor) Date

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ______________________, understand that as part of my/minor child's health care, Childrens Lung Specialists originates and maintains paper and/or electronic records describing my/minor child's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my/minor child's care and treatment
- A means of communication among the many health professionals who contribute to my/minor child's care
- A source of information for applying my/minor child's diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a ***Notice of Privacy Policies*** brochure that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Childrens Lung Specialists is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me/minor child as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Childrens Lung Specialists reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Childrens Lung Specialists change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept / decline the terms of this consent.

______________________________ ______________________________

Patient's Signature Date

CHILDS NAME ________________________ DOB: ____________

FOR OFFICE USE ONLY

[ ] Consent received by ____________________________ on ____________________.

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to the patient's medical record on ______________________.

CLS Policy of Billing Insurance

We, at CLS, are providers of MOST insurance plans. If you wish for us to bill your insurance carrier for your office charges, then our office policy is for you to provide us with the insured's SOCIAL SECURITY NUMBER and DATE OF BIRTH. If you do not want to provide this information to us, you have the option to pay cash for the total charges and bill the insurance carrier yourself (we will provide a copy of the total charges if you choose this option). However, if you choose not to provide this information to us and opt to bill your insurance company to get reimbursed yourself, we will not discount the charges with a contractual discount and we will not send a claim to your insurance carrier at any time. You will be expected to pay the total charges IN FULL at the time of service.

Parent / Guardian or Patient's Initials: ______________

Date: ___________________

A Professional Medical Corporation

Our spirometries (PFT's) are billed the next day after the visit due to the interpretation being done next day by Dr. Nakamura. Your insurance may access a separate co pay for these services. We do not determine your benefits with your insurance company. If you get a bill after your visit for a co pay for these services, please do not contact our office asking why. You need to contact your carrier.

thank you

Date_______________

initials_________________

3820 Meadows Lane • Las Vegas, Nevada 89107 • (702) 598-4411 • Fax (702) 598-1988