Long Island Pulmonary and Sleep Medicine Associates PLLC

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| **ACKOWLEDGEMENTOF RECEIPT OF**  **LONG ISLAND PULMONARY AND SLEEP MEDICINE ASSOCIATES, PLLC**  I acknowledge that I have received a copy of Long Island Pulmonary and Sleep Medicine Associates, PLLC& Louis Saffran Physician PLLC Notice of Privacy Practices.  Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **PATIENT CONSENT**  I hereby give **Long Island Pulmonary and Sleep Medicine Associates, PLLC & Louis Saffran Physician PLLC** its physicians and staff, my consent to release my protected health information as needed in connection with my care and treatment.  I understand that under HIPAA regulations my consent is not necessary for **Long Island Pulmonary and Sleep Medicine Associates, PLLC & Louis Saffran Physician PLLC** its physicians and staff, to release my protected health information for purposes related to my treatment, payment for my treatment, and healthcare operations.  Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **MEDICAL CLAIMS INSURANCE**  **UNDERSTANDING AND CONSENT**  **I understand and agree to the following:**  Should the physician participate with my medical insurance carrier, I am responsible for any and all co-payments, co-insurance, and deductible amounts. I am responsible for all charges incurred should I fail to obtain any necessary referral/ authorization as required by my insurance carrier.  Should the physician not participate with my medical insurance carrier, I am responsible for full payment of all charges incurred.  I consent to the release of any of my protected health information necessary to process medical claims for professional services rendered to me.  Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **MEDICARE ASSIGNMENT OF BENEFITS**  I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Long Island Pulmonary and Sleep Medicine Associates, PLLC&/or Louis Saffran Physician PLLC** for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.  Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Printed Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |