ONeal Medical - CPAP Plus

New Patient Form

Fax to 205-989-9903

1. PATIENT INFORMATION

Acct #

Patient name: _____ Date of Birth: _____ Social Sec #_____

Home phone: _____ CELL# _____ Email address: _____

Service address (where equipment is used): _____

City: _____ St:_____ Zip:_____

Billing address (if different from above): _____

City: _____ St:_____ Zip:_____

Next of kin: _____Relationship: _____ Alternate phone: _____

2. PAYMENT INFORMATION

Primary Insurance:_____ Policy #_____ Effective date of this policy:

Insured Name: _____ Deductible amount: _____

Secondary Ins:_____ Policy #_____ Effective date of this policy:

Insured Name: _____ Deductible amount: _____

Payment for CoPay & Deductible: ☐ Visa ☐ MasterCard ☐ Discover ☐ ***AUTO-PAY***

*Card number*_____ *Exp Date* _____/_____

CV2 code _____ *Billing Zip* _____ *Name on card* _____

☐ Check by phone - routing #_____ acct# _____

Routing # first 9 numbers printed on bottom of check. Account # (usually 10-12 digits) second set of numbers

office use only

_____
amount paid

_____
processed by / date

3. CPAP / BIPAP INFORMATION - if applicable

Where did you have your sleep study?_____

Who is the doctor treating you for sleep apnea now?_____

Who was the company that provided your machine?_____

Make and model of your current machine:_____

What mask do you currently use?_____ Size _____

4. AUTHORIZATION AND RELEASE

I authorize 02 Neal Medical, Inc. d/b/a "ONeal Medical" or "CPAP Plus", to receive copies of all of my medical records, including, but not limited to progress notes, operative notes, laboratory results, sleep studies, prescriptions, and diagnostic tests. Disclosure of personal health information will be handled as outlined in 02 Neal Medical, Inc.'s Current Notice of Privacy Practices. A photographic copy of this authorization shall be as valid as the original. This authorization is valid until cancelled in writing by either party. This release shall be valid while services are being rendered from 02 Neal Medical, Inc., unless cancelled in writing. I further elect to choose 02 Neal Medical, Inc., as my provider effective the date of this notice and authorize and direct any previous supplier, to release all documents to 02 Neal Medical, Inc. relating to my prior service.

X_____ _____

Patient's Signature — Date

_____ _____

If Patient is unable to sign, Personal Representative Signature — Date