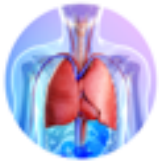
Asthma & Respiratory Center of South Dayton, Inc.
445 Byers Rd., Miamisburg, Ohio 45342



PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____
DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____ RACE: _____
SOCIAL SECURITY #:_____ ETHNICITY: _____
ADDRESS 1: _____ ADDRESS 2: _____
CITY: _____ STATE:_____ ZIP: _____
LANGUAGE: _____ LANGUAGE COUNTRY:_____
MARITAL STATUS: ___SINGLE ___MARRIED ___PARTNER ___DIVORCED ___WIDOWED
___PREGNANT (check if applicable) ___NURSING (check if applicable)
Whom may we thank for referring you to our practice?

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT:____
CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____
CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____
RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

FAMILY MEMBERS IN THE PRACTICE

_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____
PHARMACY LOCATION: _____

By signing below, I attest that the information provided above is true and accurate:

Signature of Insured / Guardian: _____ Date: _____

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PATIENT REGISTRATION

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by the Asthma & Respiratory Center of South Dayton in order to carry out treatment, payment, or health care operations. You should review the Practice s Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manners:

	PLEASE INITIAL
VIA MAIL	
_____OK TO MAIL TO HOME ADDRESS	_____
-OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	
_____OK TO LEAVE DETAILED MESSAGE	_____
_____LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	
_____OK TO LEAVE DETAILED MESSAGE	_____
_____LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	
_____OK TO FAX TO: _____	_____

If we contact you and you are NOT available, may we leave information such as appointment confirmation, negative test results, surgery information and/or billing matters with another person?

_____YES _____NO

If yes, please list authorized person(s) name(s) here:

_____ _____ _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____

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NOTICE OF ATTENDANCE POLICY

ATTENDANCE POLICY

Our staff will provide you with appointment cards, which will indicate the day, date and time for each appointment.

We will attempt to notify you of your scheduled appointment by phone but this is a courtesy call and is not required by our office.

We will do our best to schedule your appointments for the days and times that are most convenient for you.

Please understand that we do not accept walk-in patients. All of our appointments are scheduled.

This policy is to ensure that we can schedule new patients in a timely manner, along with offering our current patients convenient and timely appointments.

CANCELLATIONS

We understand that occasionally difficulties arise which may prevent you from keeping a scheduled appointment.

You will be charged a fee of $50.00 for each appointment not cancelled within 24 hours of your scheduled appointment. This fee is not billable to your insurance company and is your responsibility.

If you miss more than (3) three appointments, you will be dismissed from the practice.

LATE ARRIVALS

We will make every effort to see you at your scheduled time. In case of an emergency at the hospital or office we will offer you the option to wait to see the physician or to reschedule your appointment.

If you are more than (15) fifteen minutes late for your appointment you may be asked to reschedule.

I acknowledge being informed about the Asthma & Respiratory Center of South Dayton, Inc. Attendance Policy.

_____	_____	_____
Print Patient Name	Patient Signature	Date