Richard M Snow, MD
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Tuscaloosa, Al. 35401
Phone 205 349-4043 Fax 205 758-5132

SSC
Snow Sleep Center, P.C.

Patient Name (last, first, middle)	**Date of Birth**	**Social Security #**	**Home Phone** ( )
Home Address			**Cell Phone** ( )
City / **State** / **Zip Code**			**Work Phone** ( )
Patient's Employer	**Occupation (Indicate if Student)**		**Alternant Phone** ( )
Marital Status S M D W / **Sex** M F / **Age** / **Race** / **Disabled** Yes No / **Retired** Yes No			**E-Mail Address**
Spouse's Name	**Spouse's Employer**		**Spouse's Work Phone** ( )
			Spouse's Cell Phone ( )
Next of Kin (Not living with you)	.....		**Phone** ( )
Friend (Not living with you)	.....		**Phone** ( )
Whom may we contact in case of an emergency?	.....		**Phone** ( )

Whom may we thank for referring you?	**Person responsible for payment**		**Relation to patient**
	Date of birth	**Social security #**	**Employer**
Who is your Primary Care Physician?			
	Address		**Home Phone** ( )
Preferred Pharmacy / **Phone** ( )	**City** / **State** / **Zip code**		**Work Phone** ( )

Primary Insurance Provider	**Effective Date**	**Secondary Insurance Provider**	**Effective Date**
Contract Number	**Group Number**	**Contract Number**	**Group Number**
Name of Insured (as it appears on card)		**Name of Insured (as it appears on card)**	

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. Should collection become necessary, I agree to pay all cost of collection including a reasonable attorney's fee and do hereby waive all rights to claim personal property exempt under the laws and constitution of the state of Alabama. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status of the above information.

SIGNATURE_____**DATE**_____

Signature of PARENT or GUARDIAN (if patient is a minor)_____**DATE**_____

AGREEMENT TO PAY

The Patient and/or Responsible Party agree to pay all amounts of the charges submitted by Snow Sleep Center, P.C. (referred to as SSC) for services rendered by its physicians who are now employed or become employed by SSC in the future, by any of its employees, or by any contractors who are obligated to accept payment solely from a third-party. The Patient and/or Responsible Party understand and agree that they are financially responsible to SSC even though there may be insurance or third-party coverage. The Patient and/or Responsible Party agree that failure to make payment when requested is the basis for legal action, and agree to pay all costs of collections, including a reasonable attorney's fee. The Patient and/or Responsible Party acknowledge their understanding that payment is due in full upon receipt of the statement. The Patient and/or Responsible Party agree that their obligations to make payments are joint and severable and the SSC may pursue both parties for payment. The Patient and/or Responsible Party agree that they, not any insurance company, are solely responsible for the entire bill, even though the cost of the medical care may exceed the amount reimbursed by the third-party insurers of the payers.

RESPONSIBILITY FOR NON-COVERED SERVICES

SSC and/or its physicians may determine that there are certain routine services that are necessary for the maintenance of good health and standard medical care that are not covered by your insurance company. Charges not covered may include charges rejected as not medically necessary, denied as non-covered services, and/or any annual deductibles or copays. The Patient and/or Responsible Party agree to be fully responsible for charges by SSC for such non-covered services in the amounts set forth on the fee schedule. SSC's physicians will order only tests that are deemed necessary in the physicians' opinions. Any questions regarding if your carrier covers a certain service should be discussed directly with your insurance carrier. The Patient and/or Responsible Party acknowledge their understanding of this non-covered service policy of SSC.

AUTHORIZATIONS

The Patient and/or Responsible Party understand that the following authorizations are to be used by SSC to effect the collection of benefits on the patient's behalf. These authorizations become effective on the date of the first service rendered and remain in effect until specifically revoked in writing by the Patient and/or Responsible Party.

Release of Information: The Patient and/or Responsible Party authorize the release and disclosure of all medical information related to the patients' treatment and care to any entity which is, or may be liable, for Physicians and/or SSC charges, to any Professional Review Organization, or to any Utilization Review organization associated therewith. The Patient and/or Responsible Party authorize the release and disclosure of all or any part of the patients' records to any other health care provider who may be of assistance, in the opinion of SSC, in providing medical care and treatment for the Patient and/or assisting in any reimbursement of benefits that the patient may be entitled.

Assignment of Benefits: The Patient and/or Responsible Party authorize and request payment of any authorized insurance benefits to be made either to the patient or on the patients' behalf to SSC. This authorization allows SSC to file "assigned" claims only for the purpose of having benefits paid to SSC. This does not imply that SSC accepts insurance as payment in full, unless SSC has a contractual agreement with the patients' carrier or is otherwise obligated to accept less than the actual charges. The signature(s) below are deemed sufficient for all insurance forms on a continuing basis. The Patient and/or Responsible Party requests that all insurance benefits, including Medicare, be made on my behalf to SSC for any services furnished to me. The Patient and/or Responsible Party authorizes any holder of medical information about me to release such information as is necessary to determine the amount of available benefits for services rendered and to pay the claim(s). This assignment of my benefits shall continue until I cancel it in writing.

For Treatment: The patient and/or Responsible Party authorize SSC and/or any of the physicians to perform any procedure that may be deemed necessary in the judgment of the attending physician in the diagnosis and treatment of the patients' condition. The Patient and/or Responsible Party consent to the administration of such drug(s) as may be considered necessary or advisable for treatment of the patient, with the exception of the following:

DATE

PATIENT AND/OR RESPONSIBLE PARTY

SSC

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Accredited by the American Academy of Sleep Medicine since 1991

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE SLEEP
MEMBER CENTER

DCH MEDICAL TOWER I
701 UNIVERSITY BLVD., EAST
SUITE 707
TUSCALOOSA, ALABAMA 35401
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FAX (205) 758-5132

RICHARD M. SNOW, M.D., F.C.C.P., A.C.P.
BOARD CERTIFIED IN INTERNAL MEDICINE,
PULMONARY MEDICINE & SLEEP MEDICINE

Snow Sleep Center, P.C. has implemented a policy requiring a credit or debit card be held on secure file for each patient, effective February 15, 2017.

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is stored and later used to pay your bill. **Physicians extend more credit than any business except banks,** who charge interest and fees to do so.

As you may be aware, the current healthcare market has resulted in much higher deductibles, coinsurances, and co-pays not known at the time of service. We will file your claim with your insurance and any balance on your account unpaid by your insurance, will be charged to your card 60 days from the date of service.

If you do not have a credit or debit card you will be required to pay for services in full, prior to being seen.

This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. You are also encouraged to call your insurance sompany to confirm your benefits before your visit.

Any amounts credited to your account will be refunded to your card immediately.

It is the patient's responsibility to make sure the card on file with our office is current and up to date. Unpaid accounts will be turned over to our third party collection service with an added 28% collection fee.

_____ _____

Patient/Responsible Party Signature Date

APPOINTMENT REMINDER CONSENT FORM

Please complete the information below if you would like to receive appointment reminders by text to your cell phone or by email. We will send you an appointment reminder prior to your appointment date.

Patient Name (please print):_____

Date of Birth: _____

Parent / Guardian (if patient is a minor under 18): _____

- My email I authorize to be used for appointment reminders is:

_____@_____

- My cell phone number I authorize to receive text reminders is:

(_____)_____-_____

I am aware that my cell service provider may charge me additional fees if I do not have a text messaging feature on my phone plan.

CELL PHONE SERVICE PROVIDER (please circle one):

AT&T VERIZON T-MOBILE NEXTEL SPRINT PCS US CELLULAR ALLTEL Other:_____

I (the Patient or Guardian) consent to receive appointment reminder emails and/or text messages to my cell phone from Snow Sleep Center. I understand this request to receive messages will apply to all future appointment reminders unless I request a change in writing.

I (the Patient or Guardian) am aware that Snow Sleep Center will not respond to any text messages or emails that I might send in response. This service is provided to inform me of upcoming appointments. The text service and/or email service is not a method of further communication. If I have any questions, I will call Snow Sleep Center during regular business hours.

_____ _____

Signature of Patient or Guardian **Date**

It is the responsibility of the Patient, Parent, or Guardian to notify our office of any change in the email or cell phone number provided, or if you choose to stop any or all forms of appointment reminders.

FOR OFFICE USE ONLY

___ I hereby revoke my request to receive any future appointment reminders by email. **DATE:** _____

___ I hearby revoke my request to receive any future appointment reminders by text. **DATE:** _____

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MEMBER CENTER

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PULMONARY MEDICINE & SLEEP MEDICINE

EPWORTH SLEEPINESS SCALE

NAME: _____

TODAY'S DATE: _____

AGE (years) _____ **SEX**_____

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION*	CHANCE OF DOZING
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____

Thank you for your cooperation

SIGNATURE: _____