

**JOHN S. SUEN, M.D.  
MICHAEL TONNER, M.D.  
Patient Information**

**PLEASE COMPLETE ALL LINES**    **TODAY'S DATE:** \_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_

**NAME: MR/MS/MISS** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP:** \_\_\_\_\_

**HOME PHONE:** \_\_\_\_\_ **CELL:** \_\_\_\_\_

**WORK PHONE:** \_\_\_\_\_ **EMAIL:** \_\_\_\_\_

**HOW MAY WE CONTACT YOU?** \_\_\_\_\_ **EMAIL** \_\_\_\_\_ **HOME #** \_\_\_\_\_ **CELL** \_\_\_\_\_ **WORK**

**DATE OF BIRTH:** \_\_\_\_\_ **SOCIAL SEC. #** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**EMPLOYER & ADDRESS:** \_\_\_\_\_

**MARITAL STATUS: M S D W - NAME OF SPOUSE:** \_\_\_\_\_

**EMPLOYER & ADDRESS:** \_\_\_\_\_

**IN CASE OF EMERGENCY, PLEASE CONTACT:**

**NAME** \_\_\_\_\_ **PHONE:** \_\_\_\_\_

**INSURANCE INFORMATION: WE WILL NEED A COPY OF YOUR CARDS AND DRIVERS LICENSE.** IF THE SUBSCRIBER ON THE INSURANCE IS DIFFERENT, PLEASE LIST NAME, DATE OF BIRTH, SOCIAL SECURITY # AND BILLING ADDRESS (PARENT, SPOUSE OR LEGAL GUARDIAN)

**NAME:** \_\_\_\_\_

**D.O.B** \_\_\_\_\_ **SOCIAL SECURITY #** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**PHONE:** \_\_\_\_\_

**WILL YOU BE PAYING BY CASH** \_\_\_\_\_ **CHECK** \_\_\_\_\_ **CREDIT CARD** \_\_\_\_\_  
(WE ACCEPT MASTER CARD, VISA AND DISCOVER)

**ARE YOU ALLERGIC OR SENSITIVE TO ANY MEDICATIONS OR OTHER SUBSTANCES?**

**IF SO PLEASE LIST:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## **LIFETIME AUTHORIZATIONS**

### **PLEASE READ THIS CAREFULLY AND SIGN**

- 1) I authorize the release of any medical information necessary to process my claim. I also request payment of benefits either to myself or to the party who accepts assignment. I understand that even though I have insurance, I am responsible for any balance due.
- 2) Dr. Suen accepts assignment on all Medicare patients. I understand that I am responsible for being aware of and meeting any deductibles. I understand that the 20% co-payment not covered by Medicare, or any co-payment not covered by private insurance, is expected on the day services are rendered. In case of financial hardship or difficulty, a financial arrangement must be made prior to initiation of treatment.
- 3) Our office will file all the primary and secondary insurance claims for our patients. In most cases, we will receive payment from the insurance companies. However, in cases of the insurance company sending the payment to the patient, we expect the payment to be surrendered in it's entirety. We ask that the patient endorse the check and forward to our office upon receipt as payment for services rendered by Dr. Suen. By signing below you have indicated that you have read the aforementioned insurance disclosure and agree to comply with the policy set forth by our office.

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT,  
PAYMENT, OR HEALTHCARE OPERATIONS**

I hereby authorize the release or use of my individually identifiable health information (protected health information) and medical record information by John S. Suen, M.D. or Michael Tonner, M.D., (the Practice) in order to carry out treatment, payment, or healthcare 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.

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 health 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 acknowledge and agree that the Practice may disclose my protected health information and medical record information to the following individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf:

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I agree that the Practice may also disclose the following types of information contained in my medical record (please initial the appropriate categories listed below)

\_\_\_\_\_ HIV/AIDS Information  
\_\_\_\_\_ Mental Health Information  
\_\_\_\_\_ Substance Abuse Information  
\_\_\_\_\_ Sexually Transmitted Disease Information  
\_\_\_\_\_ If Patient is under the age of eighteen (18), Pregnancy Information

I have read and understand the information in this consent. I have received a copy of this consent and I am the patient or the authorized party to act on the behalf of the patient to sign this document verifying consent to the above terms.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
Patient or Authorized Representative

**Print:** \_\_\_\_\_

**John S. Suen, M.D.**  
**Michael Tonner, M.D.**

**Acknowledgement Form**

Our Notice of Privacy Practices provides information about how we may use and release protected health information about you. You have the right to review our Notice before signing this form. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy by writing our Practice or requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and release of protected health information about you for treatment, payment and health care operations as described in our Notice. You have the right to revoke this consent, in writing, except where we have already made releases in reliance on your prior consent.

**Patient Name:**

**Print**

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**Signature**

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**Date:**

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**Witness:**

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## **PRESCRIPTION DRUG POLICY**

**The law requires responsible usage of prescription drugs by physicians and patients. If you accept a prescription from one of our physicians, you are also accepting the responsibility to use the drug for yourself and only as prescribed. Our responsibility is to prescribe medications in an appropriate dosage and amount, with clear instructions. We will also inform you of the reasons we are prescribing the drug, the expected benefits from its use, and the major precautions and side effects.**

**Prescription drugs have potential for abuse and are regulated closely by state and federal agencies. Certain, more closely controlled drugs (narcotic pain medications and tranquilizers) require even more responsibility on your part. We will accept NO excuses for their loss, theft and will not order replacement. We expect you to notify our office if you change drug stores so that the order at the first store may be cancelled.**

**Many prescription drugs are appropriate for short-term use only. If and when we feel it is not in your best interest to continue on a medication, we will tell you. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the correct course of action.**

**Our office also requires a 24-48 hour call-in policy for the refill of your prescriptions. When your medications are getting low and you feel you will need a refill, please call our office with the name of your pharmacy and pharmacy phone number 24-48 hours prior so that we will have ample time to ask your treating physician and then call your medication in to your pharmacy. Please do not call the office again until we have been given the 24-48 hour time frame. Prescriptions will NOT be refilled after 12:00pm (noon) on Friday or on weekends.**

**Failure to follow these policies will force our office to terminate our professional relationship and may require us to file a report with the Department of Professional Regulation (DPR).**

**If you are in agreement with all the information that has been provided above, please sign your acceptance to abide by these policies.**

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**Patient's Signature or Patient's Guardian**

**Date**

## **IN-NETWORK PAYMENT POLICIES**

### **PLEASE READ THE FOLLOWING PAYMENT POLICIES BEFORE YOUR APPOINTMENT**

**Our office files your insurance as a courtesy twice. After the second try, the responsibility is yours,**

**If your Doctor is an IN-NETWORK provider for your insurance,  
YOUR CO-PAY MUST BE PAID AT THE TIME OF SERVICE AND  
ALL DEDUCTIBLES ARE DUE AT THE TIME OF THE VISIT.**

**Please note – Each insurance policy is different. It is YOUR responsibility to know your policy. If pre-authorization is needed, then it is YOUR responsibility to notify our staff so we may obtain authorization. If authorization is not obtained, it is YOUR responsibility to pay for all charges incurred. Remember, your insurance policy is a contract between you and your insurance company. It is NOT a contract between you and our doctor.**

**I you have any questions or are not prepared to pay for your appointment, please notify one of our office staff prior to your appointment. If your are unable to pay for residual balances from previous dates of services, you may be asked to reschedule your appointment.**

**There is a \$25.00 charge for NSF checks.**

**WE DO NOT PARTICIPATE WITH ANY HMO PLANS.**

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**Signature**

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**Printed Name**

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**Date**

**Person your information can be communicated to:**

**Name:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Preferred Pharmacy:**

**Name:** \_\_\_\_\_

**Location:** \_\_\_\_\_

**Phone Number:** \_\_\_\_\_

**Any other pertinent information you want us to know:** \_\_\_\_\_

**This information will become part of your permanent medical record and will not be shared with anyone or adjusted unless we are given specific written instructions.**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Date**



# SLEEP DISORDERS CENTER FLORIDA

Accredited by the American Academy of Sleep Medicine

3735 11th Circle, Suite 103  
Vero Beach, FL 32960  
(772) 563-2910  
Fax (772) 316-0805  
www.sleepdisordersflorida.com

John Suen, M.D.  
Diplomate American Board of Sleep Medicine

150 SW Chamber Court, Suite 203  
Port St. Lucie, FL 34986  
(772) 446-7116  
Fax (772) 446-7112  
Toll Free (866) 446-7022

## No Show/ No Call Policy

Your appointment is important to us and to your health. If you miss an appointment you may delay the treatment that you need. You may also have to wait longer than you would like for a new appointment date. We do not want to keep you waiting, but our health care providers are heavily booked and may not be able to reschedule you immediately.

If you must change your appointment, in consideration to others who are waiting to be seen here, please call us at least 24 hours in advance to cancel the appointment. You may leave a voice message. Failure to do so will result in a charge of \$25 for office visits and \$200 for sleep studies. This charge is not covered by insurance and is to be paid before another appointment can be scheduled.

We greatly appreciate your understanding and cooperation with this policy.

My signature below indicates that I have read and understand the above policy.

\_\_\_\_\_  
Patient –Print Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date