Pulmonary and Allergy Associates

Pulmonary Diseases, Critical Care Medicine, Allergy And Immunology, Sleep Disorders, Clinical Research

## PATIENT INFORMATION DATE: PAA PHYSICIAN:

Patient name: ___________________________________ Single _______ Married_______ Widow______

Home address: ____________________________________________________________________________

City, State, Zip: ___________________________________________ Home Phone (___) ________________

E Mail: ____________________________________ Cell Phone (___) ________________________

Date of Birth: ___________________________ Age: __________ SS # ____________________________

Occupation: _____________________________ Employer's Name: ______________________________

Employer's address: __________________________________ Phone: _______________________________

Emergency Contact: ___________________ Relation: ___________________ Phone: ___________________

## REFERRAL SOURCE

Patient referred by: Physician______ Friend______ Other______ Is this a second opinion? __________

Referring Physician: _____________________________________________________________________

Address: _____________________________________________________________________

Primary Care Physician: ____________________________________________________________________

Address: __________________________________________Phone: ____________________

## PRIMARY INSURANCE

Policyholder name: __________________________________________________ Managed Care? Yes or No

Policyholder relation to patient: __________________________SS #_________________DOB:__________

Insured Employer: _________________________________ Work Phone #: _______________________

Insurance Company: __________________________________ Phone: ____________________________

Insurance address: _____________________________________________________________________

ID Number: _________________________Group #_______________ Plan: ________________

## SECONDARY INSURANCE

Policyholder name: __________________________________ Managed Care? Yes or No

Policyholder relation to patient: ________________________SS #_________________DOB:__________

Insured Employer: ________________________________ Work Phone #: ________________________

Insurance Company: __________________________________ Phone: ____________________________

Insurance address: _____________________________________________________________________

ID Number: _________________________Group #_______________ Plan: ________________

## PHARMACY INFORMATION

Name ______________________________ PH: (___)________________FAX: (___)____________

Address___________________________________________________________________________

*January 2010*

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**NAME:**_______________________________________________**DATE:**_______________________

**Thank you for trusting us with your health care.**
**In order to provide you with the best of care, we ask that you take a few moments and fill out the information below.**

**What is your reason for today's visit?**______________________________________________________________________

**Have you had any of the following symptoms recently? (please circle all that apply)**

chest pain, chills, cough, fever, headaches, heartburn, hives, hoarseness, indigestion, nasal congestion, post nasal drip, rash, sinus pain, shortness of breath, sore throat, swelling in legs or ankles, vomiting, weight loss, wheezing

## MEDICAL HISTORY CURRENT OR PAST

**CARDIAC**
Atrial fibrillation
Angina
Arrythmia
Congestive heart failure
Heart Attack
Hypertension
Mitral Valve Prolapse
Other:__________

**GASTROINTESTINAL**
Acid Reflux
Anemia
Bleeding
Colitis
Cancer
Diverticulosis
Hiatal Hernia
Irritable Bowel
Ulcer
Other:_____________

**RESPIRATORY**
Asthma
Bronchiectaisis
Chronic Bronchitis
Collapsed lung
COPD
Cystic Fibrosis
Emphysema
Lung Cancer
Pneumonia
Pulmonary Fibrosis
Sarcoidosis
Sleep Apnea
Other:____________

**RHEUMATOLOGY**
Arthritis
Lupus
Osteoporosis
Rheumatoid Arthritis
Scleroderma

**NEUROLOGICAL/PSYCH**
Anxiety
Depression
Multiple Sclerosis
Neuropathy
Psychosis
Schizophrenia
Seizures
Stroke
TIA
Other:_____________

**ALLERGY/SINUS**
Eczema
Hives
Nasal polyps
Rash
Rhinitis/seasonal allergies
Sinusitus
Other:______________

**ENDOCRINE**
Cholesterol
Diabetes
Thyroid (over/under)
Other:______________

**URNINARY**
Bladder
Kidney failure
Kidney Stones
Enlarged Prostate
Urinary tract infection
Other:______________

**Gynecology**
Bleeding
Breast Cancer
Cervical Cancer
Hysterectomy
Other:_______________

**EYES**
Glaucoma
Cataracts
Other:______________

**Describe any serious illnesses or operations**___________________________________
______________________________________________________________________________
______________________________________________________________________________

**HEALTH HABITS**

Have you ever smoked cigarettes? Yes / No If yes, how old were you when you started?_______ Are you currently smoking? Yes / No If no, what age did you quit? _____ About how many packs/day on average did you smoke?_____

Do you drink? Yes No If yes, how many drinks per week?________

Do you exercise regularly occasionally not at all

What is your current occupation?__________________________________________________________________

Are you or have you been exposed to dust, fumes, solvents, asbestos or silica? Yes No

| FAMILY HISTORY | Alive | Deceased | Present state of health or cause of death |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Siblings | | | |

**Other significant family medical history**_____________________________________________________________
______________________________________________________________________________

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**NAME** ________________________________**Date**_______________

**Please fill out the information below and bring it with you on the day of your appointment.**
**THANK YOU.**

**ALLERGIES Check here if None** ☐

| DRUG/OR ALLERGEN | REACTION |
|---|---|
| | |
| | |
| | |
| | |

**CURRENT ASTHMA OR BREATHING MEDICATIONS if any (ex: inhalers)**

| MEDICATION | DOSAGE/FREQUENCY | DATE STARTED |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**OTHER CURRENT MEDICATIONS**

| MEDICATION | DOSAGE/FREQUENCY | DATE STARTED |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**PRIOR ASTHMA OR BREATHING MEDS LAST 6 MONTHS**

| MEDICATION | DOSAGE/FREQUENCY | DATE STARTED |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

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## INSURANCE/PAYMENT ISSUES

We are committed to providing you with the best possible service. If you have insurance, we will help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance in understanding our policies.

**You should be knowledgeable of your health insurance benefits.** Do not assume that we know what your benefits are. Your insurance contract is between you and the insurance company unless you have been advised by our staff that your Physician is a participant. If this is not the case, then we are not a part of your contract nor are we bound by its rules.

**Non-Covered Services:** All Services/Supplies deemed NOT COVERED as noted in your carrier coverage manual are the sole financial responsibility of the patient. These items include but are not limited to Supplies, Equipments, Bandages, Splints, and Braces. Any and all charges that are Above the Reasonable and Customary are also the sole responsibility of the patient.

**Payment/co-payment for services is due at the time services are rendered** unless payment arrangements have been negotiated with your insurance carrier. Upon payment we will help you process your insurance claim for your reimbursement.

**If your carrier requires a REFERRAL one must be presented at the time of service.** By law a patient may not be treated without a current, valid referral from your primary care physician, to authorize all services, including X-rays and Supplies. If your referral is not available, your appointment will be rescheduled.

**Laboratory Services.** You must notify us with the name of your insurance carrier's participating lab. If this is not available, you will be responsible for all lab fees.

**Precertifications and Preauthorizations.** You are responsible for confirming with our office any preauthorizations/ precertifications for procedures, tests, and studies. You must also alert us of any change in the date and time of said procedures.

**Patient Cancellations.** We require a 24 hour prior notification of appointment cancellation. If this is not achieved, we reserve the right to impose a cancellation fee for that visit.

## PATIENT AUTHORIZATIONS

**Claims Authorization-** I hereby authorize any treating physician to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to my health insurance carrier(s). I also authorize my insurance carrier(s) to disclose to a hospital or health care service plan, self insurer, or other insurer any medical information obtained if such disclosure is necessary to allow the processing of any claim. If my coverage is under a group contract held by my employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review of audit. This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of coverage with my insurer(s) including a reasonable time thereafter, until its final consummation. This authorization is binding upon me, my dependents, heirs, executors and administrators.

**Assignment of Benefits- Private and Federal (Medicare)** - I authorize payments of medical and surgical benefits, including Medical benefits, to be made either to me or on my behalf to this office for any services furnished by my physician(s) to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

**Litigation Disclaimer-** It is understood and agreed that I am requesting examination and treatment for medical purposes only, and not in connection with pending or proposed litigation. Should such litigation arise, it is further understood and agreed that the treating physician will not participate in any way in litigation except to provide a true and accurate copy of any medical record and X-ray in the possession and control of this office, pursuant to receipt of a properly notarized consent for medical information, requested by the patient or his/her legal guardian, and upon payment of the usual fee.

**Name**:______________________________**Signature**:____________________________**Date**:_________

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## Financial Policy

In order to maintain clear communication with our patients, the following statement of policy has been prepared, along with an accompanying explanation. Please read this information carefully, and sign where directed.

1. Every patient must present their current insurance ID card for each of their policies **at each visit**. We must be notified immediately of any change of coverage.
2. A valid referral for the specific service being provided must be obtained prior to your visit. If not done, we will provide you with the opportunity to speak with your primary care physician and obtain one immediately. If a valid referral is not obtained your appointment will be rescheduled.
3. All required **copays are collected during the check-in process**. Likewise, Medicare patients who do not have additional coverage are expected to pay their 20% co-insurance at the time of their check-out.
4. If we do not participate in your insurance plan, or you are uninsured, **full payment** for all professional services rendered is due **at the time of your visit**. If your plan allows you to go out-of-network, you will be responsible for your unmet deductible and out of network co-insurance at the time of service.
5. In the rare event that your delinquent account is sent to a collection agency, you agree to be **responsible for any collection costs incurred**, not to exceed 50**%**.
6. If any part of a patient's account is in bad debt or assigned to a collection agency, no future appointments will be scheduled until your balance is paid in full.
7. The time we have reserved for your visit is very valuable. Missed appointments seriously affect our doctors' ability to see all patients requiring care. Consequently, we impose a **$50** charge for missing a follow-up appointment, unless we receive cancellation notice at least **24 hours** prior to your allotted appointment time. The **ONLY** exception to this rule is verifiable medical emergency.
8. Patients who accumulate a total of 3 or more NO SHOWS/ SAME DAY CANCELLATIONS in a calendar year, will automatically be terminated from PAA as a patient.
9. If you have not seen PAA Physicians in over one (1) year **NO PRESCRIPTIONS WILL BE REFILLED UNTIL YOU ARE SEEN**.
10. A $25 administrative fee along with a $25 bank fee will be charged for any bank fee incurred by PAA on your behalf. This fee is **your** responsibility and will NOT be covered by insurance.
11. PAA charges the following rates for the completion of Forms: Disability Form - $10; Oxygen Form - $25; Child school, camp, sports, etc. Form - $10; Jury Duty Form - $10; Electric Company Form - $10. **We require a one week turn around period for these records.**
12. Please note when requesting a copy of your medical records (i.e. test results, lab work, etc.) there will be a fee of $1.00 per page up to $100. Any page thereafter is $0.25 up to $200. **We require a thirty day turn around period for these records**.

I have read and understand the above Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

| ______________________ | ______________________ | ________ |
|---|---|---|
| PRINT Patient Name | Patient, Parent or Guardian Signature | Date |

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# Protecting Your Privacy While Permitting Communication

The following will serve as a guideline to help safeguard the privacy of your medical information while allowing us to communicate necessary information to you on your behalf. Please review the following information as **we need your written permission** to follow these guidelines.

**Appointment Reminders:** I give my permission to PAA, its employees, and physicians to call my residence regarding scheduling of appointments and tests. If I am not available, information may be left with any adult family member who answers my home phone, answering machine, or voice-mail.

**Please check :** ☐ Yes **or** ☐ No

**Test Results:** I give my permission to PAA, its employees and physicians to call my residence to provide information regarding results of tests and/or information regarding my medications. If I am not available, information may be left with any adult family member who answers my home phone, answering machine, or voice mail.

**Please check :** ☐ Yes **or** ☐ No

**Contacting me at home**: (     ) _________-__________ (*home phone number*)

**Contacting me via E-mail**:____________________________________________(*e-mail address*)

**Reaching me at OTHER locations (Leaving Messages)**

I give my permission to PAA, its employees, and physicians to reach me at the following number(s):
**Work**: (     )_________________ **Cell**: (     )____________________**Other**: (     ) ____________________

I give permission for information to be given to someone who answers these numbers, voice-mail, or answering machine. The message will include a clearly identified employee of physicians name and call back number. Our policy is that **no specific medication information will be left with anyone other than yourself at any non-residential number.**

**Medical emergency or hospitalization:** If my doctors consider there to be a medical emergency that requires urgent attention or if I am hospitalized or incapacitated, I give permission for my doctors at their sole discretion to communicate with *any* immediate family member to discuss the nature and treatment of my medical condition. **Any specific immediate family member exclusions please list below:**

_____________________________ _____________________________

**Communication with others:**
**Other Healthcare Professionals:** I give permission to PAA, and its employees, and physicians to communicate by any means including the sharing of office records and test results, with any **healthcare professionals** involved in my treatment.

**Pharmacy:** I give my permission to PAA, its employees, and physicians to communicate by any means with my prescription plan or pharmacy in order to provide information regarding my medication.

**DESIGNATION OF RELATIVE AND / OR CAREGIVERS TO RECEIVE PRIVATE HEALTH INFORMATION:** I designate the person (s) listed below as individual (s) who are permitted to be involved with my health care provided by PAA. They have my permission to receive and / or discuss Private Health Information with a PAA Employee and/or Physician. I also understand that I may change this list at any time by submitting a written request to Pulmonary & Allergy Associates. **Print name(s) here:**

______________________________ ______________________________ ____________________________

*Print* Patient Name:__________________________Signature_________________________Date:____________

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# ACKNOWLEDGEMENT OF PRIVACY PRACTICE NOTICE AND DESIGNATION OF DISCLOSURE

## I. Acknowledgement of Privacy Practice Notice

I have received a copy of the Pulmonary & Allergy Associate's Notice of Privacy Practices.

Signature of Patient/Parent / Guardian Date

Print Patient's Name

☐ Check here if you do not wish voice messages to be left on your answering machine or voicemail.

## II. Designation of Relatives and / or Caregivers to Receive Private Health Information

I designate the person (s) listed below as individual (s) involved with my health Care and/or payment for services provided by PAA and they have my permission to Receive and/ or discuss Private Health Information with a PAA Health Care Provider. I also understand that I may change this list at any time by submitting a Written request to PAA.

Print Name:____________________________Date of Birth-Month/Date__________

Print Name:____________________________Date of Birth-Month/Date__________

________________________________ ______________________

Signature of Patient/Parent/Guardian Date