PULMONOLOGY ASSOCIATES INC. PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name:_____ First: _____ Middle:_____

Address: _____ Apt:_____

City:_____ State:_____ Zip Code:_____

Home Phone #:_____ Work Phone #:_____ Cell #:_____

May We Leave a Message? Y or N Preference? Home/Work/Cell EMAIL_____

Social Sec #:_____Date of Birth:_____ Sex: Male or Female

Marital Status: Single Married Divorced Widowed Spouses Name:_____

Race: American Indian Asian African American Native Hawaiian White Other _____

Ethnicity: Hispanic/Latin Not Hispanic/Latino Other _____ **Preferred Language:** _____

INSURANCE INFORMATION:

Insurance Co: _____Policy #:_____Group #: _____

Subscriber Information (if different from patient):

Name:_____ Social Sec #: _____

Date of Birth: _____ Relationship to Patient:_____

Second Insurance:_____ Policy#:_____Group#:_____

PATIENT EMPLOYMENT INFORMATION:

Employer: _____ Occupation:_____

Address, City, State:_____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name:_____Relationship: SP Parent Child Other

Address, City, State: _____

Home Phone #:_____ Work Phone #:_____ Cell #:_____

FAMILY PHYSICIAN: _____

Address, City, State _____Phone#_____

REFERRING PHYSICIAN: _____

Address, City, State_____Phone#_____

PHARMACY INFORMATION:

Local Pharmacy :_____ Phone #: _____

Address, City, State: _____

Mail Order Pharmacy :_____ Phone #: _____

Address, City, State: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Pulmonology Associates, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any deductibles or co-insurance payments and non-covered services.

_____ _____

Patient or Guardian Signature Date

Lung Health Questionnaire

Patient Name: _____ **Date of Birth:** _____ **Age:** _____
Referring Doctor: _____ **Primary Care Doctor (if different):** _____

Chief complaint that brings you to our office today / main breathing problem:

_____

Questions About Your Medical History:

Please check any medical problems you have:

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ GERD/reflux
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Obesity
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Other (please list)

_____
_____
_____
_____

What **Surgeries** have you had? _____

_____

Please list any **Medication Allergies**: _____

_____

Please list all your **Medications and Doses** or bring a current list:

Medication	Dose	Frequency

Family History:	Status	Age	Diseases
Father:	Alive/Deceased	___	_____
Mother:	Alive/Deceased	___	_____
Sibling(s):	Alive/Deceased	___	_____
	Alive/Deceased	___	_____
	Alive/Deceased	___	_____
Son(s):	Alive/Deceased	___	_____
	Alive/Deceased	___	_____
Daughter(s):	Alive/Deceased	___	_____
	Alive/Deceased	___	_____

Social Information

Do you or have you ever smoked:	**Quit?**	**When did you quit?**
• Cigarettes: # _____ pack(s) per day for _____ years	Yes / No	_____
• Cigars: # _____ cigars per day for _____ years	Yes / No	_____

Have you ever been exposed to asbestos? Yes / No
What pets do you have at home? _____

What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other
Do you drink alcohol? ☐ No ☐ Yes - how often do you drink? _____
Do you use any of the following: ☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Other:

Please check any other symptoms you currently have:

General:	☐ Weight gain ☐ Weight loss ☐ Fever ☐ Chills ☐ Fatigue ☐ Other:
Eyes:	☐ Itchy eyes
Ears, Nose, Throat:	☐ Itchy throat ☐ Sore throat ☐ Nasal congestion ☐ Runny nose
	☐ Cough ☐ Coughing up sputum ☐ Other:
Cardiovascular:	☐ Chest pains ☐ Palpitations ☐ Swelling in ankles or legs ☐ Other:
Respiratory:	☐ Wheezing ☐ Shortness of breath ☐ Sputum ☐ Other:
Gastrointestinal:	☐ Heartburn ☐ Diarrhea ☐ Constipation ☐ Blood in stools ☐ Other:
Musculoskeletal:	☐ Joint pains ☐ Joint swelling ☐ Other:
Skin:	☐ New rash ☐ Insect bite ☐ Other:
Neurologic:	☐ Headaches ☐ Dizziness ☐ Difficulty walking ☐ Other:
Psychiatric:	☐ Depression ☐ Anxiety ☐ Other:
Endocrine:	☐ Excessive thirst ☐ Excessive urination ☐ Other:
Heme/Lymph:	☐ Easy bruising ☐ Easy bleeding ☐ Other:

Please check any of the following breathing problems you have:

☐ Allergies	☐ Lung nodule (spot on x-ray)	☐ Sleep disorder: _____
☐ Asbestos exposure	☐ Nasal polyps	☐ Tuberculosis
☐ Asthma	☐ Obstructive sleep apnea	☐ (+) PPD test (TB test)
☐ COPD or Emphysema	☐ Pulmonary embolism	☐ Other lung disease: _____
☐ Cystic fibrosis	☐ Pulmonary hypertension	☐ Prior lung/chest surgery:
☐ Deep venous thrombosis	☐ Sarcoidosis	Explain: _____
☐ Lung cancer	☐ Sinusitis	

Please check any of the following lung symptoms you have:

- ☐ Chest pains
- ☐ Cough
- ☐ Coughing up blood
- ☐ Difficulty with sleep
- ☐ Daytime sleepiness (excessively tired)
- ☐ Frequent awakenings while sleeping
- ☐ Frequent heartburn
- ☐ Leg pains while falling asleep
- ☐ Leg swelling
- ☐ Shortness of breath
- ☐ Sinus problems
- ☐ Snoring
- ☐ Sputum or mucous
- ☐ Wheezing

Please check any of the following that makes it harder for you to breathe:

- ☐ Cold weather
- ☐ Cold or flu
- ☐ Paint
- ☐ Perfume
- ☐ Runny nose
- ☐ Sinus infections
- ☐ Smoke
- ☐ Stressful events
- ☐ Warm weather
- ☐ Other: _____

Do you have any environmental allergies? Yes/No (please circle)

Allergic to what?: _____

Please answer the following questions: ***(use a separate sheet as necessary)***

Where were you born? _____
Where did you grow up? _____
Where do you live now? _____
Where have you traveled to recently? _____
Do you currently work? Yes / No
Please list your current and past jobs: _____
_____

Have you ever had a pneumonia shot (Pneumovax)? Yes / No
Do you get a yearly influenza shot (flu shot)? Yes / No

NOTE: Please refrain from wearing perfumes/colognes to our office. Thank you!

PULMONOLOGY ASSOCIATES, INC.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Pulmonology Associates, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The notice of Privacy Practices provided by DFP describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pulmonology Associates, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pulmonology Associates, Inc., 100 Lancaster Ave., Suite 230, Wynnewood, PA, 19096.

With this consent, Pulmonology Associates, Inc. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent Pulmonology Associates, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Pulmonology Associates, Inc. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Pulmonology Associates, Inc. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Pulmonology Associates, Inc. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Pulmonology Associates, Inc. may decline to provide treatment to me.

Signed by:_____ _____

Signature of Patient or Legal Guardian — Print Name of Legal Guardian, if applicable

_____ _____

Print Patient's Name — Relationship to Patient

_____

Date

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Pulmonology Associates Inc. *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information. I further understand that Pulmonology Associates Inc. may update *its Notice of Privacy Practices* at any time and that I may receive an updated copy of Pulmonology Associates Inc. *Notice of Privacy Practices* by submitting a request in writing for a current copy of Pulmonology Associates Inc. *Notice of Privacy Practices.*

_____

Printed Patient Name

_____ _____

Patient Signature Date

I permit the following to receive and give information on my behalf:

_____ _____

_____ _____

_____ _____

If completed by patient's personal representative, please print name and sign below.

_____ _____

Printed Patient Personal Representative Name Relationship to Patient

_____ _____

Patient Representative Signature Date

For Pulmonology Associates Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Pulmonology Associates Inc. made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other: _____

_____ _____

Employee Printed Name Employee's signature

PULMONOLOGY ASSOCIATES PAYMENT POLICY

Thank you for choosing us as your care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

PULMONOLOGY ASSOCIATES, INC TELEMEDICINE INFORMED CONSENT FORM

Patient Name: _____ DOB: _____

1. Telemedicine is a service that uses technology to provide health services from a distance without having to meet in-person at an office. Patients may benefit from telemedicine, but just with any other professional service, results cannot be guaranteed or assured. Benefits include improved access to services and reductions of barriers by enabling patients to remain at remote site while the healthcare professional provides care elsewhere, more efficient coordination and management of services. Obtaining the expertise of a distant specialists not available locally. I agree to engage in a telemedicine consultation/visit.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation/visit will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the visit other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation/visit and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine visit. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation/visit, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing will occur from both my practitioner all co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. **Non-covered services: Please be aware that these services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You agree to pay for these services in full if not covered by insurance.**

8. I have received this consent form, during which I had the opportunity to ask questions in regard to telemedicine. I understand the risks, benefits and any practical alternatives.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient's/parent/guardian signature Date