Pulmonary, Critical Care, & Sleep Associates, P.C

Please Print Clearly

First Name _____ **Middle Initial** _____

Last Name: _____

Date of Birth _____ **Sex** _____

Social Security # _____

Billing Address:_____

City _____ **State:** _____ **Zip Code:** _____

Home Phone #_____

Cell Phone #_____

Marital Status **Single ( )** **Married ( )** **Divorced ( )** **Separated ( )** **Widowed ( )**

Emergency Contact Name _____

Emergency Contact Number _____

Primary Care Physician

_____

Referring Doctor if Different from Primary

_____

Insurance Carrier

_____

Pharmacy of Choice

_____

_____

Pulmonary, Critical Care, and Sleep Associates P.C

This is an acknowledgement of receipt of notice and consent to use and disclose your health information.

Please read all information before signing this consent form

This acknowledgment of notice and consent authorizes Pulmonary Critical Care and Sleep Associates P.C to use and disclose health information about your treatment, payment, and health care purposes.

Notice of Privacy Practices

Pulmonary Critical Care and Sleep Associates P.C has an notice of privacy practices, which describe how we may use and disclose your protected information and how you can access your own personal health records and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

Amendments

We reserve the right to change our notice of privacy practice and to make the terms of any change effective for all protected health information that we may maintain. Including information created or obtained prior to the date of the effective date of the change. You may obtain a copy by calling our office and requesting that a revised copy be sent to you in the mail to your current and updated address on file or you may ask to pick it up in the office at your next upcoming appointment

PLEASE PRINT AND SIGN

I have received the notice of privacy practices for Pulmonary, Critical Care and Sleep Associated P.C and they are authorized to use and disclose my health information about

_____ **(Patient Name)** for treatment, payment, and healthcare operations purposes consistent with notice of privacy practices.

_____ _____

Patient Signature or Personal Representative ***Date***

Name of Personal Representative _____ Relationship _____

Pulmonary, Critical Care, and Sleep Associates P.C

HIPPA Patient Communication Form

A) Family and Friends. It is the office policy of Pulmonary Critical Care and Sleep Associates P.C not to release confidential medical information regarding your treatment to family members, friends, except for (i) parent/ legal guardian, (ii) Other persons authorized by the patient , (iii) as we may reasonable infer from the circumstances (For example, if you bring a family member or friend into the exam room, we will assume, unless you object, that person is entitled to receive information regarding your treatment.), (iv) in emergency situations , or (v) other as otherwise permitted by the health insurance portability and accountability act of 1996 (HIPPA)

- If you anticipate that you will need or want your medical information to be provided to family members, friends or caretakers, please indicate that below, so that we may best serve you. By signing below, you authorize that following people to receive information regarding your treatment or care. (You may also add additional people to your list at a later date.)

Spouse_____ **YES** _____ **NO**_____

Parent: _____ **YES**_____ **NO**_____

Other_____ **YES**_____ **NO**_____

May we leave Messages on your answering Machine at you residence? YES_____ NO_____

B) Alternative Communications: you are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of communication only:

_____

PRINT PATIENT NAME: _____

PATIENT SIGNATURE: _____

DATE: _____

Pulmonary, Critical Care, and Sleep Associates P.C

Patient Release and financial agreement

Name: _____ Date Of Birth_____

We will assist in the preparation of the insurance claims provided that direct payment to the physician is authorized by the insured.

Please sign the authorization below:

I request that payment of authorized MEDICARE benefits be made either to me or on my behalf to Pulmonary Critical Care and sleep Associates P.C. for any services furnished to me by one of the physicians associated with Pulmonary Critical Care and Sleep Associates P.C. I authorize any holder of medical information about me to release to the centers of Medicare and Medicaid services (CMS) previously the Health Care Financing Administration and its agents and information needed to determine these benefits payable to related services.

I understand my signature request that payment be made and authorizes release of medical information necessary to pay the claim. If "Other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing the information to the insurer or agency shown. If Medicare assigned cases, the physician or supplier agrees to accept the charges determination of Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non- covered services. Coinsurance and the deductible are based upon the charges determination of the Medicare carrier.

Patient Signature: _____ Date: _____

I, Understand and certify that I or my dependent have insurance coverage with _____. And assign directly to Pulmonary Critical Care and Sleep Associates P.C. All insured benefits, if any otherwise payable to me for services rendered. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all insurance submissions. I acknowledge that a billing fee may be charged on past due balances.

Patient Signature: _____ Date :_____

Pulmonary, Critical Care, and Sleep Associates P.C

Patient Medication List

MEDICATION	DOSE	ORDERING DOCTOR