PLEASE PRINT!

PULMONARY MEDICINE ASSOCIATES, P.C.

DATE	DOCTOR	ACCOUNT#	CHART#

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE,)	PREFIX	SUFFIX	CREDENTIALS

PREFERRED NAME

MAIDEN NAME	D.O.B.	SEX

SSN	RACE	ETHNICITY
		☐ DECLINED ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO

MARITAL STATUS	DRIVERS LICENSE	PRIMARY LANGUAGE

ADDRESS	CITY/STATE/ZIP

HOME PHONE	WORK PHONE	CELL

PRIMARY PHONE	FAX	PAGER

EMAIL	PREFERRED METHOD OF COMMUNICATION
	☐ EMAIL ☐ PHONE ☐ MAIL

EMPLOYER NAME AND ADDRESS	EMPLOYER PHONE/EXT.

RESPONSIBLE PARTY	RELATIONSHIP	PHONE	SSN	D.O.B.

PREFERRED PHARMACY NAME	CITY/STATE	PHONE

INSURANCE COMPANY - PLEASE PROVIDE COPY OF INSURANCE CARD

OVER

HOME PRINTING CO. 205-755-0764 .0911

REFERRING PHYSICIAN _____

Address _____ Phone #_____

FAMILY PHYSICIAN_____

Address _____ Phone # _____

OTHER PHYSICIAN INVOLVED IN YOUR CARE _____

Address _____ Phone # _____

Names and phone numbers of two relatives or friends (not already listed) and not living with you.

Name _____ Relationship to you _____

Phone# _____

Name _____ Relationship to you _____

Phone# _____

We at Pulmonary Medicine Associates, P.C. want to provide you the best and most effective care possible. There may be certain services that are necessary for the maintenance of good health that may not be covered by your insurance contract. You will be expected to pay for these services in full. Let us reassure you that we will only order tests we feel are necessary for your treatment and care. Examples of possible non-covered services are: tests considered to be routine or preventive by your insurance contract, some blood or body fluid analyses, and pre-existing conditions. I understand Pulmonary Medicine Associates, P.C. will send any laboratory studies ordered by the physician to one of the following laboratories: LabCorp, LabSouth, Smith Kline Laboratories, and/or Cunningham Pathology. I authorize Pulmonary Medicine Associates, P.C. to provide the laboratory with information needed for billing and insurance purposes. I further agree to be responsible for payment of laboratory tests not covered by my insurance.

Pulmonary Medicine Associates, P.C. has informed me that should I have one of the following insurance contracts I must have a referral from my Primary Care Physician: BCSS AHC, BCBS PERSONAL CHOICE, ACIPCO BCBS. HEALTH ADVANTAGE, UNITED HEALTH CARE, CIGNA. HEALTH PARTNERS, MERIT HEALTH PLAN. MEDICAID PATIENT FIRST, HEALTH CHOICE, MEDICARE COMPLETE. If I do not have a referral from my Primary Care Physician and I agree to be seen without a referral, I will waive my rights under my insurance contract, release Pulmonary Medicine Associates, P.C. from their contractual agreement with my insurance, and agree I will be responsible for payment in full at the time services are rendered.

I authorize Pulmonary Medicine Associates, P.C. to initiate a complaint with the Insurance Commissioner on my behalf should my insurance company fail to pay or deny claim for services rendered within 30 days.

I hereby authorize Pulmonary Medicine Associates, P.C. to furnish any information concerning my medical condition, treatment, and prognosis to my insurance carriers, attorneys involved in my case, and other treating physicians. I hereby assign Pulmonary Medicine Associates, P.C. all payments for medical services rendered to me or my dependents due or received from third-party payors. A photocopy of this assignment shall be considered as effective and valid as the original. I agree to be responsible for any amount not covered by insurance or other providers. I agree to pay a monthly late fee of $10 on any balance 60 days past due, not pending insurance claims, on my account. I agree to pay all costs of collections including attorney fees should this account be placed with an attorney for collections.

I have read and understand your policy and agree to the conditions of this legal and binding contract as indicated by my signature below.

DATE: _____ SIGNATURE: _____

PULMONARY MEDICINE ASSOCIATES, P.C.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES (9/23/13)

I, (PRINT NAME) _____,
ACKNOWLEDGE THAT I HAVE BEEN MADE AWARE THAT PULMONARY MEDICINE ASSOCIATES, P.C HAVE A PRIVACY PRACTICE POLICY. (YOU MAY ASK FOR A PRINTED COPY OF YOU LIKE)

_____ _____
SIGNATURE DATE

_____ _____
LAST 4 OF YOUR SSN DATE OF BIRTH

IF APPLICABLE:

_____ _____
SIGNATURE OF LEGAL REPRESENTATIVE DATE

_____ _____
PRINT NAME OF REPRESENTATIVE RELATIONSHIP TO THE PATIENT

IF YOU WOULD LIKE TO HAVE ANY OF YOUR MEDICAL INFORMATION DISCUSSED WITH A FAMILY MEMBER OR FRIEND, PLEASE LIST BELOW.

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

NAME_____RELATIONSHIP_____

FOR CLINICAL USE ONLY: Pulmonary medicine Associates, P.C. made to following good faith efforts to obtain the above referenced individual's written acknowledgement of information of the Notice of Privacy Practices: (identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if know) why the written acknowledgement was not obtained.)

Pulmonary Medicine Associates

Billing Policy

November 1, 2019

1) **<u>We will bill your insurance company for services provided within these limitations:</u>**
   a) You must provide a valid insurance card at each visit. If for any reason your insurance terminates, you will receive a bill. We ask that you respond to statements in a timely manner and please do not assume your insurance will take care of it- many times a statement is sent because something is wrong. We cannot bill insurance after the carrier's time limit.
   b) We bill "Gap" plans only when there is coverage for office visits.
2) **<u>Copays/Coinsurance/Deductibles</u>**: We collect these as a pre-requisite for providing a service. Copays will be assessed according to plan requirements and MUST be paid at the time of service. The same guidelines apply to your deductible.
   a) Patients whose carriers pay at a percentage of the allowable will be required to pay a deposit based on the anticipated service.
   b) We understand that there are certain hardships- we will make every effort to work with you but, you must contact us prior to your visit- not at the window.
3) **<u>Patient Balances:</u>**
   a) Your insurance provides an explanation of benefits when they process your claims. It is your responsibility to review these and to contact your carrier with any questions. We send statements based on these EOBs alone. Patient balances are due at the time a claim is processed, regardless.
   b) We assess a $10.00 late fee for ANY balances over 60 days old.
   c) Patient balances along with any copay must be paid at the time of service. Payment plans are available but, they must be approved prior to the visit.
   d) Your account must be current to make an appointment or to request a prescription
   e) Any balance that has been forwarded to collections must be paid in full at the time of service, and are not eligible for payment plans.
4) **<u>Other:</u>**
   a) Please keep your appointments. A $50.00 no show fee will be assessed for any appointment that is missed.
   b) Please keep your receipts- we do charge $10.00 for records of payments.
   c) Employment/Disability forms are assessed a $40.00 fee at the time the form is submitted for completion.
   d) We charge a $5.00 fee for claims requested for personal reimbursement or itemized bills.
5) **Please call the billing office for any questions regarding this policy. 205-620-0359**

I acknowledge that I've read the above policy

Signature _____ Date _____

BP:_____	HR:_____	RR_____	SATS%_____	LBS:_____	HEIGHT:_____
NOTES:					

PULMONARY MEDICINE ASSOCIATES, P.C

NEW PATIENT INFORMATION SHEET

NAME: _____ DATE: _____

D.O.B:_____ PT. #:_____

*COVID Testing: Y N Results Positive Negative Date of testing.*_____

WHO REFERRED YOU TO OUR CLINIC? _____

WHO IS YOUR PRIMARY CARE DOCTOR? _____

WHAT PHARMACY DO YOU USE? _____

BRIEFLY DESCRIBE THE REASON FOR YOUR VISIT:_____

_____

PLEASE CIRCLE IF YOU HAVE ANY OF THESE MEDICAL PROBLEMS:

DIABETES,	HYPERTENSION	HEART DISEASE	ASTHMA
EMPHYSEMA	STROKE	THYROID DISEASE	REFLUX
CANCER,	HIGH CHOLESTEROL.	OTHER:_____	

PLEASE LIST ALL SURGERIES WITH DATES:

_____

_____

_____

HAVE YOU EVER SMOKED? NO YES HOW MUCH DO YOU SMOKE?_____, HOW LONG?_____

PLEASE TELL US ABOUT YOUR FAMILY MEDICAL HISTORY:

MEMBER:	AGE:	LIVING? (Y/N)	MEDICAL PROBLEMS:	
MOTHER:				
FATHER:				
SISTERS:				
BROTHERS:				

PLEASE LIST PRESENT AND PAST EMPLOYMENT:

_____

_____

PLEASE CIRCLE THE ITEMS BELOW THAT YOU HAVE EXPERIENCED IN THE LAST 3 WEEKS.

A.GENERAL:	FEVER	CHILLS	NIGHT SWEATS	WEIGHT LOSS	WEIGHT GAIN
B.EYES:	CHANGE IN VISION	DRY EYES			
C.HEAD,EARS,NOSE, THROAT:	HEADACHE	SINUS PAIN	NASAL CONGESTION	NASAL DISCHARGE	HOARSENESS
D.CARDIOVASCULAR:	PERIPHERAL EDEMA	IRREGULAR BEAT	RAPID HEART RATE	DYSPNEA ON EXERTION	
E.RESPIRATORY:	SHORT OF BREATH HEMOPTYSIS	SPUTUM PRODUCTION	COUGH	CHEST PAIN	WHEEZING
F.GASTRO-INTESTIONAL:	STOMACH PAIN VOMITING	HEARTBURN	DIARRHEA	CONSTIPATION	NAUSEA
G.GENITOURINARY:	URGENCY	DIFFICULT URINATION	BLOOD IN URINE	PAINFUL URINATION	
H. SKIN:	RASH	ITCHING	BRUISING		
I.NEUROLOGICAL:	TINGLING	NUMBNESS	SEIZURES		
J.MUSCOSKELETAL	JOINT PAIN	JOINT SWELLING			
K.ENDOCRINE:	POLYURIA-(HEAVY URINATION)		POLYDIPSIA- (EXCESSIVE THIRST)		
L.PSYCHIATRIC:	ANXIETY	DEPRESSION			
M. ALLERGIES:	ANIMAL DANDER	DUST	POLLENS		
N.SMOKING HISTORY:	HAVE YOU EVER SMOKED?		**NO**	**YES**, HOW LONG?_____	
	DO YOU SMOKE NOW?		**NO**	**YES**, HOW MUCH?_____	

DO YOU OR HAVE YOU EVER DRANK ALCOHOL CONTAINING BEVERAGES?				**YES**	**NO**
DO YOU STILL DRINK?	**NO**	**YES, IF SO, WHEN?**	**DAILY**	**WEEKENDS**	**SOCIALLY**

LAST CHEST X-RAY_____	**LAST TB TEST**_____
HAVE YOU HAD A FLU SHOT? **NO YES, WHEN?**_____	
HAVE YOU HAD A PNEUMONIA SHOT? **NO YES, WHEN?**_____	
MEDICAL EQUIPMENT COMPANY(NAME,CITY):_____	
ADVANCE DIRECTIVE (LIVING WILL) YES NO	**POWER OF ATTORNEY:** YES NO

(*IF YES, PLEASE PROVIDE PHYSICAL DOCUMENTION OF PROOF OF THESE THINGS.)

NAME: ______________________________ DOB: ____________

PHARMACY NAME, CITY, & PHONE#: ______________________________

DATE: ____________

NAME OF MEDICATION	REASON FOR TAKING	DOSAGE	HOW OFTEN	DR. WHO PRESCRIBED

MEDICINE ALLERGIES:

____

____

____