Welcome to Southeast Pulmonary and Critical Care, LLC

Patient Information (Provide Insurance Card and Driver's License for scanning)

Name: _____DOB: _____ Age:_____

Address: _____ City: _____ State:_____ Zip:_____

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

Email:_____ Primary Care Physician: _____

Marital Status: (please circle) M S W D

Emergency Contact:_____Phone:_____Relationship:_____

Reminder calls about your appointments & other information will be made to you. Please confirm appointments when called. If we are unable to contact you, we may leave a message. Please circle your preferred methods of contact.

Please circle all that apply: Home Phone Cell Phone Work Email

OUR PATIENT PORTAL ALLOWS YOU TO: communicate with your provider, request medication refills, access your medical records, pay bills online and more! We will provide you with your login information to access your record.

Are you interested in access to our patient portal? YES/NO (Please Circle)

AUTHORIZATION TO RELEASE/OBTAIN INFORMATION: I hereby authorize Southeast Pulmonary & Critical Care, LLC to release any information related to my treatment and care to the insurance company/companies. I authorize Southeast Pulmonary & Critical Care, LLC to obtain my medical history. I grant Southeast Pulmonary & Critical Care, LLC the authority to download patient medication history automatically from pharmacy benefit managers (PBMs).

FINANCIAL RESPONSIBILY and ASSIGNMENT OF INSURANCE BENEFITS: I guarantee payment to Southeast Pulmonary and Critical Care, LLC for all charges for services provided to the patient. I understand that I am personally responsible for all charges not covered by insurance. I hereby authorize payments of medical insurance benefits to Southeast Pulmonary & Critical Care, LLC for services rendered. I understand that if I do not have insurance coverage, payment in full is due at time of service.

SOUTHEAST PULMONARY & CRITICAL CARE, LLC WILL FILE THE CLAIM TO YOUR PRIMARY AND SECONDARY (IF APPLICABLE) INSURANCE. IF THERE IS NO PAYMENT FROM YOUR CARRIER, THE BALANCE WILL BECOME PATIENT RESPONSIBILITY AND WILL BE DUE UPON RECEIPT.

_____ _____

SIGNATURE OF PATIENT/RESPONSIBLE PARTY **DATE**

Southeast Pulmonary & Critical Care, LLC

Medical History

Have you ever had any of the following surgeries? If so, Please Circle

Amputation	Carotid Endarterectomy	Lumpectomy
Appendectomy	Cataract Surgery	Mastectomy
Arthroscopic Surgery	Gall Bladder Removal	Prostate Surgery
Back Surgery	Gastric Bypass	Septoplasty
Breast Biopsy	Hemorrhoidectomy	Splenectomy
Bronchoscopy	Hernia Repair	Thyroid Surgery
Coronary Artery Bypass Graph	Hysterectomy	Tonsillectomy
Cesarean Section	Joint Replacement	Tubal ligation
Cancer Surgery	Knee Surgery	Vasectomy
Other_____		

Vaccination History

Influenza/Flu Shot Date:_____ Colonoscopy Date(if >50):_____

Pneumonia Shot Date:_____

Drug Allergies (Please List)_____

Have you ever had any of the following medical problems? If so, Please Circle

Anxiety Disorder	Kidney Disease	Chronic Bronchitis
Asthma	Kidney Stones	Chronic Renal Failure
COPD	Liver Disease	Congestive Heart Failure
Cancer Type:_____	Obstructive Sleep Apnea	Emphysema
Coronary Artery Disease	Osteoporosis	Peptic Ulcer Disease
Diabetes	Pulmonary Embolism	Perennial Allergic Rhinitis
GERD/Reflux	Stroke	Seasonal Allergic Rhinitis
Gout	Tuberculosis	Seizure Disorder
High Cholesterol	Anemia	Insomnia
Hypertension	Benign Prostatic Hypertrophy	Arthritis
Hyperthyroidism	Cardiac Arrythmia	Heart attack
Hypothyroidism		

Social History:

Smoking Status: (please circle) Current Former Never Smoked

#Packs per day _____ Years Smoked _____ Quit When_____

Do you vape or use e-cigarettes: Y/N

Second Hand Smoke Exposure: Y/N

Alcohol Consumption: Y/N How Much? _____

CPAP/BIPAP (please circle if either apply) Oxygen Yes/No How many Liters? _____

Caffeine Intake: Y/N How Much? _____

Chewing Tobacco: Y/N How Much? _____

Illicit Drugs: Y/N _____

Pets: Y/N What Type _____

Exercise: Y/N What type and frequency? _____

Occupation _____(former- if retired) Employer: _____

Exposures: _____

Married: Y/N Number of Children _____ _

Family History:

Mother: Alive/Deceased Age at death_____ cause of death_____

Current Age_____ health problems_____

Father: Alive/Deceased Age at death_____ cause of death_____

Current Age_____ health problems_____

Sister(s): Alive/Deceased How many____ (Please list information for all sisters)

Age at death_____ cause of death_____

Current Age_____ health problems_____

Brother(s): Alive/Deceased How many____ (Please list information for all brothers)

Age at death_____ cause of death_____

Current Age_____ health problems_____

Southeast Pulmonary and Critical Care Financial Policies

Thank you for choosing us as your healthcare provider. We are committed to providing you with high quality, affordable health care. Please review the following financial policies of Southeast Pulmonary & Critical Care, LLC. A copy will be provided upon request. Payment is due at time of service. We accept payment by credit cards (Visa & Mastercard), debit cards, cash and checks.

Insurance/Co-payments/Deductibles

We participate in many insurance plans. **As an insured patient, you agree to provide us with your current valid insurance card, your driver's license (or ID) and co-payment each time at check in.** If you 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, such as whether a referral or prior authorization is required from your Primary Care Physician, is your responsibility.** Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their requests. Please contact your insurance company with any questions regarding your coverage.

Self Pay

Payment in full is due at the time the service is provided. All self-pay patients are required to make a payment of $200.00 at appointment check in. Please be aware that this is a deposit and may be not considered as total payment for services rendered. Conversely, if payment exceeds charges, the balance will be refunded at check out.

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. NIOX testing (considered investigational by some insurance companies) and Home Sleep Tests may not be covered. You may be responsible for these services.

Nonpayment

Balances that are not paid within 30 days from the date of service are considered past due. If we have not received payment from your insurance carrier, we may ask for your assistance or require you to make a payment on the balance. If you are unable to pay a balance in full, a payment plan with a credit/debit card may be established. Past due accounts will be turned over to collections after 90 days or 3 billing statements. Patients in collections may be discharged from our practice, if this is to occur, you will be notified by 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.

Appointment Arrival

In our efforts to make your visit pleasant and to minimize your wait time, our office has implemented a late arrival policy. **If a patient is more than 15 minutes late for an appointment, the appointment may need to be rescheduled.** Patients may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible.

Cancellation Policy

We ask that you call us **no later than 24 hours in advance if you need to cancel or change your appointment**. If you fail to comply, you will be charged a cancellation fee of $25.00. Patients with a history (two times) of missed appointments will be required to make a deposit in the amount of their co-pay or $50 to schedule another appointment. Repeated offenses may result in dismissal from the practice.

Returned Check Fee

A $30.00 fee will be charged for returned checks.

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

_____ _____

Signature of patient or responsible party **Date**

Southeast Pulmonary & Critical Care, LLC's Patient Authorization Request Form

The Health Insurance Portability & Accountability Act of 1996 is a federal program that requires all health care providers to protect medical records and other individually identifiable information used or disclosed by us in any manner, whether electronically, on paper, or orally for all patients. This Act gives you, the patient, new rights to understand and control how your health information is used and disclosed. Your information may be released without your consent to obtain payment, referral for treatment, support the operation of the physician's practice and other instances as allowed by law. A complete copy of this notice is available upon request.

I have reviewed a copy of the Notice of Privacy Practices for Southeast Pulmonary & Critical Care, LLC

Signature:_____ Date: _____

As described in our privacy notice, you may authorize another person to receive your protected health information (PHI). We are not permitted to give your PHI to another person unless we have legal permission. One way to give us permission is to sign this Authorization Request Form. If you rely on a spouse, family members or a close friend to contact us for medical information, you need to sign this form allowing us to discuss your PHI.

Please complete the following information for each person you would like to provide with access to your PHI and indicate the appropriate items.

Name: _____ Relation: _____ DOB: _____

Phone: _____is allowed the following information (**INITIAL all you would like them to have access to**).

_____ All Information _ ____ Appointments _____Office Records/Notes _____Prescriptions _____ Billing /Insurance

Name: _____ Relation: _____ DOB: _____

Phone: _____ is allowed the following information (**INITIAL all you would like them to have access to**).

_____ All Information _ ____ Appointment _____Office Records/Notes _____Prescriptions _____ Billing /Insurance

Name: _____ Relation: _____ DOB: _____

Phone: _____ is allowed the following information (**INITIAL all you would like them to have access to**).

_____ All Information _ ____ Appointment _____Office Records/Notes _____Prescriptions _____ Billing/Insurance

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken previous action regarding requests that were received. This will remain in effect until a change is requested.

Signature: _____ Date: _____