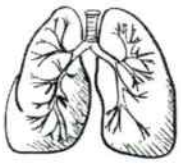

Premier Pulmonary and Sleep Medicine

Name: _____ Date of Birth: _____

Social Security Number: _____

Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Ethnicity: ☐ Caucasian ☐ Hispanic ☐ Asian ☐ African American ☐ Other

Home Address: _____ City: _____ ST: _____ Zip: _____

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

Primary Contact: ☐ Home ☐ Cell ☐ Work

E-mail address: _____ Preferred Method of Contact: ☐ Phone ☐ Email

Employer Name: _____ Occupation: _____ If retired, list previous occupation

Primary Care Physician: _____ Preferred Pharmacy: _____

Are you a resident of a nursing facility? ☐ No ☐ Yes: where? _____

Emergency Contact Name: _____ Phone #: _____ Relationship: _____

Insurance Information

Primary Insurance Carrier: _____ Subscriber #: _____ Group #: _____

Secondary Insurance Carrier: _____ Subscriber #: _____ Group #: _____

OFFICE POLICIES

FINANCIAL & INSURANCE POLICY

If you have a Premier Pulmonary and Sleep Medicine participating insurance: At the time of your appointment your copay, co-insurance and/or deductible will be collected. After Premier Pulmonary and Sleep Medicine bills your insurance, the balance remaining will be due, unless arrangement is made for payment with the Financial Counselor. If you have an insurance that Premier Pulmonary and Sleep Medicine does not participate in, you are responsible for payment of your bill at the time of service. Premier Pulmonary and Sleep Medicine will, however, file non-assigned claims to these insurance companies as a courtesy to you. If you do not have insurance: At the time of your appointment, you will be expected to pay the discounted financial portion in full at time of service.

Authorization and Assignment of Benefits

Release of Medical Information Authorization: I authorize Premier Pulmonary and Sleep Medicine to release pertinent information about my medical condition for the purpose of securing health insurance benefits information, authorization or payment for services and tests. I will provide a current copy of any insurance identification cards, policy numbers and demographic information to Premier Pulmonary and Sleep Medicine upon request. I also authorize Premier Pulmonary and Sleep Medicine to act as my representative and on my behalf to secure all authorization necessary from my insurance company regarding procedures or orders involving a surgical procedure or medical test performed by Premier Pulmonary and Sleep Medicine or an associate, including, if necessary, any appeal of a denial of benefit and in billing my insurance carrier for medications and/or supplies. I understand that I may revoke this authorization at any time by giving Premier Pulmonary and Sleep Medicine a written statement to withhold my personal and medical information from that time forward.

Assignment of Benefits: I request that payment of authorized insurance benefits be made on my behalf to Premier Pulmonary and Sleep Medicine for any services or tests provided to me by Premier Pulmonary and Sleep Medicine. I understand and agree that a copy of this authorization and/or assignment of benefits, when signed by me, my authorized representative, or a legal guardian, may be sent to my insurance company or health care provider, if requested. A copy of this authorization and assignment of benefits shall be as valid as an original, and Premier Pulmonary and Sleep Medicine may refer to my signature on file regarding this authorization and/or this assignment of benefits.

By my signature, or an authorized signature, below, I understand and agree to the following:

I am financially responsible to Premier Pulmonary and Sleep Medicine for any charges not covered by my health care benefits and for any portion of any charges denied by my health care benefits, in accordance with applicable law; I am financially responsible to Premier Pulmonary and Sleep Medicine for any nuclear pharmaceutical agent costs due to failure to re-schedule nuclear stress test appointment by 2:00 p.m. the business day prior to appointment day and/or not showing for the appointment. I am responsible to notify Premier Pulmonary and Sleep Medicine for any changes in my address and in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim and this may result in balances billed to me, such as deductibles, pre-existing clauses, etc…I acknowledge receiving a copy of Premier Pulmonary and Sleep Medicine Notice of Privacy Practices, I understand that Premier Pulmonary and Sleep Medicine will endeavor to obtain authorization from my insurance provider to reimburse Premier Pulmonary and Sleep Medicine for services and/or tests that may be covered. However, there is no guarantee that Premier Pulmonary and Sleep Medicine will receive authorization or payment from my insurance provider.

PRESCRIPTIONS AND SAMPLES REFILL POLICY

Prescriptions Refill: Plan on a 72-hour turn-around time for routine refills, and place call to the pharmacy to see if the medication is ready. When you request for a refill via online or telephone, please include all medications that need to be refilled within the next thirty days. When you come into the office, please ask for refills of prescription medications that you keep on hand. If you have mail-in pharmacy paperwork, we will be happy to assist you in completing the paperwork. However, it is the patient's responsibility to forward the paperwork or prescriptions to their pharmacy.

Samples Refill: Plan on a 24-hour turn-around time for sample refills.

MEDICAL RECORD REQUEST POLICY

Please allow 3-5 business days to complete requests for medical records. Premier Pulmonary and Sleep may charge a reasonable and customary fee for all medical record requests that will be collected prior to records being released.

PATIENT RIGHTS & RESPONSIBILITIES

As a patient of Premier Pulmonary and Sleep Medicine, you have specific rights and responsibilities during your care. We believe that an informed patient, taking an active interest in his or her care, is happier emotionally and headed for a more satisfactory outcome. Premier Pulmonary and Sleep Medicine, its physicians and staff treat all persons without regard to race, creed, national origin, age or disability.

PATIENTS RIGHTS

1. You will receive medically indicated care regardless of race, creed, gender, national origin or source of payment.

2. You have a right to considerate, respectful care as an individual at all times and under all circumstances.

3. You have a right to a safe environment for your treatment and care. You also have a right to care and accommodations that take into consideration physical disabilities that would otherwise impact your care.

4. You have a right to personal and informational privacy, within the law.

5. You have a right to know the identity and professional status of your caregivers and to know which physician is primarily responsible for your care.

6. You have a right to complete information from your primary practitioner on your diagnosis, treatment and any known prognosis.

7. You have a right to reasonable, informed participation in decisions on your care.

8. You have a right to visitors and to telephone or written communication with others.

9. You have a right, at your own expense, to consult a specialist.

10. You may refuse treatment to the extent permitted by law, although it may result in the termination of the physician-patient relationship.

11. You will not be transferred to another facility without a full explanation of the need and an explanation of alternative. The other facility must also accept you before your transfer.

12. You are entitled to complete information from your practitioner on any continuing health care requirements following your discharge.

13. You have a right to an itemized and detailed explanation of your bill for services.

14. You are entitled to an explanation of Premier Pulmonary and Sleep Medicine's rules and regulations for patient conduct as well as the office's systems for handling patient complaints.

15. You are entitled to information about Advanced Directives and Durable Power of Attorney for healthcare. You should share this information with your family and physicians.

PATIENT RESPONSIBILITIES

1. You should provide, as fully as you can, accurate and complete information on present complaints, past illnesses and hospitalizations, medications and other matters regarding your health. You are also responsible for reporting any changes to your practitioner.

2. You should tell the staff if you do not understand explanations of your care or what is expected of you.

3. You are responsible for following the treatment plan your physician recommends.

4. You are responsible for your actions if you refuse treatment or do not follow your physician's orders.

5. You are responsible for having your bill paid as promptly as possible.

6. You are responsible for following PREMIER PULMONARY AND SLEEP MEDICINE's rules for patient care and conduct.

7. You are responsible for being considerate of the rights of other patients and office personnel, including controlling noise, the number of visitors and no smoking.

By signing below, I hereby consent to treatment necessary for the care of the patient indicated on this form. I certify that the information I have provided is truthful, correct and complete, and I understand and agree to the terms of this authorization and assignment of benefits. I acknowledge that any inaccurate information provided, or omission of accurate information may delay the processing of my services and tests and shall result in Premier Pulmonary and Sleep Medicine billing me for the services and tests provided.

Patient/ Parent/ Guardian Name: _____ Date: _____

Patient / Parent / Guardian Signature: _____ Date: _____

RELEASE OF INFORMATION FOR MEDICAL RECORD OF:

PATIENT NAME: _____

PATIENT ADDRESS: _____

PATIENT DATE OF BIRTH: _____

PATIENT DATE OF SERVICE: _____

PATIENT PHONE #: _____ **PATIENT SSN:** _____

I hereby authorize _____ to release information and forward to:

(provider)

_____

_____

_____

_____

Please check type of information to be released:

Complete Medical Record	Lab Results	X-Ray Results/Film
Notes/Results for DOS:	Consultation Reports	Billing Records
Immunizations	Other, please specify	

Please check the reason the above information is released:

Transfer to another physician	Legality Purposes	Specialist/2nd opinion
Personal File	Disability Benefits	Other, please specify

I understand that the specific information to be disclosed may include history of DRUG AND ALCOHOL ABUSE, or MENTAL HEALTH TREATMENT, or information concerning communicable diseases such as HUMAN IMMUNODEFICIENCY VIRUS (HIV) and ACQUIRED IMMUNE DEFICIENCY SYNDROME(AIDS), and laboratory test results, treatment progress or any other such related information.

I understand that my treatment or payment for services will not be denied should I elect not to sign the authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for per-employment purposes. However, no protected information will be release without a signature. Also, I understand that information disclosed in accordance with this authorization may be subject to re-disclosure by the recipient and no longer protected by the Standards of Privacy and Individually Identifiable Health Information (45 CFR parts 160 & 164).

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it. The authorization will expire 180 days from the date of my signature on or otherwise specified by date, event or condition as follows:

_____

I further authorize that a photocopy of this authorization is acceptable as an original.

I understand I may be charged a processing fee for copies of my medical records according to Texas Hospital Licensing Law.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

Relationship to Patient

Date of Request: __/__/__ Record copying cost: $ _____.00 _____ Cash _____ Check # _____ C.C.

Premier Pulmonary Critical Care & Sleep Medicine Release of Information for Medical Records

Phone: 903-465-5012 Fax: 866-307-7513

Patient Name: _____

Patient DOB: _____

Release of Information for Medical Records

Name	.Phone	Relation to Patient

I understand that the specific information to be disclosed may include history of DRUG or ALCOHOL ABUSE, or MENTAL HEALTH TREATMENT, or information concerning communicable diseases such as HUMAN IMMUNODEFICIENCY and ACUIRED IMMUNE DEFICIENCY SYNDROME, and laboratory results , treatment progress, or any other such related information.

I understand that my treatment or payment for services will not be denied should I elect not to sign the authorization, except in certain circumstances such as for participation in research programs, or authorization of the release of testing results for pre -employment purposes. However, no protected information will be released without a signature. Also, I understand that information disclosed in accordance with this authorization may be subject to re-disclosure by the recipient and no longer protected by the Standards of Privacy of individually identifiable Health information.

I understand that I may revoke this authorization in writing at anytime except to the extent that action has been taken in reliance on it. The authorization will expire in 180 days from the date of my signature on or otherwise specified by date, event or condition as follows:

_____

I further authorizate that a photocopy of this authorization is acceptable as an original

I understand I may be charged a processing fee for copies of my medical records according to Texas Hospital Licensing Law.

_____ _____ _____

Signature of Patient or Legal Guardian *Relationship to Patient* *Date*

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

Name: _____ Date of Birth: _____

Current Medication List

Please list all current prescription medications, including those taken as needed (PRN).

Medication Name	Dose	Frequency