Tuscaloosa Lung, Critical Care, & Sleep
Office Policies

Name: ________________________________ Date of Birth: __________

1. THERE WILL BE A $25 NO SHOW FEE FOR OFFICE VISITS.
2. THERE WILL BE A $50 NO SHOW FEE FOR PULMONARY FUNCTIONS TEST (PFT).
3. AS A COURTESY TO OUR ASTHMA PATIENTS, PLEASE DO NOT WEAR PERFUME OR COLOGNE.
4. NARCOTICS ARE FILLED ONLY AT OFFICE VISITS.
5. SAMPLES ARE ONLY GIVEN AT OFFICE VISITS.
6. PLEASE ALLOW 72 HOURS FOR REFILL REQUESTS (multiple calls only slow down the process).
7. BRING ALL MEDICATIONS TO EACH VISIT.
8. CO-PAYS ARE DUE AT CHECK-IN EACH VISIT.
9. PATIENTS WHO HAVE MEDICARE AS THEIR ONLY INSURANCE WILL BE REQUIRED TO PAY THEIR 20% CO-INSURANCE.
10. THERE WILL BE A $30 FEE FOR ALL RETURNED CHECKS.

By signing this you acknowledge and agree to all of the above policies.

SIGNATURE ____________________________ **DATE** ____________

TUSCALOOSA LUNG, CRITICAL CARE & SLEEP

Patient Demographic & Insurance Information

Basic Patient Information

Name of Patient ______________________________
First Middle Last

Patient's Social Security Number ______________ Date of Birth ______________

Race ______________ Ethnicity Hispanic or Non-Hispanic Gender F M

Mailing Address ______________________________

City ______________ State ______________ Zip ______________

Home Phone ( ) ______________ Work Phone ( ) ______________ Cell ( ) ______________

Email Address ______________________________

Which Physician are you seeing today?

Physician:

- ☐ PEDRO LOPEZ, MD
- ☐ MOHAMMAD AZAM, MD
- ☐ KM DINESH CHANDRA, MD
- ☐ F. FABIAN SALINAS, MD
- ☐ SYED ASLAM, MD
- ☐ RANJU CHANDRASHEKARIAH, MD (Dr. SHEKAR)

Additional Patient Information

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Patient's Employment Status ☐ Full-Time ☐ Part-Time ☐ None ☐ Retired

Spouse's Employment Status ☐ Full-Time ☐ Part-Time ☐ None ☐ Retired

Student Status (If Applicable) ☐ Full-Time ☐ Part-Time ☐ None

Patient's Employer ______________________________

Preferred Pharmacy ______________ Location ______________

Referring Physicians ______________________________

All other Physicians ______________________________

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hereby authorize all insurance payments, including Medicare, to be made directly to Tuscaloosa Lung, Critical Care & Sleep for medical services rendered. I authorize he release of any medical information deemed necessary in the processing of a claim. I understand that I am responsible for any and all charges, regardless of nsurance coverage. I also agree that failure to make payment when requested is the basis for legal action, and agree to pay all costs of collections, including 33% collection fees. Until my accounts are finally settled, I give my direct consent to receive communications regarding my accounts from any servicers and any collectors of ny accounts, through various means such as 1) any cell, landline, or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail nessages, and other forms of communications. I authorize the physicians to perform any procedures which may be deemed necessary in the judgement of the attending hysician in the diagnosis and treatment of the patient's condition.

Date ______________ Signature ______________

Please present your insurance card to the front desk receptionist when returning this form

Insurance Coverage - Primary

Name of Insurance ______

Contract # or Member ID ______ Effective Date: (if applicable) ______

Group Number ______

Primary Care Physician ______

Name of Insured

Patient's Relationship to Insured?

☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other

Birth Date of Insured ______ Retire Date (if applicable) ______

Gender F M Phone ( ) ______

Name of Insured's Employer ______

Address of Insurance Holder ______

(If different than Patient Address) ______

City State Zip

Insurance Coverage - Secondary

Name of Insurance ______

Policy or Contract Number ______ Effective Date: ______

Group Number ______ Expiration Date: ______

Name of Insured ______
First Middle Last

Patient's Relationship to Insured?

☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other ______

Birth Date of Insured ______ Retire Date (if applicable) ______

Gender F M Phone ( ) ______

Name of Insured's Employer ______

Address of Insurance Holder ______

(If different from Patient Address) ______

City ______ State ______ Zip ______

Emergency Contact Information - Primary Contact

Name ______ Relationship ______

Home Phone ( ) ______ Cell Phone ( ) ______ Work Phone ( ) ______

Street Address ______

City ______ State ______ Zip ______

Patients' Rights Under HIPAA and Red Flags Rule

Patients have the right to inspect or obtain a copy of their protected health information (PHI) that is maintained in the patient's designated record set. Patients will be charged a fee for any requested copies of their PHI. The fee will be consistent with Alabama law and HIPAA regulations. Patients may request a copy of their PHI to be mailed to them. If an error is discovered in the patient's PHI or a record in a designated record set, then the patient has the right to have Tuscaloosa Lung, Critical Care & Sleep amend their information. However, Tuscaloosa Lung, Critical Care & Sleep reserves the right to deny an individual's request for amendment under conditions listed by HIPAA. Tuscaloosa Lung, Critical Care & Sleep also reserves the right to deny access to any patient's records under conditions listed by HIPAA. If a patient is denied the right to view their records, then a written denial will be furnished to the individual in a timely manner.

In general, parents will be able to access and control the health information about their minor children. When a minor opts to view their medical records without parental consent when allow by state or other applicable laws, the minor may exercise their privacy rights attributed by the Privacy Rule.

Patients have a right to review who their PHI has been transmitted to within six years prior to the date on which the request was made, except for conditions listed under HIPAA regulations.

All other sensitive patient information is strictly confidential and protected by Tuscaloosa Lung, Critical Care & Sleep according the Red Flags Rule. Any "red flags" or discrepancies in documents or patient information that suggests identity theft or fraud will be investigated by Tuscaloosa Lung, Critical Care & Sleep. If the fraudulent activity involves the patient's PHI, the existing HIPAA policies and procedures will apply.

For a more detailed version of HIPAA or Red Flags Rule regulations, please ask a Tuscaloosa Lung, Critical Care & Sleep staff member.

I have read and understand my Patients' Rights as specified by HIPAA.

_______________________ _______________________

Date Patient

Family and friends with whom we may discuss your health

Name and Relationship: _______________________

Name and Relationship: _______________________

Name and Relationship: _______________________

Name and Relationship: _______________________

Name: ____________________ DOB: ________ Today's Date: ________

Past Medical History:

Have you ever had?			Year
Diabetes	Yes	No	
Heart Disease	Yes	No	
High Blood Pressure	Yes	No	
Asthma, Emphysema, or COPD	Yes	No	
Cancer	Yes	No	
Thyroid Disease	Yes	No	
Stomach Problems(ulcer, heartburn)	Yes	No	
Surgery	Yes	No	
Colonoscopy	Yes	No	
Stool Checked for Blood	Yes	No	

Previous Surgeries:

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Family History

Any close relative ever had:

Diabetes	Yes	No
Heart Disease	Yes	No
High Blood Pressure	Yes	No
Asthma, Emphysema, or COPD	Yes	No
Stroke	Yes	No
Cancer	Yes	No

Allergic to any medicines? Yes or No ____________________

Have you had a Flu shot? Yes or No If so when: ____________

Ever had the pneumonia shot? Yes or No If so when: ____________

Last mammogram: ____________________

Have you been tested for osteoporosis? Yes or No If so year: ________

Social History:

Marital status: Married Single Divorce Widow/er

Smoking history: Former / Current / Never Packs per day: ________

Age started smoking: ________ Age stopped smoking: ________

How much alcohol do you drink? ____________________

Any recreational drugs? (Marijuana, cocaine, etc...)____________

Type of work you do/did? ____________________

How far did you go in school? ____________________

Name: ____________________ DOB: ________ Today's Date: ________

Review of Systems: **Circle issues you have had in the last week.**

Fever Weight Loss or Gain
Double vision Wear Glasses/ Contacts
Dizziness Bloody nose Deafness
Chest pain Palpitations Swelling
Wheezing Cough Shortness of breath Coughing up Blood
Diarrhea Heartburn Nausea/ Vomiting Abdominal (Stomach) Pain
Blood in urine or stool Painful urination Urinary incontinence
Back Pain Joint swelling or stiffness
Rash Breast lumps
Seizures Mental status changes
Hallucinations Depression Anxiety (nerves)
Enlarged Glands Bleeding
Hair loss Heat/ Cold intolerance Runny nose Watery/ Itchy eyes

Medication List: List all medications including over-the-counter.

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Thank you for helping us help you. Please take to the check-in window when finished.