Tuscaloosa Lung, Critical Care, & Sleep

Office Policies

Name: ______________________________ Date of Birth: _______________

1. THERE WILL BE A $50 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 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 M F

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
- ☐ RANJU CHANDRASHEKARIAH, MD (Dr. SHEKAR)
- ☐ F. FABIAN SALINAS, MD
- ☐ KM DINESH CHANDRA, MD

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 ______________________________________

____

____

I hereby authorize all insurance payments, including Medicare, to be made directly to Tuscaloosa Lung, Critical Care & Sleep for medical services rendered. I authorize the 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 insurance 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 my 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 messages, and other forms of communications. I authorize the physicians to perform any procedures which may be deemed necessary in the judgement of the attending physician 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 that 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 that patient address) ____________________

City ____________________ State ____________________ Zip ____________________

Emergency Contact Information- Primary Contact

Name ____________________ Relationship ____________________

Home Phone ( ) ____________________ Cell Phone ( ) ____________________ Work Phone ( ) ____________________

Street Adress ____________________

City ____________________ State ____________________ Zip ____________________

Patient's 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 HIP AA 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 HIP AA. Tuscaloosa Lung, Critical Care & Sleep also reserves the right to deny access to any patient's records under conditions listed by HIP AA. 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 HIP AA regulations.

All other sensitive patient information is strictly confidential and protected by Tuscaloosa Lung, Critical Care & Sleep according to 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 HIP AA policies and procedures will apply.

For a more detailed version of HIP AA 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: ______________________________