Pulmonary Associates, LLC

Hatem A. Asad, M.D Wila Zanghi, NP-C
105 Briarcliff Road, Warner Robins, GA 31088

PATIENT NAME: _____ CHART # _____

PLEASE LIST ALL ALLERGIES BELOW

Family History
Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?
Cancer (describe type)	
Hypertension (high blood pressure)	
Heart disease	
Diabetes	
Strokes	
Mental disease (anxiety, depression, etc.)	
Drug or alcohol addiction	
Glaucoma	
Bleeding diseases	
Asthma	
Other:	

PLEASE LIST ALL MEDICATIONS BELOW

Medical History *Date:* / /

Name _____ Age ____ Birthdate ____/____/____

Address _____ Sex: ☐ M ☐ F

_____ Home phone _____

_____ Work phone _____

Occupation _____ Emergency contact _____

Phone _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If married, spouse's name _____

Children's names and ages _____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If yes, please list name of medicine and type of reaction):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Past Medical History and Review of Systems

Please circle if **you** have had problems with or are presently experiencing any of the following:

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease
5. Chest pain/chest tightness
6. Shortness of breath
7. Swollen ankles
8. Palpitations
9. Lightheadedness
10. Frequent urination
11. Rheumatic fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. T.B.
17. Hay fever
18. Abdominal discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in stool
25. Ulcers
26. Change in bowel habits
27. Unexplained weight gain/loss
28. Hemorrhoids
29. Gall bladder disease
30. Colitis
31. Hepatitis or jaundice
32. Thyroid disease
33. Head or neck radiation
34. Headache
35. Kidney diseases
36. Kidney stones
37. Difficulty urinating
38. Arthritis
39. Low back problems
40. Skin diseases
41. Blood disorders
42. Venereal diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol abuse
47. Drug abuse
48. Gout
49. _____
50. _____

Please List and Supply the Dates of:

Operations: _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery: _____ _____

_____ _____

Immunization history—have you had:

Hepatitis B? ☐ No ☐ Yes When? _____

Other? _____ ☐ No ☐ Yes When? _____

Pneumovax immunization? ☐ No ☐ Yes When? _____

Flu immunization? ☐ No ☐ Yes When? _____

Tetanus immunization? ☐ No ☐ Yes When? _____

When was your last:

Pap smear? _____ Breast exam? _____ Stool check for blood? _____

Mammogram? Cholesterol check? Prostate exam?

PULMONARY ASSOCIATES
REGISTRATION FORM

Last Name _____ Legal First Name _____ MI _____ Preferred Name _____

SS# _____ ___Single ___Married ___Widowed ___Divorced

Date of Birth: _____ Age: _____ M / F Patient Employer: _____

Address: _____ Work Address: _____

City _____ State _____ Zip _____ 1st Insurance: _____ 2nd: _____

Home Phone: (_____) _____ Referring Physician: _____

Work/Cell Phone: (_____) _____ Location of Referring Phy: _____

Pharmacy _____ Phone: _____ **Email:** _____

SPOUSE INFORMATION

Name: _____ Work Phone: _____

SS# _____ Employer: _____

Date of Birth: _____ Work Addr: _____

MUST COMPLETE IF UNDER 18

Father

Name: _____

Address: _____

SS#: _____

Date of Birth: _____

Work Phone: (_____) _____

Employer: _____

Mother

Name: _____

Address: _____

SS#: _____

Date of Birth: _____

Work Phone: (_____) _____

Employer: _____

AUTHORIZATIONS

**********PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST**********

- I herby authorize and request the medical treatment necessary for the care of the above named patient.
- I authorize the release of all medical records to the referring and family physicians and to my insurance company, if applicable. I allow the fax transmittal of my medical records, if necessary.
- I acknowledge full financial responsibility for services rendered by PULMONARY ASSOCIATES. I understand payment is due at the time of service unless other definite financial arrangements have been made prior to treatment. I understand that I am responsible for any un-met deductibles and co-insurance fees..
- I further authorize and request that insurance payments be made directly to PULMONARY ASSOCIATES, for services rendered.

I have read and fully understand the above consent for treatment, release of medical information, financial responsibility and insurance authorization.

_____ _____ _____

Patient / Parent or Guardian (Please Print) Patient / Parent or Guardian Signature Date

Pulmonary Associates

PAYMENT POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our **Payment Policy**, which we require you to read and sign prior to any treatment. In addition, all patients must complete our information and insurance forms before seeing the doctor.

WE ACCEPT CASH, CHECKS OR CREDIT CARD

1. We participate and file insurance claims with a variety of Physician Reimbursement Plans. You will be responsible for any deductibles, co-payments, or non-covered services at the time of service.

2. For all other insurance companies, we provide detailed itemized receipts for you to file your claims. Assistance in filing your insurance is available upon request.

3. You are responsible for any balances remaining after your insurance pays and for any non-covered services. Your payment of this balance must be received within 30 days of the date you are billed. If your account has to be turned over for collection, you will have to pay any and all collection fees, court costs, and expenses.

4. <u>NON-INSURANCE PATIENTS</u>:

   All patients without insurance will be required to pay in full at the time of service. Credit cards, cash and checks will be accepted.

_____ _____

Signature of Patient or Responsible Party Date

_____

Relationship to Patient

Pulmonary Associates LLC
105 Briarcliff Road
Warner Robins, GA 31088
Phone (478) 922-8900 Fax (478) 922-8989

Controlled Substances Prescription
Physician-Patient Agreement

Patient:_____

It is understood by the above patient/care giver that **ALL** prescription renewals for controlled substances must be anticipated in a timely manner by the patient/care giver, that is within seven days of prescription expirations or exhaustion in order to obtain a renewal if deemed medically appropriate by the physician.

The patient/care giver is responsible for informing the physician within this time period either in person at follow-up or by telephone during regular business hours (9am-5pm). After hours, weekend and holiday request will **NOT** be considered.

The patient/care giver must then bring the **MOST RECENT** prescription container for **EACH** controlled substance that requires renewal, and these containers **MUST** correspond to the last prescription recorded in the medical record with the prescription labels intact and legible so that appropriate control information may be documented by the physician in the medical record. Specifically, the prescription registration number and pharmacy telephone number will be noted and verified. The patient is **STRONGLY** encouraged to trade with only **ONE** pharmacy regarding the controlled substances so as to facilitate this agreement.

Should a patient/care giver experience a theft or loss of controlled substances, the local police must be notified and a copy of the **OFFICIAL** police report be brought to this office, which **MUST** include the Officer's printed name, badge number and telephone number of the police department making the report. Only then will the physician consider the patients/care giver's request for a prescription renewal.

At the physician's discretion, periodic patient urine and/or blood toxicology drug screens for controlled substances may be ordered to substantiate patient/care giver compliance and adherence with the above. This shall also apply to the primary care giver whose signature appears below.

Should the patient/care giver receive controlled substances, such as **NARCOTICS & SEDATIVES** from other physicians, this office **MUST** be informed by the patient/care giver **WITHIN 72 HOURS** of having filled the prescription.

The following information will be given to this office: the physician's name and telephone number, the pharmacy's name and telephone number and the medical reason for the controlled substances.

Should the patient/care giver not adhere to or otherwise violate the above agreement or furnish false information, then the patient will be discharged from our medical care with a two weeks notice being given immediately, in writing, sent to the above address.

_____ Date_____

Patient

HIPPA Notice of Privacy Practices

Pulmonary Associates
105 Briarcliff Road,
Warner Robins, GA 31088
478-922-8900

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means that you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature_____ Date_____

Pulmonary Associates LLC
Hatem Asad, MD Wila Zanghi, NP-C
105 Briarcliff Road
Warner Robins, Ga. 31088
Phone (478) 922-8900 Fax (478) 922-8989

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

SSN: _____ DOB: _____

I hereby authorize Pulmonary Associates, LLC

◊ Obtain From: _____
(Name, Address, Phone of Person or Agency)

The following medical records, which I understand may include Psychiatric information, drug and alcohol information and /or HIV information.

The extent or nature of information to be released is indicated below:

◊ Laboratory Reports From: _____ (date(s) of service)
◊ Complete Medical Record
◊Other_____ (date(s) of service)
◊ Request Pulmonary Associates, LLC to provide me an explanation or summary of the information provided from Pulmonary Associates, LLC. I understand that Pulmonary Associates may charge me a fee of $25.00 for the explanation or summary, and I may be required to pay the fee in full before I can obtain the summary.

The purpose for release of the above information is indicated below:
◊ Continued Care ◊ Insurance ◊ Legal ◊ Other: _____

I understand this consent is voluntary and that I may revoke this authorization at any time(except to the extent that action based on this consent has already been taken) by written, dated, and signed communication sent to Pulmonary Associates, LLC Attention: Privacy Officer, and are not effective until received by the Privacy Officer.

I understand I may refuse to sign this authorization. If I refuse, the identified records will not be disclosed. Whether I sign or refuse to sign, my treatment will not be affected. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by Health Insurance Portability and Accountability Act.

_____
Signature of Patient/Guardian

If signed by other than the patient, state relationship and reason for patient's inability to sign:

_____