Pulmonary and Critical Care Associates of San Antonio

Patient's Name: _____

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

Home/Cell Phone: _____ Work Phone: _____ Ext_____

DOB: _____ Gender: Male □ Female □ Social Security # _____

Email Address: _____ Primary Source of Contact: Home Phone □ Cell Phone □

Marital Status: _____ Occupation: _____

Preferred Language: _____ Race: _____

Driver's License # _____ Employer: _____ Work Phone: _____

Employer's Address: _____ City: _____ State: _____ Zip: _____

Whom may we call in Case of Emergency? Name: _____

Relationship to patient: _____ Primary Phone #: _____

Primary Care Physician/Phone: _____

Address: _____

Specialist Physician/Phone: _____

Address: _____

Specialist Physician/Phone: _____

Address: _____

Collection Policy: All payments are due at time of services rendered. This practice has a legal obligation to the insurance companies that we are contracted with to collect co-payments, co-insurance and deductibles at time of service. Once a balance reaches 90 days old without payment, it may be transferred to a third party for further collections or other actions. There may be a charge of **$25.00** for filling out forms that require more than a signature and for writing letters each time these services are provided. Our office will obtain benefits for your insurance; however, it is your responsibility to know your benefits per your contract with your health insurance carrier. It is your responsibility to provide our office with new insurance information prior to your appointment to avoid unnecessary wait times. I hereby assign all medical and/or surgical benefits to which I am entitled to PACSA. I understand that I am financially responsible for all charges whether paid by insurance or not. I hereby authorize said assignee to release all information necessary to secure payment.

Patient's Initials _____

Primary Insurance: _____

Insured Name: _____ Patient Relationship to Insured and DOB: _____

Insured Social Security Number: _____ Insurance ID#: _____ Group#: _____

Secondary Insurance: _____

Insured Name: _____ Patient Relationship to Insured and DOB: _____

Insured Social Security Number: _____ Insurance ID#: _____ Group#: _____

Pulmonary and Critical Care Associates of San Antonio

Consent for Purpose of Treatment, Payment, Healthcare Operations and Notice of Privacy Practices

I consent to the use or disclosure of my protected health information by Pulmonary and Critical Care Associates of San Antonio (PACSA), for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of PACSA. I understand that diagnosis or treatment of me by PACSA may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. PACSA is not required to agree to the restrictions that I may request. However, if PACSA agrees to a restriction that I request, the restriction is binding on PACSA and

_____.

(Write patient's name here)

I have the right to revoke this consent, in writing, at any time, except to the extent that **PACSA** has acted in reliance on the consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review PACSA Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices is available to me for review. The Notice of Privacy Practices describes the types of use(s) and disclosures of my protected health information that will occur in my treatment, payment of my medical claims or in the performance of health care operations of PACSA. This Notice of Privacy Practices also describes my rights and PACSA duties with respect to my protected health information.

PACSA reserves the right to change the privacy practices described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Name of Patient (Print)

_____ _____

Date | Description of Personal Representative's Authority

I am giving authorization to Pulmonary and Critical Care Associates of San Antonio to disclose my medical and insurance information to the below person(s).

Name: _____ Phone #: _____

Address: _____ Relationship: _____

Name: _____ Phone #: _____

Address: _____ Relationship: _____