NEW PATIENT PAPERWORK

Please Read Carefully and Fill out with the best of your Abilities

All Highlighted fields are **Required** to be Filled out

Cover Sheet

Premier Pulmonary Critical Care and Sleep Medicine

*5012 S U.S Hwy 75 Suite 200, **Denison**, TX 75020*
*3094 Laura Lane, Suite 100, **McKinney**, TX 75070*
*3100 Midway Road Suite 168, **Plano**, TX 75093*
Phone: 903-465-5012 Fax: 866-307-7513

Patient Information

Name (Printed): ________________________ **Date of Birth:** ________________

Social Security Number: ________________________

Status: ❐ Single ❐ Married ❐Widowed ❐Divorced ❐ Other: ________

Ethnicity:

❐ Caucasian ❐ Hispanic ❐ Asian ❐ African American ❐ Other:

Home Address: ____

City: _________________ **State:** ________________ **Zip code:**_______________

Primary Phone Number: ________________________

Home Phone: _______________________ **Cell Phone:** __________________

Email Address: ________________________________

Preferred Contact: ❐ Home ❐ Cell ❐ Email

Would you like Patient Portal Access? ❐ Yes ❐ No

Employment Information

Employer Name: _________________________

Occupation: _____________________ If retired: please check box ❐

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Physician and Pharmacy Information

Primary Care Physician (PCP): ___________________________

Referring Physician: ______________________________

Preferred Pharmacy Name: ___________________________

Pharmacy Address: _________________________________

Pharmacy Number: _________________________________

Are you a resident of a **Nursing Facility**? ❒ No ❒ Yes

❒ **if Yes:** Name of Facility (Printed) ________________________________

Emergency Contact:

Full Name (Printed): ____________________________

Phone Number: _________________________ **Relationship:** ________________

Insurance Information: Check Box if Self Pay ❒

Primary Insurance Carrier: __________________________________

Subscriber #: _________________________ **Group #:** ___________________

Secondary Insurance Carrier: _____________________________________

Subscriber #: _________________________ **Group #:** ___________________

Tertiary Insurance Carrier: _____________________________________

Subscriber #: _________________________ **Group #:** ___________________

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OFFICE POLICIES

FINANCIAL & INSURANCE POLICY:

At your appointment, your copay and deductible will be collected. After billing insurance, any remaining balance is due unless payment arrangements are made. If we do not accept your insurance, you're responsible for full payment at the time of service, though we will file a claim as a courtesy. If you don't have insurance, you must pay the discounted amount in full at the time of service.

Authorization and Assignment of Benefits:

I authorize Premier Pulmonary Critical Care and Sleep Medicine to release my medical information to secure insurance benefits, authorization, or payment for services and tests. I will provide current insurance details for them to act on my behalf for necessary approvals or billing. I understand I can revoke this authorization at any time with a written request.

I request that insurance payments be made directly to Premier Pulmonary and Sleep Medicine for services provided. I understand I am responsible for any charges not covered by insurance, including nuclear test costs if appointments are missed or not rescheduled. I will notify the office of any changes to my address or coverage. I acknowledge receiving the Notice of Privacy Practices and understand that Premier Pulmonary and Sleep Medicine will try to obtain insurance authorization, but there's no guarantee of payment.

PRESCRIPTIONS AND SAMPLE REFILL POLICY:

Allow 72 hours for routine refills and 24 hours for sample refills. Check with your pharmacy for medication readiness. For mail-in pharmacy paperwork, we can assist, but it's your responsibility to send it to the pharmacy.

MEDICAL RECORD REQUEST POLICY:

Allow 3-5 business days for medical record requests. A fee may apply, payable before records are released.

PATIENT RIGHTS & RESPONSIBILITIES:

As a patient, you have rights and responsibilities in your care. We treat all individuals equally, regardless of race, creed, national origin, age, or disability.

Patient or Legal Guardian Name: ___________________________

Patient or Legal Guardian Signature: _______________________

Date: _________________

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PATIENT 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 a 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 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 the need and an explanation or 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 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 physician’s

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PATIENT RESPONSIBILITIES:

1. You should provide, as fully as you can, accurate and complete information on present complaints, past illnesses and hospitalizations, medications, and any 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 insurance 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 or Legal Guardian Name: ___________________________

Patient or Legal Guardian Signature:________________________

Date: _________________

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RELEASE OF INFORMATION FOR MEDICAL RECORD:

(Physician's Offices or Medical Providers)

Patient Name: ___________________

Patient Address: ____________________

Patient Date of Birth: __________________

Date of Service: _________________

Patient Phone Number: ________________

I hereby authorize Premier Pulmonary Critical Care and Sleep Medicine to release information and forward to:

___________________ **(Provider Name)**

___________________ **(Provider Name)**

___________________ **(Provider Name)**

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 above information is released:

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

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I understand that the specific information to be disclosed my 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 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 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 (if Patient, write "SELF")

Date of Request: ___________________
Record copying cost: $ ________ ❐ Cash ❐ Check ❐ Credit ❐ Debit

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Release of Information for Medical Records

(Family Member or Patient Representative)

Patient Name: ______________________________

Patient DOB: _______________________________

Patient Signature: _____________________________

Date: _______________________________

Release of Information for Medical Records to the Following Individuals:

(Family Member or Patient Representative)

Name	Phone	Relation to Patient

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I understand *that the specific information to be disclosed may include history of DRUG or ALCOHOL ABUSE. Or MENTAL HEALTH TREATMENT, of information concerning communicable diseases such as HUMAN IMMUNODEFICIENCY 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 per-employment purposes. However, no protected information will be released without a signature.*

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.*

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 Guardian: ______________________________

Relationship to Patient: ___________________________

Date: ______________________

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Policy for Lab Work and Diagnostic Imaging

Purpose:
The purpose of this policy is to ensure that patients receive accurate and timely information about their test results. We believe that it is important for patients to have the opportunity to discuss their test results with their doctor in order to fully understand their meaning and implication.

Policy:
1. All test results will be reviewed with the patient during an appointment.
2. Patients may not request test results without an appointment.
3. If a patient wants to obtain their results without an appointment. They must contact the testing facility directly.
4. The testing facility will provide the patient with their test results.

Exceptions:
1. In some cases., it may be necessary to release test results to a patient without an appointment. This will be done on a case-by-case basis and with the approval of the physician.

Rationale:
We believe that this policy is in the best interest of our patients. By requiring patients to discuss their test results with their doctor, we can ensure that they receive accurate and timely information. We also believe that it is important for patients to have the opportunity to ask questions and receive clarification about their results.

Review:
This policy will be reviewed annually to ensure that it is up to date and effective.

Name: ________________________________

Date of Birth: _________________________

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Current Medication List

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

Medication Name	Dose	Frequency