PULMONARY PHYSICIANS
OF SOUTH FLORIDA, LLC

Dear_____

Thank you for choosing the Pulmonary Physicians of South Florida.
Your appointment has been scheduled with:

_____M.D.
On_____at_____.

Please complete the enclosed forms. Return the forms by mail or fax 2 days prior to your appointment along with a copy of the front and back of your insurance card. If there is not time to do so, bring the completed forms the day of your visit.

We also request the original insurance card and a photo I.D. at the time of your appointment. Please arrange for an appropriate referral in advance of the appointment if your insurance company requires it.

Please fill out all the pages in the packet including the list of medications. If you have reports of recent testing like lab work, x-rays, scans, etc. or actual films or CD's of any x-rays or scans, please bring them. You may obtain these from the radiology department of the facility where you had your test done.

As a new patient to our practice, please call us to confirm your appointment. If by any reason you need to cancel, please give us enough time so that we may schedule someone else in your place. We look forward to seeing you shortly.

Sincerely,

Pulmonary Physicians of South Florida

7000 SW 62nd Avenue • Suite 201 • South Miami, Florida 33143 • Office: 305-661-9404 • Fax: 305-661-1510

REGISTRATION INFORMATION

(PLEASE PRINT)

Date_____ Home Phone_____

Patient_____
Last Name First Name Initial

Responsible Party (if a minor)_____

Street Address_____

City_____ State_____ Zip_____

Sex ☐ M ☐ F Age____ Birthdate_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

☐ Employed ☐ Full-Time Student ☐ Part-Time Student Patient's School Name_____

Patient Employed By_____

Business Address_____

Occupation_____ Business Phone_____

Spouse (or responsible party) Name_____ Birthdate_____

Business Name and Address_____

Occupation_____ Business Phone_____

Who is responsible for this account?_____ Relationship to Patient_____

Social Security #_____ Spouse's Social Security #_____

Do you have Medical Insurance? ☐ No ☐ Yes If yes,

Name of Primary Insurer_____

Contract #_____ Group #_____ Subscriber #_____

Name of Secondary Insurer (if any)_____

Contract #_____ Group #_____ Subscriber #_____

Are you covered under any of these programs? ☐ Medicare ☐ Medicaid ☐ CHAMPUS ☐ CHAMPVA

☐ Worker Compensation ☐ FECA Black Lung I.D. # for program you've checked_____

If Welfare, your number_____ County of_____

Is your condition related to employment (current or previous) ☐ No ☐ Yes

Is your condition related to auto accident? ☐ No ☐ Yes In which state?_____

Other Accident? ☐ No ☐ Yes Please describe_____

In case of emergency, who should be notified?_____

Phone_____ Relationship to patient_____

(OVER)

Please list other doctors you have seen in the past 5 years:

1._____ City/State_____
(General Practitioner, Specialist, or other)

Reason for seeing_____

2._____ City/State_____
(General Practitioner, Specialist, or other)

Reason for seeing_____

How did you learn of our practice?_____

Whom may we thank for referring you?_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

and assign directly to Dr._____all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature of Insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr._____ for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

OFFICE NOTES

_____

_____

_____

_____

_____

_____

PULMONARY PHYSICIANS OF SOUTH FLORIDA, LLC

PATIENT AUTHORIZATION AND FINANCIAL RESPONSIBILITY FORM

CONSENT TO TREATMENT

I hereby voluntarily consent to the rendering of medical treatment by the physicians and medial staff of the Pulmonary Physicians of South Florida. This may include examinations, diagnosis and/or surgical procedures, administration of injections and/or any other such medical treatment deemed necessary for the diagnosis and treatment of the patient's medical condition.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize my insurance company to make payments on my behalf of any and all Individual, Group, Worker's Compensation, Liability or PIP benefits directly to the provider, physicians and medical staff of the Pulmonary Physicians of South Florida for medical services rendered to me.

MEDICARE/MEDICAID ASSIGNMENT OF BENEFITS

Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVII or XIX of the Social Security Act is correct. I request that Medicare, Medicaid, Medigap and supplementary insurance companies make payments of authorized medical benefits to the physicians and medical staff of the Pulmonary Physicians of South Florida on my behalf.

GUARANTY OF PAYMENT

I understand that I am Financially responsible for payment to the physicians and medical staff of the Pulmonary Physicians of South Florida for any charges not covered or allowed by my insurance company and all applicable out of pocket expenses, including deductibles, co-insurance and co-payments. I further understand and agree that if this account is placed for collection, I will be responsible for paying the balance owed to the physicians and medical staff of the Pulmonary Physicians of South Florida plus any attorney fees, if applicable.

THIRD PARTY BENEFIT COLLECTIONS

I, hereby authorize the Pulmonary Physicians of South Florida to act on my behalf as attorney in fact in (1) the collection of benefits from any responsible third party payer through any legal means necessary and (2) in the endorsement of benefit checks made payable to me or the physicians and medical staff of the Pulmonary Physicians of South Florida.

I,_____(PRINT NAME) ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND EACH OF THE ABOVE PROVISIONS APPEARING ON THIS FORM AND THAT BY SIGNING THIS FORM, I CONSENT TO THESE PROVISIONS INDIVIDUALLY AND COLLECTIVELY.

_____ _____

Patient or Legal Guardian Date Witness Date

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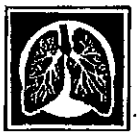

PULMONARY PHYSICIANS

OF SOUTH FLORIDA, LLC

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

(this general optional form supplements the Notice of Privacy Practices enabling the entity to use / disclose Protected Health Information in specific situations for its own purposes, or in cases in which there is doubt regarding coverage by the Notice of Privacy Practices)

I hereby consent to the use or disclosure of my protected health information by _____ for the purpose of diagnosing or providing treatment to me, obtaining payment *(insert name of entity) (the "Provider")* for my health care bills or to conduct health care operations of the Provider. I understand that diagnosis or treatment of me by the Provider 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. The Provider is not required to agree to the restrictions that I may request. However, if the Provider agrees to a restriction that I request, the restriction is binding on the Provider and all physicians associated with the Provider.

I have the right to revoke this consent, in writing, at any time, except to the extent the Provider has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or revoked by my physicians, 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 the Provider's Notice Practices prior to signing this document. The Provider's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of the Provider. The Notice of Privacy Practices for the Provider is also provided in the waiting room. This Notice of Privacy Practices also describes my rights and the Provider's duties with respect to my protected health information.

The Provider and all physicians associated with the Provider reserve the right to change the privacy practices that are 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 or Personal Representative Date

_____

Description of Personal Representative's Authority

7000 S.W. 62nd. Ave., Suite 201 • South Miami, Florida 33143 • Office 305 / 661-9404 • Fax 305 / 661-1510

LIST OF MEDICATIONS

(please include name, dosage, and quantity)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____
22. _____
23. _____
24. _____
25. _____
26. _____
27. _____
28. _____
29. _____
30. _____

PHARMACY INFORMATION:

Pharmacy Name _____ **Store #** _____

Pharmacy Address _____

Telephone # _____ **Fax #** _____