



Pulmonary Health Consultants
1306 North High Street Millville, NJ 08332 * 1100 Liberty Place Sicklerville, NJ 08081

PATIENT REGISTRATION FORM
Please PRINT in INK

DATE: _____

Name _____ Preferred Name _____
Last First MI

Date of Birth ____/____/____ Social Security # ____ -- ____ -- ____
Sex: Male/Female/_____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone _____
Email: _____

Marital Status: Single Married Widowed Separated Divorced Not applicable

Spouse's/Partner's Name: _____

Race: American Indian/Alaska Native Asian Native Hawaiian/Other Pacific Black or African
American Caucasian Hispanic Other Race Do not wish to answer
Ethnicity: Hispanic or Latino Not Hispanic
Primary Language: _____

Employment
Employer: _____ Full Time Part Time
Retired
Student
None
Occupation: _____

Address: _____ Phone # _____

Physician/ Pharmacy Information:

Primary Care Physician: _____ Phone # _____

Address: _____

Referring Physician: _____ Phone #: _____

Address: _____

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PATIENT REGISTRATION FORM

Preferred Pharmacy: _____ Phone _____

Address:

Responsible Billing Party

_____ *Please check if Responsible Billing Party is the patient.*

Name: _____ Date of Birth: ___/___/___
Last First MI

Address: _____
Street City State Zip

Social Security #: _____ - _____ - _____ Phone #: _____

Relationship to patient: Self Spouse Partner Other: _____
Please specify

PRIMARY Insurance Information:		
Insurance Name:		
Subscriber's Employer:		
Policy Holder Name:		Date of Birth:
Social Security #: _____ - _____ - _____	Member ID #:	Group #:

SECONDARY Insurance Policy (if any)		
Insurance Name:		
Subscriber's Employer:		
Policy Holder Name:		Date of Birth:
Social Security #: _____ - _____ - _____	Member ID #:	Group #:

TERTIARY Insurance Policy (if any)		
Insurance Name:		
Subscriber's Employer:		
Policy Holder Name:		Date of Birth:

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ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

I hereby give permission to Pulmonary Health Consultants, LLC to bill my insurance company for professional medical services rendered. I agree to pay all charges due or that become due to Pulmonary Health Consultants, LLC for the care and treatment provided to me by Pulmonary Health Consultants, LLC.

I understand that insurance benefit verification and authorization is not a guarantee of payment and if the charges are denied, the medical charges will become my responsibility and obligation. I am responsible to pay all copayments, coinsurance and deductible applied to my account after the insurance payment is made and/or the claim is processed.

In addition, any charges denied by the insurance company because they do not meet the criteria for medical necessity would be my responsibility.

And if I do not or did provide Pulmonary Health Consultants, LLC with accurate and current information regarding my insurer, I will be personally responsible for the cost of the care rendered.

I agree that all bills are to be paid when presented or in advance of treatment, myself pay. And if I fail to pay my bill, I realize that my account will be forwarded to the collection agency and attorney and court fees will be added to my due balance.

*X

Signature of Patient or Legally Authorized Representative Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

By signing this form, you acknowledge receipt of Pulmonary Health Consultants' Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

If you have any question regarding Pulmonary Health Consultants' Notice of Privacy Practices, please contact our Privacy Office at 1-856-875-3630.

I acknowledge receipt of Pulmonary Health Consultants' Notice of Privacy Practices.

*X

Signature of Patient or Legally Authorized Representative Date

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

Attempts have been made to obtain written acknowledgement of receipt of Pulmonary Health Consultants' Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Barrier(s) to communication prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please specify) _____

*X

Signature of Provider Representative Date

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CONSENT FORM FOR THE AUTHORIZATION OF TREATMENT & RELEASE OF INFORMATION

Name: _____ Date: _____
Date of Birth: _____ MRN#: _____

Consent for Medical/Surgical/ Urgent Care

I hereby authorize Pulmonary Health Consultants, LLC to provide initial and ongoing medical/surgical treatment that is necessary and reasonable as based on acceptable standards of care for my wellness and the treatment of my physical condition.

I consent to examination, blood tests, (including blood tests for communicable disease such as Hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physician, and their associate and assistants, or rendered by facility personnel under the instructions, orders and direction of such physician(s).

Authorization to Release Medical Information

I hereby authorize Pulmonary Health Consultants, LLC to release information obtained in the course of my medical/surgical/urgent care to my insurance carrier and other providers of health care and healthcare organizations involved in my care. In the event of an employee blood or body fluid exposure, I authorize Pulmonary Health Consultants, LLC to release pertinent testing for the treatment of the employee. I also authorize Pulmonary Health Consultants to receive my medication history.

Assignment of Benefits

I hereby assign all medical/ surgical/ urgent care benefits to which I am entitled, including major benefits, Medicare, private insurance and any other health plans, to Pulmonary Health Consultants, LLC. A photocopy of this assignment is to be considered as valid as the original.

I understand that I am financially responsible for all costs not covered by my insurance plan (s). This includes but not limited to co-pays, coinsurances, deductibles, and non-covered procedures and/or diagnoses. I understand that if my insurance requires a referral for me to receive treatment here that is my responsibility to obtain that referral from my primary care physician. I also understand that I am expected to make payment for previous balances or balances sent o collections prior to my office visit. If I am unable to pay my balance in full, I understand that I can speak to the office manager to setup a payment plan.

I understand that Pulmonary Health Constants, LLC reserves the right to impose a fee for un-cancelled (failure to show) appointments.

Consent to Call, Text, or Email

I consent to receiving the following automated communications from Pulmonary Health Consultants, LLC.

Health Notifications Email Phone Text Message
Appointments Email Phone Text Message
Announcements Email Phone Text Message
Billing Email Phone Text Message

If email was chosen as a communication preference above, please provide your email address:

I authorize the release of information including the diagnosis, records and examinations rendered to me as well as claims information, to the persons listed below:

Name _____ Relationship _____

Phone Number _____

Name _____ Relationship _____

Phone Number _____

Check here if you DO NOT want this information release to anyone other than yourself

Patient or Legal Representative Signature: *X _____ Date _____

Relationship to Patient: _____

Witness: _____ Date: _____

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act --45 CFR Parts 160 and 164)

1. I hereby authorize all medical service sources and health care providers to use and/or disclose the protected health information ("PHI") described below to my agent identified in my durable power attorney for health care named _____

2. Authorization for the release of PHI covering the period of health care (check one)

a. _____ from (date) _____ - to (date) _____ OR

b. _____ all past, present and future periods.

3. I hereby authorize the release of PHI as follows (check one)

a. _____ my complete health record (including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse). OR

b. _____ my complete health record with the exception of the following information

(check as appropriate):

_____ Mental health records

_____ Communicable disease (including HIV and AIDS)

_____ Alcohol/drug abuse treatment

_____ Other (please specify): _____

4. In addition to the authorization for release of my PHI described in paragraphs 3a and 3b of this Authorization, I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the

following individual(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

5 This medical information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

6. This authorization shall be in force and effect until nine (9) months after my death or _____, (date or event) at which time this authorization expires.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization

or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

9. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

*X _____ Date: _____

Signature (18 years or older)

*X _____ Date _____

Signature of Legal Representative Relationship to Patient

Keep original, and give copies to your health care provider, agent and family members

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CANCELLATION / NO SHOW POLICY

Thank you for entrusting your medical care with Pulmonary Health Consultants.

When you schedule an appointment with Pulmonary Health Consultants, we set aside enough time to provide comprehensive and higher quality of care.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment.

For missed provider appointments there will be a \$25.00 no show fee. For missed breathing tests appointments there will be a \$80.00 no show fee. This gives us time to schedule other patients who may be waiting for an appointment and reschedule yours as well.

Thank you for understanding and your cooperation as we strive to best serve the needs of all our patients.

By signing below, you acknowledge that you have received this notice and understand this policy.

Printed Name

Date

Signature



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REQUEST FOR RELEASE OF HEALTHCARE INFORMATION

Patient Name: _____

Today's Date: _____

Last 4 digits of SSN: _____

Date of Birth: _____

I hereby authorize: _____

Address: _____

Phone: _____

Fax: _____

To release, use, and disclose health information about me as described below to:

**Pulmonary Health Consultants
1306 North High Street
Millville, NJ 08081
P:(856) 875-3630
F:(856) 300-7591**

This request and authorization applies to :

[] All Healthcare information

Patient Signature: X _____

Date Signed: _____



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COVID- 19 Pandemic – Patient Disclosures

This patient disclosure form seeks information from you that we must consider before making treatment decisions in this circumstance of the COVID-19 virus.

	Yes	No
Do you have a fever of above normal temperature?		
Are you experiencing shortness of breath or having trouble breathing?		
Do you have a dry cough?		
Do you have a running nose?		
Have you recently lost or had a reduction in your sense of smell/taste?		
Do you have a sore throat?		
Are you feeling nauseous?		
Do you have diarrhea?		
Are you feeling fatigued?		
Do you have muscle aches?		
Have you been experiencing headaches?		
Even if you don't currently have any of the above symptoms, have you experienced any of these symptoms in the last 14 days?		
Have you been in contact with someone who has tested positive for COVID 19 in the last 14 days?		
Have you tested positive for COVID -19?		
Have you been tested for COVID-19 and are waiting for results?		
Have you travelled outside of New Jersey for any reason in the past 14 days?		
Have you travelled outside of the United States for any reason in the past 14 days?		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history, which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have promised above are true and accurate.

Signature

Date

Witness