Pulmonary, Critical Care & Sleep Medicine Associates

Registration Form

PATIENT INFORMATION:

Name: _____ **Social Security #**_____ **Aliases:** _____
First Middle Last

Sex: __Male __Female **Birthdate:** _____ **Marital Status:** _Single _Married _Widow _Divorced _Other

Home Address:_____ **City/State** _____ **Zip**_____

(X preferred contact #) __**Home Phone** _____ __**Cell** _____ __**Work**_____

Would you like to provide an email address? _____

Primary Care Physician: _____ **Physician who referred you if not your primary:** _____

EMERGENCY CONTACT INFORMATION:

Name: _____ **Relationship to Patient:** _____

Address_____ **City/State** _____ **Zip**_____

(X preferred contact #) __**Home Phone**_____ / __**Cell**_____ / __**Work** _____

GUARANTOR INFORMATON: (person responsible for your medical charges)

Responsible Party: __Self __Spouse __Father __Mother __Other_____ **Sex**: __Male __Female

Guarantor Full Name: _____ **Birthdate**: _____ **Social Sec #**:_____

Guarantor Employer: _____ **Employment Status**: _____ **Phone**: _____

Employer Address:_____ **City/State**:_____ **Zip**:_____

PRIMARY INSURANCE:

Insurance Company: _____ **Effective Date**: _____ **Co. phone**: _____

Company Address: _____ **Co-pay amount**: _____

Subscriber's Name: _____ **Birthdate**: _____ **Relationship to patient**: _____

Employer Name: _____ **Identification/Policy #**: _____ **Group #:** _____

Employment Status: __full time __part time __retired __self employed __not employed __active military duty __student

Covered through: __employment __retirement __COBRA __other **Number of employees**: __1-19 __20-99 __100+

SECONDARY INSURANCE:

Insurance Company: _____ **Effective Date**: _____ **Co. phone**: _____

Company Address: _____ **Co-pay amount**: _____

Subscriber's Name: _____ **Birthdate**: _____ **Relationship to patient**: _____

Employer Name: _____ **Identification/Policy #**: _____ **Group #:** _____

Employment Status: __full time __part time __retired __self employed __not employed __active military duty __student

Covered through: __employment __retirement __COBRA __other **Number of employees**: __1-19 __20-99 __100+

TETRIARY INSURANCE(if applicable)

Insurance Company: _____ Identification/Policy # _____ Group #: _____

INJURY: Is this related to a motor vehicle accident? __yes __no Did this injury occur at work? __yes __no

_____ _____

Date Signature of patient or authorized person

Pulmonary, Critical Care & Sleep Medicine Associates
10 Office Park Drive Suite B
Hamilton, Ohio 45013

Patient Name: _____

Assignment and Release

I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I agree and acknowledge that my signature on this document authorizes Pulmonary, Critical Care & Sleep Medicine Associates to submit claims for benefits for services rendered or to be rendered, without obtaining my signature on each submitted claim for myself and/or dependents. I also authorize my insurance company to pay Pulmonary, Critical Care & Sleep Medicine Associates directly all benefits for services rendered.

Financial Responsibility

I understand I am financially responsible for all charges incurred and agree to pay co-payments, co-insurance, and deductible amounts set forth by my insurer. I further agree that I am ultimately responsible for payment of all charges regardless of my insurance coverage.

"No Show" Appointments

If I do not keep a scheduled appointment or cancel that appointment at least 24 hours prior to the scheduled time I may be billed a missed appointment charge. I understand that if I miss multiple appointments I run the risk of being dismissed from the office practice for noncompliance.

_____

Patient/Responsible Party Signature

_____

Date

HIPAA Notice of Privacy Practices

Revised 2013

Effective as of April/14/2003

Pulmonary, Critical Care & Sleep Medicine Associates, LLC

10 Office Park Drive, Suite B, Hamilton, OH 45013
Phone: (513) 893-5864

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 is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry 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 condition and related health care services.

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 offices 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, 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 of 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, employee review, training of medical students, licensing, fundraising, 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 your 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 or your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

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, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

USES AND DISCLOSURES THAT REQUIRE YOUR AUTHORIZATION

Other Permitted and Required Uses and Disclosures will be made **only with your consent, authorization** or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes.

You may revoke the 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

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information (fees may apply) – Pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes, information compiles in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or to another person, or information that was obtained under a promise of confidentiality.

You have the right to request a restriction of your protected health information – This means 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 restriction to apply. Your physician is not required to agree to your requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

You have the right to request to receive confidential communications – You have the right to request confidential communication 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 have the right to request an amendment to 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 – You have the right to receive an accounting of disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations: required by law, that occurred prior to April 14, 2003, or six years prior to the date of the request.

You have the right to receive notice of a breach – We will notify you if your unsecured protected health information has been breached.

You have the right to obtain a paper copy of this notice from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.\

COMPLAINTS

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

HIPAA Compliance Officer: Terri Johnson

Phone: 513-893-5864 **Email:** tjohnson@pccsm.com

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. We are also required3to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. Please sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Pulmonary, Critical Care and Sleep Medicine Associates, LLC

Acknowledgement of Notice of Privacy Practices

Patient Name: _____

I have received a copy of the Notice of Privacy Practices for Pulmonary Critical Care and Sleep Medicine Associates, LLC. I am aware that it details how my health information may be used and disclosed under Federal and State laws.

_____ _____

Patient/Legal Representative Signature Date

I authorize Pulmonary, Critical Care and Sleep Medicine to release my healthcare information to the person/persons listed below. Other physicians do not need to be listed.

Name of person	Telephone Number	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

The following information can be left on my answering machine/voice mail if you are unable to reach me personally:

___ appointment reminders and medical insurance questions

___ test results and instructions regarding my care

___ Do not leave messages.

_____ _____

Patient Signature Date