PCCSS, LLP
Pulmonary, Critical Care & Sleep Specialists

PATIENT INFORMATION

Referred By: _____ Date: _____

Patient's Name: _____
(Last) (First) (Middle)

Address: _____

City: _____ State: ____ Zip: _____ Home Phone: ( ) _____

Cell Phone: ( ) _____ Work Phone: ( ) _____

Sex: ____ Marital Status: _____ Date of Birth: ____/____/____ Social Security #: _____-_____-_____

Employer: _____ Occupation _____

Address: _____

IN CASE OF EMERGENCY, PLEASE NOTIFY:

Name: _____ Phone: ( ) _____ Relationship: _____

INSURANCE:

Primary Insurance Co: _____ Policy Holder's Name _____

Secondary Insurance Co: _____ Policy Holder's Name _____

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY:

This office does not accept responsibility for collecting your insurance proceeds or for the negotiating settlement of a disputed claim. If for whatever reason your insurance company does not pay your claim in full, you are responsible for payment of the entire balance including any finance charge or collection fees that may be included.

Date: _____ Signature: _____

ASSIGNMENT OF BENEFITS:

I hereby assign all medical benefits for services provided by PCCSS, LLP, including Medicare, Medicaid, private insurance and any other health plans to PCCSS, LLP. I further authorize a release of any medical information necessary to process the claim and payment of benefits. A photocopy of this assignment is to be considered as valid as an original. This assignment remains in effect until revoked by me in writing.

Date: _____ Signature: _____

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NOTIFICATION INFORMATION

1) Please list the family member or significant other and the phone number, if any, whom we may inform about your general medical condition.

_____

2) Please list the family member or significant other and the phone number, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

_____

3) Please list the address of where you would like your billing statements and/or correspondence from our office to be sent to if other than your home:

_____

4) Please indicate if you want all correspondence from our office to be sent in a sealed envelope marked "CONFIDENTIAL." YES _____ NO _____

5) Please print the telephone number, if any, where you want to receive calls regarding your appointments, lab and x-ray results, or other health care information if other than your home number:
( ) _____

6) Can confidential messages be left on your home answering machine or voicemail? YES _____ NO _____

7) If you do not have voicemail or answering machine, can a confidential message be left at your place of employment? YES _____ NO _____

_____ _____
Patient's Signature or Representative Relationship (if Representative)

_____ _____
Patient's Name (Printed) Date

PCCSS, LLP
Pulmonary, Critical Care & Sleep Specialists

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent to PCCSS, LLP to use and disclose protected health information about me to carry out treatment, payment and healthcare operations. (PCCSS, LLP Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. PCCSS, LLP reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to PCCSS, LLP at 7500 Beechnut, Suite 250, Houston, Texas 77074.

With this consent, PCCSS, LLP or their representative may call my home or other alternative location and leave a message on voicemail or in person in reference to any item that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others.

With this consent, PCCSS, LLP or their representative may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that PCCSS, LLP restrict how it uses or discloses my protected health information to carry out treatment, payment and healthcare operations.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I give my consent to PCCSS, LLP to use and disclose my protected health information to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, PCCSS, LLP may decline to provide treatment to me.

_____ _____

Signature of Patient or Representative | Relationship (if Representative)

_____ _____

Patient's Name (Printed) | Date

PCCSS, LLP
Pulmonary, Critical Care & Sleep Specialists

Dear Patient:

It is the patient's responsibility to know his insurance plan. If this information cannot be provided correctly at the time of the visit, we cannot be responsible for any reimbursement for incorrect billing.

I hereby certify that I have been made aware of the above information and agree to abide by it.

_____ _____
Signature of Patient or Representative Relationship (if Representative)

_____ _____
Patient's Name (Printed) Date

My insurance plan is: _____
This is a: _____ PPO
_____ HMO
_____ Group
_____ Medicare (If you are covered by Medicare, please read and sign the paragraph below).

MEDICARE PATIENTS

_____ Office Consultation
_____ Return Office Visit

Have you had 4 visits this month? YES _____ NO _____
Do you have a referring physician? YES _____ NO _____

PHYSICIAN NOTE

*Medicare will only pay for services that it determines to be 'reasonable and necessary' under Section 1892(a) of the Medicare Law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare program standards, Medicare is likely to deny payment for today's visit for the reasons:

"You have already seen 4 physicians this month" or "You do not have a referring physician for this consultation."

BENEFICIARY AGREEMENT

"I have been notified that, in my case, Medicare is likely to deny payment for the services identified above, for the reason stated. If Medicare denies payment, I agree to be personally and fully responsible for payment."

_____ _____
Signature of Patient Medicare #

_____ _____
Patient Name (Printed) Date

PCCSS, LLP
Pulmonary, Critical Care & Sleep Specialists

ACKNOWLEDGEMENT OF REVIEW OF
NOTICE OF PRIVACY PRACTICES

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Signature of Patient or Representative

_____
Relationship (if Representative)

_____
Patient's Name (Printed)

_____
Date

FOR OFFICE USE ONLY

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____

Pulmonary Critical Care Sleep Specialist

Notice of Denied or Non- Covered Services

__ (please initial) I have been notified that because I do not have a referral form and this visit is not authorized, or because PCCSS is not on my insurance plan, I will be responsible for today's visit. I understand that if I obtain a referral form or the visit is authorized, PCCSS will file directly with my insurance company and will refund my payment less any copayments/coinsurance amounts.

__ (please initial) I have been notified that PCCSS is a participating provider under Medicaid. The claim will be filed but if the claim is rejected, it is understood that I will be responsible for the balance not covered.

__ (please initial) I have been notified that Medicare, Medicaid, and private insurance plans will not cover the costs of peak flow meters and spacer chambers. For your convenience, we are happy to provide these in our office but you are responsible for the cost of these items. They are also available at most drug stores.

__ (please initial) I have been notified that provisions in my insurance plan may or may not cover:

Pulmonary Function Tests	Xolair injections
Spirometry Tests	Cpap card downloads

I understand that should these procedures be rejected, I am responsible for this cost.

Please Initial

__ (please initial) I have been notified that my services may fall under s pre-existing clause with my insurance company. The claim will be files but if the claim is denied, it is understood that I will be responsible for the balance not covered.

_____ _____

Patient's Signature Date

FINANCIAL POLICY FOR PULMONARY CRITICAL CARE SLEEP

(MUST BE SIGNED AND DATED BEFORE TREATMENT)

In the interest of good health care practice, it is desirable to establish a credit policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward the end.

- You will need to provide our office with your driver's license and current health insurance card. Your appointment may be postponed if the above are not furnished by the patient at the time of your appointment.
- Insurance is gladly billed (except for third parties) as a courtesy to our patients, when you provide us with your current and corrected information. Even though you may have an insurance claim pending, you may receive a monthly statement for the outstanding balance on your account. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. All Accounts are to be paid in full 60 days after services rendered. Insurance reimbursement is a contract between you, your employer and the insurance carrier. **YOU** (not the insurance company) are responsible to us for all fees for service rendered to you. Keep in mind not all services are a covered benefit in all contracts. It is your responsibility to know your contract with your insurance company.
- I hereby authorize PCCSS, LLP. to submit a claim to my insurance company for services rendered by PCCSS, LLP and direct my insurance carrier to issue payment check(s) directly to PCCSS, LLP.
- I hereby authorize PCCSS, LLP. to release all information necessary regarding services rendered to my insurance company and all physicians involved in my medical care.

Referrals:

- I understand that in order to cover my services an up to date referral from my primary care physician may be necessary. I also understand that if PCCSS, LLP. **does not** receive a written referral authorization or referral from my primary care physician, I will be held financially responsible for any and all charges incurred. In some cases, we may need to reschedule your appointment.
- If you do not have insurance, we are happy to offer a 20% discount but services are payable at the time of your visit.

Cancellations and missed appointments:

- There will be a flat fee of $25.00 for any appointment not cancelled within 24 hours of the appointment. The clinic will not reschedule any patient after two appointments have been missed. The clinic's time must be used as efficiently as possible to keep our expenses at a minimum and the fees within reasonable limits.
- There will be a flat fee of $15.00 for copays not paid on the day of your appointment.

PAST DUE ACCOUNTS:

- Patients, who have not made an effort to make payment arrangements or have not expressed an interest in meeting their financial obligations to us, may be turned over to a collection agency. Patients will not be seen unless balances are paid or payment agreements are arranged. Patients who have allowed their account to be turned into a collection agency will be expected to satisfy their financial obligation to us, and pay for any future services in advance, before being seen by our physician.

Additional Requests:

- Any other professional services that require longer than 5 minutes such as report writing, telephone conversations (non-emergency), preparation of treatment summaries, or time spent performing any other services you may request will start from $50. Temporary Disability and FMLA paperwork will be charged starting at $55. Letters such as parking placard, employment, Diagnosis and medication letters will start at $25 administration processing fee.

By signing below, I acknowledge that I read and understand the above office policies.

Signature: _____ Date: _____

PCCSS, LLP.
Dr. Tehmina Badar
7500 Beechnut Ste.250 Houston, Texas 77074
Phone: 713-988-0850 Fax: 713-988-0866

Authorization for Request of Protected Health Information

Patient Name: _____ Date of Birth: _____

Phone: _____ Social Security# (Optional):_____

I hereby request that my medical records be released to Dr. Tehmina Badar

From: _____ (Name of person/ organization releasing disclosure)

Address: _____ (Address of person/ organization releasing disclosure)

City: _____ State: _____ Zip code: _____

Fax: _____ Phone: _____

For treatment date: _____

OR

For the following purpose: [ ] Medical Care [ ] Legal [ ] Insurance [ ] other (listed below)

_____

Select Portions:

[ ] Office Visit Progress Notes
[ ] Lab
[ ] Imaging/ Radiology
[ ] MD Orders
[ ] Registration Summary [ ] Other _____

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 2 years, or unless it is revoked and covers only treatment (s) for the dates specified above.

_____**(Initials) I acknowledge, and hereby consent to such, that the release information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information.**
I, the undersigned, have read the above and authorized the staff of PCCSS, LLP. To disclose such information as here in contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that this information is being used for medical reason.

_____ _____ _____
Date Signature of Patient/ Parent/ Guardian Authority/ Relation to Patient