D P A C C
Dallas Pulmonary and Critical Care, PA

NEW PATIENT INFORMATION

Name:_____ D.O.B.: _____/_____/_____ Social Security:_____

Sex:_____ Marital Status: _____ Ethnicity/Race: _____ Language: _____

Primary Phone:_____ Alternate Phone: _____

Address:_____ State: _____ Zip Code: _____

Email Address:_____

PREFERRED PHARMACY/Crossroads:: _____

Referring Physician: _____ Primary Physician: _____

Insurance Information:

We accept assignment for Medicare/Medicaid and will be responsible for filling on these claims. Please provide us with your Medicare/Medicaid card and other insurance cards at the time of the patient's appointment.

If at any time your insurance changes please inform us before the start of the appointment, so that we may verify the new insurance information. Failure to do so may result in insurance claim denials.

If your insurance is a managed care plan and copay is required, the patient is responsible for the payment at the time of check in. We accept check, credit/debit cards preferably or cash.

Primary Insurance:_____ Policy # :_____

Secondary Insurance:_____ Policy # :_____

HIPPA --Medical Health Disclosure

Do you grant permission to Dallas Pulmonary and Critical Care, it's representatives and employees the right to disclose your complete medical record (including but not limited to diagnosis, lab tests, treatment, prognosis and billing, for all conditions) to a designated Personal Representative? Check: ( ) Yes ( ) No

Name of Representative: _____ Relationship: _____

Name of Representative: _____ Relationship: _____

_____ _____
(Signature of patient or representative) (Date)

_____ _____
(Print name of patient or representative) (Relationship to Patient)

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Patient Name:_____ Date of Birth:_____

Notice of Privacy Practices Acknowledgment

Please Initial:

_____ I have been presented with a copy of the Notice of Privacy Practices detailing how my health information may be used and disclosed and outlining my rights.

_____ I acknowledge that Dallas Pulmonary and Critical Care P.A. provided me with a written copy of the practices Notice of Privacy Practices.

_____ I also acknowledge that I have been provided the opportunity to read the Notice of Privacy Practices and ask questions.

I grant to Dallas Pulmonary and Critical Care, it's representatives and employees the right to take a photograph of me for identification purposes. This photograph will ONLY be in my electronic chart.
Check: ( ) Yes ( ) No

Fax Privacy Walver

_____ I understand that my medical records may be transmitted electronically by fax and may be received by error by a third party. In this event that this should occur, I absolve Dallas Pulmonary and Critical Care, PA of all liability. I give my consent to fax my records for the purpose of treatment, payment or healthcare operations and understand that I may withdraw consent at any time in writing.

Patient Consent to Treat

_____ I hereby give my consent to Dallas Pulmonary and Critical Care P.A. and authorization the practice to provide my medical treatment. I understand that Dallas Pulmonary and Critical Care P.A. will explain my condition(s), foreseeable risks, and methods of treatment for my condition before my treatment that is thought necessary if, in an emergency situation, a conditions discovered that was not previously known.

_____ I have carefully read and fully understand that this Practice Consent to Treat form and have had the opportunity to discuss my condition and the above procedure(s) with the care provider. All my questions have been adequately answered.

_____ _____
(Signature of patient or representative) (Date)

_____ _____
(Print name of patient or representative) (Relationship to Patient)