NEWPORT PULMONARY ASSOCIATES
320 SUPERIOR AVE, SUITE 200
NEWPORT BEACH, CA 92663

DEAR PATIENT,

PLEASE DO NOT SEND THIS INFORMATION BACK TO OUR OFFICE. **BRING IT WITH YOU TO YOUR APPOINTMENT**. PLEASE HAVE IT FILLED OUT AHEAD OF TIME.

THANK YOU,

NEWPORT PULMONARY STAFF

Newport Pulmonary Associates Medical Group
320 Superior Ave., Suite 200 • Newport Beach, CA 92663

Thomas Diamant, M.D. (G43620) • Robert I. Hewlett, M.D. (A30292) • R. Bruce Moricca, M.D. (G49411) • Dennis R. Novak, M.D. (G29857)

PATIENT INFORMATION

NAME: _____
LAST FIRST MIDDLE INITIAL

ADDRESS: _____
STREET APT/ UNIT

_____
CITY STATE ZIP CODE

HOME PHONE (plus area code) (_____) _____ CELL PHONE (_____) _____

☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ DEPENDENT

SOCIAL SECURITY # _____ DATE OF BIRTH _____

DRIVER'S LICENSE # _____ AGE _____

EMPLOYER _____
BUSINESS NAME

_____
BUSINESS ADDRESS STATE/ ZIP

(_____) _____ _____
BUSINESS PHONE OCCUPATION

SPOUSE NAME: _____

SPOUSE EMPLOYER: _____
BUSINESS NAME

_____
BUSINESS ADDRESS STATE/ ZIP

(_____) _____ _____
BUSINESS PHONE OCCUPATION

PRIMARY INSURANCE COMPANY _____

INSURED'S NAME _____ ID# _____

INSURED'S DATE OF BIRTH _____ GROUP# _____

SECONDARY INSURACE COMPANY _____

INSURED'S NAME _____ ID# _____

INSURED'S DATE OF BIRTH _____ GROUP# _____

REFERRED BY _____

In case of emergency, whom should our office contact?
NAME _____ PHONE _____ RELATIONSHIP _____

Who has the power of attorney for health care decisions?
NAME _____ Is there an advance directive? ☐ YES ☐ NO

AUTHORIZATION: I hereby authorize payment directly to NEWPORT PULMONARY ASSOCIATES MEDICAL GROUP and all insurance benefits, which may be due to me for services rendered by NEWPORT PULMONARY ASSOCIATES MEDICAL GROUP. I authorize release of any medical information necessary to process claims to my insurance company(s).

DATE: _____ SIGNATURE: _____

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

AUTHORIZATION TO BILL MEDICARE

SIGNATURE GIVES PERMISSION TO BILL MEDICARE ON MY BEHALF UNLESS NOTIFIED OTHERWISE, IN WRITING

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #) | MEDICAID (Medicaid #) | CHAMPUS (Sponsor's SSN) | CHAMPVA (VA File #) | GROUP HEALTH PLAN (SSN or ID) | FECA BLK LUNG (SSN) | OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self | Spouse | Child | Other

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS Single | Married | Other

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

Employed | Full-Time Student | Part-Time Student

ZIP CODE | TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED XX DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED XX

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1											
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) *PLEASE PRINT OR TYPE*

APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001

ITEM 053-8445(4146)

Newport Pulmonary Associates

Patient Assessment Questionnaire

Name: _____ Age: _____Date: _____

Referred by : _____

Reason for visit: _____

Immunizations: (List year of last injection or test)

Flu: _____ Pneumonia:_____ TB: _____

Respiratory History: (Check those that apply)

Do you have a cough? ☐ No ☐In the morning ☐ All day long ☐ Dry cough ☐Congested cough

☐Wakes me up at night

Mucus: ☐None ☐Color: _____

Are you short of breath? ☐No ☐ All the time ☐With walking ☐With exercise ☐ With a cold

☐ Awakens me ☐Relieved with an inhaler

Do you wheeze? ☐ No ☐Yes ☐in AM ☐ Wheeze with exercise ☐ Daily ☐ Awakens me

☐ Relieved with inhaler

Do you have sinus congestion? ☐No ☐ Yes ☐Post-nasal Drip ☐Nasal Discharge
(color_____)

Do you snore? ☐No ☐Sometimes ☐Loudly

Have you or are you: ☐ Exposed to asbestos dust ☐Sawdust/dust ☐Farm dust

☐ Exposed to paint fumes ☐ Exposed to solvent fumes ☐ Exposed to plastics ☐ Exhaust fumes

Have you ever had: (check those that apply)

☐Pneumonia ☐Asthma ☐Recurring bronchitis ☐ Childhood Asthma ☐COPD ☐ TB ☐Sleep Apnea

☐ Lung Cancer ☐ Pleurisy ☐Valley Fever ☐Blood Clots ☐Pulmonary Embolism

☐Anesthesia intolerance ☐ Other: _____

Please list all physicians that you see: _____

_____

Name: _____ **Date:** _____

Past Medical History: (Check those that apply currently or in the past)

- ☐ **Decreased Hearing**
- ☐ **Ringing in ear(s)**
- ☐ **Ear infections**
- ☐ **Glaucoma**
- ☐ **Cataracts**
- ☐ **Macular degeneration**
- ☐ **Blurred or double vision**
- ☐ **Eye infections**
- ☐ **Nose bleeds**
- ☐ **Sinusitis**
- ☐ **Hoarseness**
- ☐ **Sore throats**
- ☐ **Thyroid disease**
- ☐ Chest Pain
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Heart Murmur
- ☐ Heart Palpitations
- ☐ Irregular Pulse
- ☐ Fainting spells
- ☐ Swollen ankles
- ☐ **Loss of appetite**
- ☐ **Weight loss**
- ☐ **Weight gain**
- ☐ **Difficulty swallowing**
- ☐ **Indigestion/heartburn**
- ☐ **Persistent nausea or vomiting**
- ☐ **Peptic ulcers**
- ☐ **Abdominal pain**
- ☐ **Diarrhea**
- ☐ **Constipation**
- ☐ **Diverticulosis**
- ☐ **Blood in Stools**
- ☐ **Hemorrhoids**
- ☐ **Hernia**
- ☐ **Gallbladder trouble**
- ☐ **Jaundice**
- ☐ **Hepatitis**
- ☐ **Diabetes**
- ☐ Urine infections
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Poor bladder control
- ☐ Prostate enlargement
- ☐ Kidney stones
- ☐ **Anemia**
- ☐ **Immune deficiency**
- ☐ **Bruise easily**
- ☐ **Cancer**
- ☐ **Leg pain when walking**
- ☐ **Arthritis**
- ☐ **Gout**
- ☐ **Back Pain**
- ☐ **Bone fracture**
- ☐ **Joint injury**
- ☐ **Foot Pain**
- ☐ Hayfever
- ☐ Rashes
- ☐ Hives
- ☐ Psoriasis
- ☐ Eczema
- ☐ Allergies
- ☐ Chronic Fatigue
- ☐ Hairloss
- ☐ **Seizures/convulsions**
- ☐ **Dizzy Spells**
- ☐ **Stroke**
- ☐ **Tremor**
- ☐ **Numbness**
- ☐ **Migraines**
- ☐ **Cold, numb feet**
- ☐ Vericose veins
- ☐ Insomnia
- ☐ Drowsy
- ☐ Nervousness
- ☐ Depression
- ☐ Memory loss
- ☐ Mental illness
- ☐ Moodiness

Surgical History:

Surgery	Date	Surgery	Date

Pharmacy Name: _____ **Phone #:** _____

Pharmacy Address: _____

Name: _____ Date: _____

Family History

Relative	Alive	Deceased	Age	Cause of death	High Blood Pressure	Heart Disease	Cancer	Diabetes	Asthma	COPD	Hayfever	Stroke	Anemia	Mental illness	Arthritis	Autoimmune disorder	Blood Clots
Father																	
Mother																	
Sister																	
Sister																	
Brother																	
Brother																	
Other																	

Social History

☐Single ☐Married _____ years ☐ Widowed ☐Life Partner ☐Divorced

Children: # of Daughters: _____ # of Sons: _____

Where were **you** born: _____

Where have **you** lived:

_____

Past & Present Occupations: _____

_____

Hobbies: _____

Pets: _____

Smoking history:☐ Never ☐ Yes-- Date Started: _____ Date Quit: _____

Type: ☐ Cigarettes (Avg. packs/day _____) ☐Cigars ☐Pipe ☐Marijuana ☐Other: _____

☐ **Second-hand smoke** (Years: _____)

Alcohol consumption ☐ No ☐ Yes: What_____ Amount: _____

Name: _____ **Date:** _____

Medical Allergies:

Medicine	Reaction

Misc. Allergies: ☐ Egg ☐Iodine ☐Shell fish ☐Other: _____

Current Prescription Medications **(use back of page if needed):**

Name	Dose	Frequency	Ordering MD

Supplements:

Name	Dose	Frequency	Ordering MD

Newport Pulmonary Associates

Consultants in Pulmonary and Critical Care Medicine

Robert I. Hewlett, M.D., F.C.C.P.

Dennis R. Novak, M.D., F.C.C.P.

Thomas Diamant, M.D., F.C.C.P.

R. Bruce Moricca, M.D., F.C.C.P.

NEWPORT PULMONARY ASSOCIATES

FINANCIAL POLICY

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. If you have any questions, please call our business office at 949-642-6200 prior to your appointment.

INSURED PATIENTS

As a courtesy, we will bill your insurance company and assist you by providing them with any information needed to process the claim. We are preferred providers for many insurance groups but we suggest that you verify our participation in your specific plan before making your appointment. Please be advised that our office does not participate with any HMO, managed care or IPA health plans. You are responsible for your deductible, coinsurance and co-payment. All applicable co-payments are due at the time of service. If your insurance company has not paid their portion of the charges within 60 days, the account will revert to your responsibility.

UNINSURED PATIENTS

Payment is due in full at the time of service for all office visits. For procedures and hospital charges we will require pre-payment or authorization to charge your credit card. We accept cash, checks, Mastercard or Visa.

MEDICARE PATIENTS

We accept Medicare assignment. You will be responsible for any deductible or co-payment. The 20% coinsurance is your responsiblilty unless supplemental insurance coverage is provided. Please be advised that any charges specified as non-covered by Medicare will be your responsibility. However, we will notify you in advance of any such charges.

LAB TESTS, X-RAYS AND OTHER OUTSIDE CHARGES

Our doctors may refer you to an outside facility for testing. The information from that testing is important in the overall evaluation, however, recent Medicare changes have limited their coverage of some tests to certain diagnoses. The doctor may order testing that is not covered by Medicare for your specific diagnosis. In these cases, you will be responsible for payment of the charges. The testing facility will require you to sign a form stating that you have been notified that non-covered charges are your responsibility.

AUTHORIZATIONS

It is your responsibility to know the details of your insurance plan. We will be happy to assist you in obtaining authorizations for procedures or testing. You, the patient, MUST NOTIFY OUR OFFICE IN ADVANCE THAT PRE-AUTHORIZATION IS NEEDED. Our office will not be held responsible for out-of-pocket expenses from utilizing the wrong provider or not obtaining pre-authorization.

COLLECTIONS

Payments for outstanding patient balances are due within 30 days of the statement date. If you have an account that is 30 days past due you will be required to make payment arrangements prior to scheduling an appointment. If it is necessary to assign your account to a collection agency and/or attorney, your authorization below allows the release of information to the appropriate agency. You will be responsible for all collection agency fees, attorney fees, legal fees and court costs.

It is understood that the undersigned, whether signing as agent or as patient is financially responsible for services, accepts the terms above, and is receiving a copy thereof.

Date:

Patient/Guardian:_____ Signature:_____

Guarantor/Spouse:_____ Signature:_____

Newport Pulmonary Associates

Consultants in Pulmonary ond Critical Care Medicine

Robert 1. Hewlett, M.D., FC.C.P.
Dennis R. Novak, M.D., FC.C.P.
Thomas Diamant, M.D., FC.C.P.
R. Bruce Moricca, M.D., FC.C.P.

Dear Patient:

Our office, as well as many other medical offices, has had a growing problem with patients not showing up for scheduled appointments: so called "no shows".

If you cannot keep your scheduled appointment please notify our office no later than 24 hours prior to your appointment. The phone number is (949) 642-6200. If it is after hours, please leave a message with our exchange.

As a courtesy our office routinely calls patients to confirm their appointments. Ultimately, however, it is the patient's responsibility to note the dates and times of his or her appointments.

Effective immediately failure to notify us for missed appointments will result in a $50.00 charge. Please note, these charges are not reimbursed by Medicare or private insurance.

Please help us in this regard as your timely notification will assist us in providing same day visits for those patients with urgent problems.

Sincerely,

Thomas Diamant, M.D.
Robert Hewlett, M.D.
R. Bruce Moricca, M.D.
Dennis R. Novak, M.D.

320 Superior Avenue, Suite 200, Newport Beach, CA 92663 *Tel: 949.642.6200 Fax: 949.642.9359*