PULMONARY ALLERGY CRITICAL CARE & SLEEP ASSOCIATES

M. WAEL AL-AMERI, M.D., F.C.C.P.
ROBERT O. GO, M.D., F.C.C.P.
MUHAMMAD KASHLAN, M.D., F.C.C.P., F.A.A.S.M.
MAZEN SABBAQ, M.D.
AHMAD GHABSHA, M.D., F.C.C.P.
EMAD SHEHADA, M.D., F.C.C.P.
AMMAR GHANEM, M.D., F.C.C.P., D.A.B.S.M.
FADI ALKHANKAN, M.D., F.C.C.P.

DATE: _____

Please indicate how you were referred to our office:

☐ Friend ☐ Relative ☐ Physician (name) _____

PATIENT INFORMATION:

Race: ☐ Asian ☐ Black ☐ Hispanic ☐ Indian ☐ White ☐ Decline ☐ Other _____

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Gender: ☐ Male ☐ Female Marital Status: M S W D

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ Alternate Phone #: _____

Email Address: _____

EMPLOYER:

Employer: _____ Phone #: _____

Address: _____

SPOUSE:

Name: _____ Date of Birth: _____

Social Security #: _____

Employer: _____ Phone #: _____

Address: _____

REPONSIBLE PARTY (if patient is a minor)**:**

Name: _____ Relationship: _____

Address: _____ Phone #: _____

EMERGENCY CONTACT:

Name: _____ Phone #: _____

Relationship: _____

SECONDARY CONTACT:

Name: _____ Phone #: _____

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PLEASE READ AND SIGN THE FOLLOWING STATEMENTS:

I hereby authorize the release of medical information to insurance carriers concerning benefits payable for services rendered and I hereby assign to the doctor all payment for medical services rendered to my dependent or me. I understand I am responsible for any amount not covered by my insurance.

It is your responsibility to know your individual coverage. Failure to comply with our suggestion could result in you being responsible for all the cost incurred.

SIGNATURE: _____ DATE: _____

MEDICARE ONE TIME DIRECTION OF PAYMENTS:

I give my permission for my provider to bill Medicare and receive payment for my medical care. I understand that Medicare needs information about me and my medical condition to make a decision about these payments. I give permission for that information to go to Medicare and the companies that handle Medicare payment requests. I understand that the Health Care Financing Administration (HCFA) is the government Medicare agency.

MEDICARE BENEFICIARY SIGNATURE: _____

DATE: _____

OPTIONAL:

Authorization for the disclosure of protected health information including, but not limited to scheduling/referral information, test results, medical instructions, and billing information.

List the names of the party or parties authorized to receive protected information concerning your health care and treatment:

Name(s):

1. _____ Relationship: _____

2. _____ Relationship: _____

SIGNATURE: _____ DATE: _____

HIPAA NOTICE OF PRIVACY PRACTICES:

I acknowledge that I have read and understand the "Notice of Privacy" in accordance to HIPAA law for Pulmonary Allergy Critical Care and Sleep Associates (PACCSA). I am also aware that I may request a copy of the "Notice of Privacy" at any time. I understand and agree to the provisions as stated above.

SIGNATURE: _____ DATE: _____