**UNIVERSITY PULMONARY & SLEEP MEDICINE, LLC**

 81 VERONICA AVENUE SUITE 201 SOMERSET NJ 08873

PHONE: (732) 246-1441

 FAX:(732) 418-0676

 PATIENT INFORMATION

LAST NAME FIRST NAME DATE OF BIRTH: \_\_\_\_\_\_\_\_\_

ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY .STATE .ZIP .

[]HOME PHONE .[]CELL PHONE .

[]WORK PHONE .[]EMAIL: .

 **GENDER: [ ]** MALE [ ] FEMALE **STATUS: [ ]** SINGLE [ ]MARRIED [ ]DIVORCED [ ]WIDOWED []SEPARATED

EMERGENCY CONTACT NAME .PHONE .

PHARMACY NAME .LOCATION . PHONE .

PRIMARY PHYSICIAN .PHONE .

REFERRING PHYSICIAN (IF APPLICABLE) .PHONE .

 **PREFERENCE OF CONTACT (**PLEASE CIRCLE ONE) **HOME CELL WORK**

 **I GIVE CONSENT TO RECEIVE AUTOMATED TEXT AND VOICE MESSAGES AT THE PHONE NUMBER PROVIDED.**

**PATIENT/RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_**

 **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS AND THAT A FINANCE CHARGE OF 1% WILL ACCRUE ON MY UNPAID BALANCE OLDER THAN 30 DAYS.**

**PATIENT/RESPONSIBLE PARTY SIGNATURE: DATE: \_\_\_\_\_\_\_\_\_\_\_\_**

 **I GIVE PERMISSION TO UNIVERSITY PULMONARY & SLEEP MEDICINE, LLC TO OBTAIN OR RELEASE MY MEDICAL INFORMATION TO MY PRIMARY CARE OR REFERRING PHYSICIAN, INSURANCE CARRIER OR ANY OTHER AUTHORIZED AGENTS I ALSO AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO THE PHYSICIAN.**

**SIGNATURE: DATE: \_\_\_\_\_\_\_\_\_\_**

 **FINAL POLICY**

 UNIVERSITY PULMONARY & SLEEP MEDICINE, LLC

 81 VERONICA AVENUE SUITE 201 SOMERSET NEW JERSEY 08873

 **TEL# 732-246-1441 FAX# 732-418-0676**

 **ARVIND K. DAS, MD**

ALL CO-PAYS ARE REQUIRED AT THE TIME OF SERVICE

 YOU ARE REQUIRED TO SATISFY YOUR DEDUCTIBLE FOR THE YEAR

**MEDICARE PATIENTS:**

**•** YOU WILL BE REQUIRED TO SATISFY YOUR ANNUAL $147.00 (2013) DEDUCTIBLE AND PAY YOUR 20%

COPAYMENT. WE WILL SUBMIT THE CLAIM TO MEDICARE AND TO THE SECONDARY OR SUPPLEMENT YOU HAVE.

**•**WE WILL BILL YOU FOR ANY BALANCE THAT YOU OWE US.

**•**WE WILL PROVIDE CHRONIC CARE MANAGEMENT AND SERVICES.

**REGARDING INSURANCE:**

•YOU MUST PROVIDE US WITH YOUR INSURANCE CARDS.

**•**IF YOU RECEIVE A NEW CARD, YOU MUST PROVIDE IT TO US.

**•**IF YOUR INSURANCE HAS LAPSED OR IS NOT IN EFFECT AT THE TIME OF SERVICE, YOU WILL BE REQUIRED TO PAY THE ENTIRE BILL FOR ALL SERVICES FOR THAT VISIT.

**IF WE HAVE A CONTRACT WITH YOUR INSURANCE PLAN:**

**•**HMO INSURANCE PLANS MAY REQUIRE A **REFERRAL** FROM YOUR **PRIMARY PHYSICIANS.**

•BEFORE YOUR VISIT, YOU MUST OBTAIN A PROPER REFERRAL TO SEE: ARVIND DAS, MD CONTAINING CPT CODE 99499, DIAGNOSIS, THE NUMBER OF VISITS AND THE DATE THE REFERRAL EXPIRES

**•**YOU ARE RESPONSIBLE TO KEEP TRACK OF THE NUMBER OF VISITS USED AND THE EXPIRATION DATE

**•**IF YOUR REFERRAL EXPIRES OR YOU USE ALL THE ALLOWED VISITS AND YOU SEE DR. DAS, YOU WILL BE RESPONSIBLE FOR THE ENTIRE BILL FOR THAT VISIT.

**•**PPO OR POS INSURANCE WITH WHICH WE HAVE A CONTRACT DO NOT REQUIRE A REFERRAL TO SEE US.

**IF WE DO NOT HAVE A CONTRACT WITH YOUR INSURANCE PLAN:**

**•**PLEASE CHECK TO SEE IF YOU HAVE OUT-OF-NETWORK-BENEFITS

•WE WILL BILL YOUR INSURANCE PLAN UNLESS YOU ASK US NOT TO DO SO AND INSTRUCT THEM TO MAKE A PAYMENT TO YOU (BECAUSE YOU HAVE ALREADY PAID US). IF YOU DO NOT AGREE WITH YOUR PLAN’S PAYMENT, THAT IS BETWEEN YOU AND YOUR PLAN DUE TO US NOT HAVING A CONTRACT WITH THEM.

**•**YOU WILL BE REQUIRED TO PAY IN FULL FOR THE VISIT AT THE TIME OF THE VISIT. WE ACCEPT CASH, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS. PLEASE DO NOT ASK TO BE BILLED UNLESS APPROVED IN ADVANCED BY OFFICE MANAGER.

**I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES TO ME INCLUDING THE BALANCE REMAINING AFTER PAYMENT OF POSSIBLE INSURANCE BENEFITS AND THAT A FINANCE CHARGE OF 1% WILL ACCRUE ON MY UNPAID BALANCE OLDER THAN 30 DAYS**

 THANK YOU FOR COOPERATING WITH OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.

 I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

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SIGNATURE OF PATIENT OR RESPONSIBLE PARTY PRINT NAME OF PATIENT

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RELATIONSHIP/ AUTHORITY OF RESPONSIBLE PARTY DATE

  **UNIVERSITY PULMONARY & SLEEP MEDICINE, LLC**

 **ARVIND K. DAS, MD**

 **PATIENT CONSENT FORM (HIPAA)**

 THE DEPARTMENT OF HEALTH AND HUMAN SERVICES HAS ESTABLISHED A “PRIVACY RULE” TO HELP INSURE THAT PERSONAL INFORMATION IS PROTECTED FOR PRIVACY. THE PRIVACY RULE WAS ALSO CREATED IN ORDER TO PROVIDE A STANDARD FOR CERTAIN HEALTH CARE PROVIDERS TO OBTAIN THEIR PATIENT’S CONSENT FOR USES AND DISCLOSURES OF HEALTH INFORMATION ABOUT THE PATIENT TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS.

 AS OUR PATIENT WE WANT YOU TO KNOW THAT WE RESPECT THE PRIVACY OF YOUR PERSONAL MEDICAL INFORMATION AND WE WILL DO ALL WE CAN TO SECURE AND PROTECT THAT PRIVACY. WE WILL STRIVE TO ALWAYS TAKE REASONABLE PRECAUTIONS TO PROTECT YOUR PRIVACY. WHEN IT IS APPROPRIATE AND NECESSARY, WE PROVIDE THE MINIMUM NECESSARY INFORMATION TO ONLY THOSE WE FEEL ARE IN NEED OF YOUR HEALTH CARE INFORMATION AND INFORMATION ABOUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. IN ORDER TO PROVIDE HEALTH CARE THAT IS IN YOUR BEST INTEREST.

 WE ALSO WANT YOU TO KNOW THAT WE SUPPORT YOUR FULL ACCESS TO YOUR PERSONAL MEDICAL RECORDS. WE MAY HAVE INDIRECT TREATMENT RELATIONSHIPS WITH YOU (SUCH AS LABORATORIES THAT ONLY INTERACT WITH PHYSICIANS AND NOT PATIENTS), AND MAY HAVE TO DISCLOSE PERSONAL HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. THESE ENTITIES ARE MOST OFTEN NOT REQUIRED TO OBTAIN PATIENT CONSENT.

 YOU MAY REFUSE TO CONSENT TO THE USE OR DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION, BUT THIS MUST BE IN WRITING. UNDER THIS LAW, WE HAVE THE RIGHT TO REFUSE TO TREAT YOU SHOULD YOU CHOOSE TO REFUSE TO DISCLOSE YOUR PERSONAL HEALTH INFORMATION (PHI). IF YOU CHOOSE TO GIVE CONSENT IN THIS DOCUMENT, AT SOME FUTURE TIME YOU MAY REQUEST TO REFUSE ALL OR PART OF YOUR (PHI). YOU MAY NOT REVOKE ACTIONS THAT HAVE ALREADY BEEN TAKEN, WHICH RELIED ON THIS OR A PREVIOUSLY SIGNED CONSENT.

IF YOU HAVE OBJECTIONS TO THIS FORM, PLEASE ASK TO SPEAK WITH OUR HIPAA COMPLIANCE OFFICER.

YOU HAVE THE RIGHT TO REVIEW OUR PRIVACY NOTICE, TO REQUEST RESTRICTIONS AND REVOKE CONSENT IN WRITING AFTER YOU HAVE REVIEWED OUR PRIVACY NOTICE.

SIGNATURE BELOW IS ONLY ACKNOWLEDGE THAT YOU HAVE RECEIVED AND READ THIS NOTICE OF OUR PRIVACY PRACTICES.

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**SIGNATURE/ (RELATIONSHIP TO PATIENT) DATE**

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 **FOR OFFICE USE ONLY**

I ATTEMPTED TO OBTAIN THE PATIENT’S SIGNATURE IN ACKNOWLEDGE TO THIS NOTICE OF PRIVACY PRACTICES, BUT WAS UNABLE TO DO SO AS DOCUMENTED BELOW:

DATE: INITIALS: REASONS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT NAME DATE

 **MEDICATION LIST**

 MEDICATION DOSAGE FREQUENCY

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 **ALLERGIES**

 **▢ NO KNOW ALLERGIES**

 SEVERITY(VERY MILD,

 MEDICATION REACTION MODERATE. SEVERE)

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 **NON PRESCRIPTION MEDICATION**

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NAME DATE .

INDICATE WHETHER YOU HAVE EVER HAD A MEDICAL PROBLEM AND/OR SURGERY RELATED TO EACH OF THE FOLLOWING BY PLACING A CHECK **(✓)** IN THE APPROPRIATE BOXES. IF YOU HAVE HAD SURGERY, INDICATE THE APPROXIMATE YEAR(S) OF SURGERY. DESCRIBE THE PROBLEMS AND TYPE OF SURGERY. CIRCLE THE APPROPRIATE CHOICE WHEN MULTIPLE CHOICES ARE LISTED IN A QUESTION.

 **NO MEDICAL YEAR(S) OR SURGERY**

 **PROBLEM PROBLEM SURGERY DESCRIBE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| HERNIA |  |  |  |  |
| EYES-CATARACTS, GLAUCOMA |  |  |  |  |
| EARS,NOSE,SINUSES TONSILS  |  |  |  |  |
| THYROID OR PARATHYROID GLANDS |  |  |  |  |
| HEART VALVES OR ABNORMAL HEART RHYTHM  |  |  |  |  |
| CORONARY(HEART) ARTERIES (ANGINA) |  |  |  |  |
| VEINS OR BLOOD CLOTS IN VEINS |  |  |  |  |
| LUNGS (Example:Tuberculosis, Cancer..) |  |  |  |  |
| ESOPHAGUS OR STOMACH(ULCER) |  |  |  |  |
| BOWEL(SMALL & LARGE INTESTINE) |  |  |  |  |
| APPENDIX |  |  |  |  |
| LIVER OR GALLBLADDER (INCLUDING HEPATITIS  |  |  |  |  |
| KIDNEYS OR BLADDER  |  |  |  |  |
| BONES, JOINTS OR MUSCLES |  |  |  |  |
| BACK, NECK OR SPINE |  |  |  |  |
| BRAIN |  |  |  |  |
| SKIN |  |  |  |  |
| BREAST |  |  |  |  |
| FEMALE: UTERUS, TUBES, OVARIES |  |  |  |  |
| MALES:PROSTATE, PENIS, TESTES, VASECTOMY  |  |  |  |  |
| OTHER: DESCRIBE |  |  |  |  |

CHECK ALL THAT APPLY: ⬜ALLERGIES ⬜ASTHMA ☐ALCOHOL ⬜DEPRESSION ⬜DIABETES ⬜HEART DISEASE ⬜HIGH BLOOD PRESSURE ⬜HIGH CHOLESTEROL ⬜MENTAL ILLNESS ⬜STROKE ⬜CANCER IF YES WHAT KIND? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU SMOKE OR HAVE PREVIOUSLY SMOKED ? ☐YES ☐NO

IF YES, HOW MANY CIGARETTES SMOKED PER DAY? .

IF YES, TOTAL YEARS AS A SMOKER: .

QUIT SMOKING? HOW MANY YEARS MONTHS ETC SINCE THEN. .

**Disclaimer regarding Covid-19 and other contagious diseases: Our office is taking all necessary precautions to ensure our patients’ and staff’s safety. We cannot guarantee that there will be no exposure to the Covid 19 virus. That is why we need you to do your part by informing the doctor of all your medical history.**