SUNCOAST LUNG CENTER

3920 Bee Ridge Rd Bldg C
Sarasota, Florida 34233

PATIENT DEMOGRAPHICS

NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: ___-__-____

LOCAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

LOCAL PHONE: ( )_____ CELL PHONE: ( ) _____

EMAIL ADDRESS: _____

Alternate Address: _____

City: _____ State: _____ ZIP: _____

Phone: ( ) _____

MARITAL STATUS: Single Married Widowed Divorced Spouse Name: _____

RACE/ETHNICITY :

WHITE ____ AFRICAN AMERICAN ___ ASIAN____ HISPANIC____

DECLINE ANSWER _____

Referral Source: _____

Occupation:_____ Employer: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: ( ) _____

I certify the above information is correct and current

PATIENT SIGNATURE: _____ DATE: _____

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HIPAA - CONFIDENTIALITY FORM

In compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA) the policy of Suncoast Lung Center is not to release confidential and/or unauthorized information without patient permission.

May we:

Reach you at home and/or by cell phone?	Yes	No
Confirm appointments by leaving a message on your answering machine?	Yes	No
Contact you at work?	Yes	No
Leave a message for you at work?	Yes	No

Authorization to Release Protected Health Information

I authorize the person(s) listed below to obtain any and all Protected Health Information (PHI) from Suncoast Lung Center. This consent and authorization enables the person(s) listed below to obtain any and all billing information as well as retrieve written prescriptions for the patient from the office.

Please list the names of authorized individuals:

Name: _____
Relationship: Spouse Child Parent

Name: _____
Relationship: Spouse Child Parent

Name: _____
Relationship: Spouse Child Parent

Do you have a Durable Power of Attorney / Living Will / Appointed Health Care Representative?
Yes No *If "Yes" please provide a copy to this office.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Signature other than the patient, please indicate relationship:
O Parent O Child O Spouse O Legal Guardian

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MEDICATION LIST

Patient Name: _____ **Date:** _____

Please provide your current prescription and over- the-counter medications.

Medication Allergies / Reactions: _____

_____

PRESCRIPTIONS:

Medication Name	Dosage	Frequency	Prescribing MD

OVER-THE-COUNTER MEDICATIONS / HERBAL REMEDIES / VITAMINS:

_____ _____

PHARMACY INFORMATION (Required for prescription refills)

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone: _____

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HIPAA - CONSENT FORM

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA) I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed that the *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information and I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request you restrict in writing how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have taken action relying on this consent.

Patient Name (Print): _____

Patient Signature: _____ Date: _____

Signature other than the patient, please indicate the relationship:

O Parent O Legal Guardian OLegal Representative

Printed Name of Parent / Legal Guardian / Legal Representative: _____

Contact Information:

Suncoast Lung Center
3920 Bee Ridge Road Building C/Suite C
Sarasota, Florida 34233

941-923-8353

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AUTHORIZATION CONSENT FORM

INSURANCE AUTHORIZATION

I certify that the information given while applying for payment under Title XVII of the Social Securities Act is correct and I authorize this office to release medical information to the Social Security Administration or its intermediaries and other carriers as required for benefits on my behalf. I request this organization submit appropriate claim reimbursement information to Medicare or other insurance carriers as required for services rendered.

AUTHORIZATION TO OBTAIN & RELEASE MEDICAL RECORDS/CONSENT TO TREAT

I give my consent for treatment by this physician, and in the course of this treatment should it be necessary to consult with others, I give my permission and consent for this organization to obtain and release medical records and other pertinent information to and receive from other healthcare providers or agencies as required in the course of medical care. This includes information regarding Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) test results as it relates to the medical care and treatment provided.

TERMS OF PAYMENT FOR SERVICES RENDERED

Unless prior arrangements are made payment in full shall be made at the time medical services are rendered.

I authorize and request that all hospital, medical and/or surgical benefits be paid directly to the Physician for the services and items provided by this Physician for my health care. In the event that a claim is submitted as an unassigned claim, I authorize payment to be issued directly to this organization in the entire amount due for service of medical treatment.

The Suncoast Lung Center financial policy includes net 30 days with late charge fees of 1.5% per month (18% APR) that are assessed on past-due accounts. Collection charges and/or attorney fees will be in addition to fees for service as necessary.

A $35 return check fee will be charged in the event of nonpayment due to insufficient funds.

Missed confirmed appointments will be charged the office visit fee which will be due prior to future appointment scheduling.

The laws of the State of Florida shall govern the interpretation, construction, and enforcement of this agreement.

Patient Name (Print): _____

Patient Signature: _____ Date: _____