FollowMyHealth™
Universal Health Record

Name:____

Date Of Birth:____

e-mail Address:____

____

Sign Date

Tri-State Pulmonary Medical Practice

PATIENT INFORMATION:

NAME: **LAST** **FIRST** **MIDDLE INITIAL**

DATE OF BIRTH **SEX (Male/Female)** **SOCIAL SECURITY #**

ADDRESS: **STREET** **CITY** **STATE** **ZIP**

CONTACT INFO: **HOME #** **CELL #** **WORK #**

Which contact number do you prefer we call? (CIRCLE ONE) **Home** **Cell** **Work**

EMAIL ADDRESS: ____

MARITAL STATUS: (CIRCLE ONE) **Single** **Married** **Divorced** **Widowed**

RACE: (CIRCLE ONE)
American Indian / Alaska Native / Asian /
Black or African American / Native Hawaiian or
Other Pacific Islander / White / Decline

ETHNICITY: (CIRCLE ONE)
Hispanic / Latino /
Not Hispanic or Latino /
Unknown / Decline

REFERRING PHYSICIAN:

PRIMARY CARE PHYSICIAN:

EMPLOYMENT STATUS: (CIRLCE ONE) **Full Time** **Part Time** **Retired** **Not Employed**
STUDENT STATUS: (CIRCLE ONE) **Full Time** **Part Time** **Not A Student**

EMERGENCY CONTACT:
****Please provide the name of a person whom we may contact in care of an emergency OR in the event we are unable to reach you.****

NAME **RELATIONSHIP** **PRIMARY TELEPHONE**

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicaid, private insurance, and other health plans, which I have presented to Tri-State Pulmonary Medical Practice. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

SIGNATURE: ______________________________ **DATE:** ________________

Tri-State Pulmonary Medical Practice

Please read through the following policies/procedures. Each policy is to be initialed, followed by your printed name, signature, and date at the bottom of the page. Tri-State Pulmonary Medical Practice would like to thank you, in advance, for acknowledging and following our office policies.

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicaid, private insurance, and other health plans, which I have presented to Tri-State Pulmonary Medical Practice. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. __________

I understand that I will be charged a $50.00 fee for NO SHOWS and/or LATE CANCELLATIONS (cancelling with less than 24 hour notice): To avoid this fee, please call and cancel or reschedule all appointments within 24 hours of your scheduled appointment. If after hours, please call our office number and leave a message with our answering service. __________

I certify that I have received a copy of Tri-State Pulmonary Medical Practice's *Notice of Privacy Practices.* __________

I understand that due to asthmatic and allergy sensitive patients, Dr. Laracuente asks his patients to refrain from wearing any scented products to their appointments. __________

______________________________   _______________

Print Name   Date

____

Signature

ALLERVISION | *Allergy History Questionnaire*

Patient Name:________________________________DOB:__________ Date:__________

Do you experience any of the following more than twice per year? (Check all that apply)
__Cough __Cold __Congestion __Wheezing __Runny Nose __Sinus Pain __Skin Irritation
__Headaches __Sore Throat __Ear Pain __Itchy Eyes __Snoring __Ear Popping __Repeated Sneezing
__Unexplained Fatigue __Difficulty Breathing

Have you ever been diagnosed with asthma or bronchitis? __Yes __No

Do you experience symptoms of allergies? __Yes __No

Regarding possible food allergies, do you experience any of the following? (Check all that apply)
__Constipation __Vomiting __Stomach pain __Diarrhea __Indigestion __Upset Stomach __Nausea
__Cough __Wheezing __Tingling feeling of the mouth or tongue __Bloating after eating

Have you had an allergy skin or blood test within the past 3 years? __Yes __No When?__________

Current symptoms you are experiencing:________________________________
When are your symptoms the worst? __Spring __Summer __Fall __Winter __Year round
Do you have any family history of allergies? __Yes __No Who? __Mother __Father __Sibling __Other
Do you own any pets? __Yes __No __Cat __Dog __Bird __Other:__________________
Do you smoke? __Yes __No If yes, how much?______________
What is your current occupation? ______________________________
What do you think are your allergic triggers? ______________________________
Current medications you are taking:______________________________
Are your current medications relieving your allergy symptoms? __Yes __ No
Explain:____

Have you ever had anaphylaxis? __Yes __No __Not sure

Have you ever had a reaction to peanuts or bee stings? __Yes __No Which one:______________

If you have asthma, is it under control? __Yes __No How often do you use your inhaler?__________

Are you currently taking Beta Blockers? __Yes __No

Are you pregnant? __Yes __No __ N/A

Are you significantly immunocompromised, have malignancy or severe chronic illness? __Yes __No

Have you taken any antihistamine within the past 72 hours (3 Days)? __Yes __No Type: __________

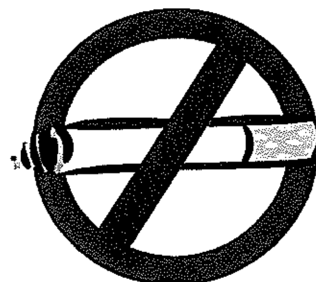
To the best of my knowledge the information provided above is correct. ______________________
Patient/Guardian Signature

CLINIC USE ONLY

Is the patient recommended to have an allergy test? __Yes __No (Skin__ or Blood__) Food Panel__
Patient to test today? __Yes __ No Scheduled for (Date) ____________________
Refer patient to a specialist. __Yes __No

Reviewed by:______________________ Date:__________

Benjamin A. Laracuente, MD, FCCP
3468 Brodhead Rd., Suite 11
Monaca, PA 15061
724-728-5995



Dear Patient,

Smoking is harmful to your health and creates a safety hazard in the presence of oxygen.

Here are a few facts regarding oxygen and smoking.

1. Oxygen supports combustion which means:
   - Oxygen causes any burning source to burn more rapidly.
   - Any material burning in air will burn more violently in an oxygen enriched atmosphere.

2. Using oxygen with a cannula (nose piece) and smoking creates the possibility that the burning tobacco will burn more rapidly, thus creating a fire hazard with the possibility of burning yourself.

3. Igniting matches or a lighter in the vicinity of the oxygen source will cause the flame to burn larger and faster, again creating a fire hazard with the possibility of burning yourself.

4. Supplemental oxygen is absorbed by clothing, fabrics, bedding materials, etc. and increases the flammability of all these materials.

5. **ALL SOURCES OF IGNITION SHOULD BE AT *LEAST* EIGHT (8) FEET AWAY FROM AN OXYGEN SOURCE**

6. Tobacco smoke will damage your equipment and may void the warranty. If your equipment is damaged, or is contaminated with tobacco odors, it will make it no longer usable for rental purposes and you will be held responsible for the cost of replacing the equipment.

For your own safety and well-being, I request that you do not smoke, especially while using oxygen.

Sincerely, Dr. Benjamin A. Laracuente

____

Patient/Caregiver Signature Date

Benjamin A. Laracuente, MD, FCCP
3468 Brodhead Road, Suite 11
Monaca, PA 15061
724.728.5995

CANCELLATION AND NO SHOW POLICY

Cancellation of an Appointment

We understand that situations arise in which you must cancel your appointment. In order to be respectful of the medical needs of our patients, please be courteous and call promptly if you are unable to keep an appointment. This time will be reallocated to someone who is in urgent need of treatment. This is how we can best serve the needs of our patients. If it is necessary to cancel your scheduled appointment, we require that you call 24 hours in advance. Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment

To cancel appointments, please call our office at (724) 728-5995. If you do not reach the operator, you may leave a detailed message on the voicemail. In the event that you reach our after hour answering service, you may cancel your scheduled appointment with that service and they will forward the information to us.

Late Cancellations

Late cancellations (less than 24 business hours in advance) will be considered as a "no show".

No Show Policy

A "no show" is someone who misses an appointment without a call to cancel it 24 business hours in advance of the scheduled appointment. (Example: your appointment is at 3pm on Tuesday. You need to call by 3pm on Monday). No shows inconvenience those individuals who need access to medical care in a timely manner. A failure to make the time of a scheduled appointment will be recorded in your chart as a "no show". A fee of $50.00 will be billed to your account and mailed to your home.

The cancellation and no show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. Please sign that you have read, understand, and agree to this cancellation and No Show Policy.

____

Patient Name (Please Print) Date of Birth

____

Signature of Patient or Patient Representative Date

TREATMENT, CONSENT, AND FINANCIAL AGREEMENT
Patient Rights/ Responsibilities

AUTHORIZATION FOR TREATMENT AND PROCEDURES: I hereby agree to and give consent to be treated by Tri-State Pulmonary Medical Practice (TSPMP) its physician, and its employees. I acknowledge that no guarantees have been made to me to the results of diagnosis, treatment, tests, or examination from TSPMP. This consent does not include procedures requiring informed consent. This consent may be used for ongoing, related services. I understand that healthcare personnel in training may participate in or be present at various times throughout the course of my treatment at TSPMP. Such personnel are under the supervision of instructors and/or the attending physician as applicable. I have no objection to the involvement of students in my care and I hereby provide consent to such involvement.

RELEASE OF INFORMATION: I give my permission to TSPMP to disclose all or any part of my medical and/or billing records to any insurance company, third party payor (including my employer, if applicable, for example in workers' compensation cases), or collection agency, which may be responsible for payment of TSPMP's charges on my behalf or for collection unpaid balances from the responsible parties. I further authorize such disclosures to any of my other treating healthcare providers as needed for treatment or billing payment purposes. TSPMP will release information as permitted by law and/or HIPAA regulations.

FINANCIAL RESPONSIBILITIES: In consideration of all services and supplies provided by TSPMP, I completely understand and fully agree that I have full responsibility to pay TSPMP. I hereby guarantee full payment for all charges. If my account is referred to a collection agency or an attorney, I guarantee payment for all collection fees and costs. I also understand that the responsibility for payment may not be deferred for any reason or assigned to any other party. TSPMP may bill my insurance(s), but I remain fully responsible for full payment. TSPMP may bill the patient if your insurance third party does not pay for the claim per Act 68. I fully understand and agree to be financially responsible for full payment if any insurance determines services were not referred, authorized, or are non-covered according to my benefits. TSPMP does not deny services to any patients based on their insurance companies' requirements or determinations. Please work closely with your physician to ensure that your insurance companies' requirements have been met to process payment on you behalf.

INSURED PATIENTS:

- Any deductibles and/or co-insurances as per your agreement with the insurance company will need to be paid upon request. Unfortunately, some elective procedures cannot be scheduled until this amount is paid.
- Participating Insurance Carriers - We do participate with numerous insurance companies, meaning we have a contract with them. Co-payments and/or non-covered services are required to be paid by you in full at the time of service. Co-pays are due at check-in or your appointment will be rescheduled. Our contract with the insurance companies states patient balances/co-pays can not be waived.
- Non-participating Insurance Carriers - There are some insurance companies with which we do not have a contract. You are required to pay all visits in full at the time of the visit. We will submit a claim, to help you, to your insurance company. Any payment from the insurance company will usually be sent directly to you. You will be responsible for following up with you insurance company regarding any potential reimbursement for the services we provide. If a surgical procedure is needed, you will be asked to pay our charged amount in full prior to services being scheduled. We offer many options for payment of this fee, inquire with our office staff.

UNINSURED PATIENTS:

- Payment for services is due IN FULL at the time of service. Payment for any elective procedures is due prior to the procedure being scheduled. Please inquire with our office staff regarding payment options.

ACCOUNT BALANCES:

- Past due balances (30 days old) may have additional fees applied to cover administrative/billing costs. Delinquent balances (over 45. days) will be referred to an outside collection agency (unless a mutually agreed upon payment plan has been established) and will result in you and immediate family members being dismissed from our practice. An additional collection fee (subject to change without notice) will be added to the balance if referred to the collection agency. Keeping your account paid in full will prevent us from having to take these actions.

REFERRALS:

- If your insurance plan requires you to obtain a referral from your Primary Care Physician (PCP), you are responsible for obtaining the referral and presenting it at your visit. If you do not have the referral, the appointment will need to be rescheduled. This is a requirement of your insurance and as a reminder; your PCP may require at least five (5) days to prepare the referral. Check with your doctor's office regarding their specific policy.

It is impossible for any medical provider to know the insurance benefits of every patient. Benefits vary greatly based on the wide variety of policies sold to employers and patients. It is your responsibility to know your medical benefits. We will assist you if necessary; however, the ultimate responsibility for knowing your benefits rests with you.

AUTHORIZE TO PAY INSURANCE BENEFITS: I authorize payment directly to TSPMP for TSPMP and/or physician benefits otherwise payable to me. I understand I am financially responsible to TSPMP for charges not covered by this authorization, considered non-payable by my insurance(s), non- referred or non-authorized. I authorize TSPMP and/or physician to submit a claim to Medicare or other applicable insurance company on my behalf.

- I authorize the release of all medical records to the referring and family physicians and to my insurance company. This includes records containing any mention of **1) HIV status, 2) Drug/ alcohol use, and 3) Mental health history.** I also allow fax transmittal of my medical records if necessary.
- I acknowledge full financial responsibility for services rendered by TSPMP. I understand that many Insurance companies do not cover all services, and I will be financially responsible for all non-covered charges including, but not limited to co-insurances and deductibles.
- I understand that payment of charges incurred is due at the time of service unless otherwise definite financial arrangements have been made prior to treatment.
- I agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges I further authorize and request that Insurance payments be made directly to TSPMP should they elect to receive such payment.

CORRECT INFORMATION: I understand that if I do not present accurate, current and complete billing insurance information at the time of services, I agree to be responsible for any amounts relating to the full payment of any amount not covered by insurance. I relieve TSPMP of any responsibility in the event correct Information was not provided at the time of service. A copy of my insurance card(s) will be maintained to verify what was presented to TSPMP.

KEEPING SCHEDULED APPOINTMENTS: Missed appointments cause delays in your progress and scheduling dilemmas. Under certain circumstances, chronic missed appointments could jeopardize your health. Our policy is as follows:

- All patients, presurgical, medical management require a 24-hour cancellation notice. If there is no 24-hour notice, a $50 fee (subject to change without notice) may be applied to your account. Accounts must be up to date in order to progress with treatment. Abuse of this policy could result in termination of your treatment with our office.
- Proper followup is an essential key for a successful outcome.

MEDICARE AUTHORIZATION: "PATIENT'S CERTIFICATION AUTHORIZATION TO RELEASE INFORMATION AND PAYMENT REQUEST": I certify that Information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment or authorized benefits to be made on my behalf.

- I request that payment of authorized Medicare benefits be made either to me or on my behalf to TSPMP for any services furnished to me by that physician. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any Information needed to determine these benefits or the benefits payable for related services.

- If other health insurance is indicated in Item 9 of the HCFA-1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient Is responsible only for the deductible, co-Insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare carrier.

PARTICIPATION IN INSURANCE PRODUCTS: I understand that it is my responsibility to verify with my Insurance or employer if TSPMP participates with my Insurance at the time of service. I relieve TSPMP or any responsibility in reference to non-participation in the insurance or if my services were to be performed by another entity.

PATIENT ACKNOWLEDGEMENT: I have read, or have had read to me, the above policy TSPMP. I acknowledge that I understand the policies above. I also understand that I forego any blame If I do not adhere to the medical advice given to me. TSPMP may terminate services to me if I fail to adhere to treatment guidelines. With my signature, I release all rights and privileges if I fail to commit to the above-mentioned policies.

______________________ ______________________ ______________

Patient Signature Witness Signature Date

____

Printed Patient Name

____

Signature of authorized person or name of person giving verbal permission

[ ] Healthcare Representative