Pulmonology Group LLC

ARIZONA
3003 Highway 95, Suite D-51, Bullhead City, AZ 86442
Phone: 928-299-5299 Fax: 928-299-5169
NEVADA
2904 W Horizon Ridge Suite #100 Henderson, NV 89052
825 N. Gibson Rd Ste 301 Henderson, NV 89011
Phone: 702-780-0300 Fax: 702-608-4977

Thank you for choosing Pulmonology Group LLC for your health care needs.

Enclosed please find the forms required of you as a new patient of Pulmonology Group LLC.

The New Patient Health form is probably the most important form that is required. Please provide accurate information in all areas; this will help the provider immensely in treating your pulmonary care needs.

If you are currently taking multiple medications, please list each one along with the dosing, frequency and reason for taking it on the medication list provided. If this is your first visit please bring all of your medication bottles with you in case a question should arise.

If you are unable to keep your appointment and need to reschedule, please call our office within 24hrs of your scheduled appointment so that we can provide that appointment time to another patient. Be aware that there might be a longer wait time due to Dr.'s Schedule on appointment day.

THE ATTACHED FORMS (**IF AT ALL POSSIBLE**) SHOULD BE RETUNRED TO OUR OFFICE AT LEASE 24 TO 48 HOURS PRIOR TO YOUR APPOINTMENT DATE/TIME SO THAT WE MAY SCAN THEM INTO OUR SYSTEM AND ENSURE A SMOOTHER CHECK IN PROCESS FOR YOU. IT MAY BE FAXED, MAILED, EMAILED OR DROPPED OFF IN THE OFFICE. IF YOU CAN NOT RETURN IT PLEASE BE ADVISED YOUR WAIT MIGHT BE LONGER AT TIME OF APPOINTMENT OR YOU MIGHT BE ASKED TO RESCHEDULE THE APPOINTMENT.

*****PLEASE BRING YOUR PICTURE ID AND INSURANCE CARD(S). NO PHOTO COPIES PLEASE, AS WE NEED TO SCAN THEM INTO YOUR FILE.

*****__ALL CO-PAY OR COINSURANCE MUST BE PAID AT THE TIME OF YOUR APPOINTMENT.__ IF YOU ARE UNSURE OF THE DOLLAR AMOUNT YOU CAN CONTACT YOUR INSURANCE ADMINISTRATOR FOR THE INFORMATION.

****THE PROVIDER IS NOT PAIN MANAGEMENT PROVIDER.**

Again thank you for choosing Pulmonology Group LLC.

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Financial Policy

Pulmonology Group LLC wants to provide our community with healthcare services and, at the same time, keep cost under control. To do this, we need your help. We ask you to read out payment policy listed below.

- *Your bill is based on the services you received. You are responsible for paying the bill if your insurance company does not cover all the costs.*
- *What your health insurance covers is based on an agreement between the company, or person who employs you, and the insurance company.*
- *You need to contact your insurance company with any questions about what they will cover.*
- *We know that temporary financial problems can sometimes prevent you from making a payment on our account on time. If this happens, you need to contact us at 928-299-5299 at once so we can help you with this problem. Pulmonology Group LLC will help to arrange a budget plan.*
- *Any Bill not paid by the date it is due will be sent to a collection agency*

IF YOU DO NO HAVE HEALTH INSURANCE

Your responsibility

- *You must pay your entire bill at the time of service or inform us of your inability to pay.*

Our Responsibility

- *Patient Financial Representatives are available to discuss financial options with you.*

IF YOU HAVE HEALTH INSURANCE

We participate with many insurance companies. This means we have signed a contract with them to provide care for the people they cover. The contracts are not all the same, and certain services may not be covered depending on your employee health benefits.

If we DO participate with your insurance plan (including Medicare):

- *You must pay any co-payment at the time you receive the services.*
- *You must pay any deductible amount or any amount that you know is not covered at the time of service.*
- *You must pay the amount not paid by your insurance payment is due upon receipt is due upon receipt of the statement.*

If you do not pay we will begin collection efforts.

Our Responsibility

We will send a bill to your insurance company for all services done in our offices.

STATEMENT OF FINANCIAL RESPONSIBILITY

The patient who receives care and treatment from Pulmonology Group LLC must pay any charges that are not paid by insurance or any other party. Other providers, such as x-ray or laboratory, will bill the patient separately. The patient must pay any amount not paid by insurance upon receipt of the statement.

Patient Signature _____*Date :* _____

Print patient name _____

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Authorization to release healthcare information

Patient's Name: _____ Date of Birth: _____

I request and authorize _____to
Release healthcare information of the patient named above to:

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This request and authorization applies to:

__Healthcare information related to the following treatment, condition, or dates: _____

_____

__All healthcare information

__Other:
_____Definition:
Sexually transmitted disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV(human immunodeficiency virus) AIDS(acquired immunodeficiency syndrome), and gonorrhea.

__yes __No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of the these test results to anyone.

__ yes __No I authorize the release of any records regarding drug, alcohol, or mental health Treatment to the person(s) listed above

Patient Signature: _____Date _____

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Authorization for release of medical information

I, _____ authorize Dr. Sayal's office to release information regarding my medical condition to the family members listed below.

This includes but is not limited to reports, labs, x-ray, office visits, psychiatric drug/alcohol abuse or other testing.

Name: _____Ph: _____ Relation _____

Name: _____Ph: _____ Relation _____

Name: _____Ph: _____ Relation _____

Name: _____Ph: _____ Relation _____

Patient Signature: _____Date: _____

Witness Signature: _____Date: _____

I refuse at this time to have any information released

Patient signature _____Date: _____

Pulmonology Group LLC

Consent for Treatment

Patient Name _____ Date of Birth _____

Pulmonology Group LLC affirms a dedication to value the individual rights of our clients. No procedures, policies, or treatment programs have been or will be designed to infringe on your right as an individual. Your rights are.

You have the right to professional respectful, and clinically appropriate care which is non-discriminatory with regard to age, race, religion, sex, ethnicity, color, national origin, marital status, sexual orientation, or handicap.

You have the right to obtain from the staff complete and current information concerning your diagnosis, treatment goals, and prognosis in understandable terms. You have the right to inspect your own medical record with the following limitations.

- You may request the correction or removal of inaccurate, irrelevant, outdated or incomplete information.
- You may submit rebuttal information or memoranda to be included in your own record.
- You may appeal a decision to limit your access to your record in writing to the Clinical Director.
- Your Primary clinician or the clinical director ay temporarily remove portions of your record if it is determined that the release of such information may be harmful. Reasons for removing sections shall be documented, kept on file, and explained to you.

You have the right to know criteria for admission, treatment, completion and discharge. You have the right to explanations regarding goals, procedures, and potential benefits of treatment explained to you. By signing this form you agree to the following: I understand that my participation in treatment is voluntary and I may terminate my treatment at any time by contacting the Pulmonolgy Group LLC office or my treating clinician.

You have the right to have all reasonable questions answered so that your consent to treatment of any type is informed. If significant alternative forms of treatment exist, you have the right to be informed of the alternatives. You have the right to know the specific nature of proposed treatment and the expected duration of such treatment.

You have the right to privacy concerning your treatment program. Case discussion, consultation, examination, details divulged in group meetings, treatment, and appointment dates/times is strictly confidential. This information will not be divulged to anyone outside the agency , including your spouse, a significant other, or your parents without your written consent except in case of threat to self or others and/or report of abuse of minor.

You have the right to expect that right to expect that within our capacity we will respond to your request for a specific service an evaluation, service, or referral, at your request, will be made if deemed clinical transfer concerning the need for such transfer.

You have the right to know of our continuing interest in you, after discharge. We may be contacting you after discharge, by phone, fax or email.

You have the right to expect continuity of care. We will inform you of appointment times, services, and resources at discharge.

You have the right to know what we believe are your continuing requirements for treatment post-discharge.

You have the right to file a complaint in writing to the clinical director if you feel that any of these rights have been violated.

You have the right to examine and receive an explanation of your bill regardless of the source of payment.

You have the right to expect that Pulmonology Group LLC staff will treat you and your family professionally. Any sexual contact or contact or sexual harassment of clients is totally unacceptable. You have the right to alert the Clinical Director to inappropriate behaviors and statements. You may expect this matter to be addressed promptly and appropriately by the administration of this agency.

As a reciprocal component of your treatment at Pulmonology Group LLC, you have certain responsibilities.

You have a responsibility to actively participate in your treatment, knowing your confidentiality will be respected per the aforementioned rights.

You have a responsibility to cancel an appointment with at least 24 hour advanced notice if you are unable to attend.

You are responsible to attend your appointments substance free (alcohol/drugs) to best utilize your appointments. Your clinician is also mandated to be substance free as a condition of employment. You are responsible to conduct yourself appropriately (i.e., no assaultive behaviors, threats of violence, obscenities, or destruction of property). Failure to conduct yourself in an appropriate manner may constitute administrative discharge.

- Thise rights and responsibilities provide the structure which governs the operations of Pylmonolgy Group LLC. With your signature below, you hive consent to treatment from Pulmonolgy Group LLC.

Patient Signature _____ Date _____

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Insurance Billing Authorization

Patient Name _____ D.O.B _____

Insurance Coverage

I request that payment is authorized commercial Benefits, Medicare and or Secondary Medicare coverage benefits be made directly to Pulmonology Group LLC for any services furnished to me by that provider of service. I understand that I am financially responsible for charges not covered by this authorization. I authorize any holder of medical information to release to my insurance company or its agents any information, which may be necessary to determine benefits payable for release services.

Primary Insurance: _____ ID #_____

Secondary Insurance: _____ID # _____

Third Insurance: _____ID # _____

Patient Signature (If minor legal guardian's) _____Date: _____

Pulmonology Group LLC
Review of symptoms

Patient Name: _____ D.O.B _____

Height ____Weight ____ Primary care Physician _____Pharmacy _____

Please check mark symptoms that applies at this time:

__ Loss of breath when walking	__ chest tightening	__ history of heart attack
__ Fever	__ Hay fever	__Shortness of breath
__Weight Loss __weight gain	__ Upper back pain	__ Snoring
__Night Sweats	__ Phlegm with (blood)	__ Phlegm Color _____
__ Chronic Fatigue	__ Wheezing	__ Heart Palpitation
__Chronic Cough	__ Leg Swelling	__ Joint Pain
__Nasal Congestion	__ Appetite Loss	__ Snoring
__sore throat	__ Dry Mouth	__ Sleepwalking
__Hoarseness	__ Sleep Talking	__ Trouble sleeping
__Blood when coughing or in sputum	__ Headaches	__ Heart Burn
__chest pain when taking deep breath	__ anxiety	__ Depression
__Nose bleeds	__ Nasal Drainage	__ Chills or fevers

Past Medical History

__ Asthma	__ copd	__ Emphysema
__ Pulmonary Fibrosis	__ Lung Nodule	__ Hypertension/high blood pressure
__ High cholesterol	__ History of heart attack	__ DVT/Blood Clot
__ History of stoke	__ Gerd/acid reflux	__ Diabetes
__ Thyroid problem ____Low or ____High	__ osteoporosis	__ arthritis
__ Kidney Failure	__ Irregular heart beat	__ Chronic Pain
__ Anxiety	__ Depression	__ History of cancer what kind _____

__ other medical problems _____

Past Surgical History

__ Tonsillectomy __ Lung Surgery __ Heart surgery __ cardiac stents __ gallbladder __ hernia __shoulder

Other: _____

Social History :

Do you currently smoke? _____ If yes how many a day _____ How long ? _____**Quit when** ? _____

Do you drink alcohol? _____ Have you ever done Elicit drugs? ____ if yes what kind? _____

Family history:

__Asthma	__ Hypertension	__ copd
__Heart problems	__ emphysema	__ stroke
__ diabetes	__Sleep Apnea	

__ Cancer if yes what kind: _____

__ Other _____

Pulmonology Group LLC
Review of symptoms

Patient Name: _____ D.O.B _____

Height ____Weight ____ Primary care Physician _____Pharmacy _____

Please check mark symptoms that applies at this time:

__ Loss of breath when walking
__ Fever
__Weight Loss
__Night Sweats
__ Chronic Fatigue
__Chronic Cough
__Nasal Congestion
__sore throat
__Hoarseness
__ Post Nasal Drip
__chest pain when taking deep breath
__Nose bleeds
__ chest tightening
__ Hay fever
__ Upper back pain
__ Phlegm with (blood)
__ Wheezing
__ Leg Swelling
__ Appetite Loss
__ Dry Mouth
__ Sleep Talking
__ Headaches
__ anxiety
__ Nasal Drainage
__ coughing up blood
__Shortness of breath
__ Snoring
__ Phlegm
__ Heart Palpitation
__ Joint Pain
__ Snoring
__ Sleepwalking
__ Trouble sleeping
__ Heart Burn
__ Depression
__ Chills or fevers

Past Medical History

__ Asthma
__ Pulmonary Fibrosis
__ High cholesterol
__ History of stoke
__ Thyroid problem ____Low or ____High
__ Kidney Failure
__ Anxiety
__ copd
__ Lung Nodule
__ History of heart attack
__ Gerd/acid reflux
__ osteoporosis
__ Irregular heart beat
__ Depression
__ Emphysema
__ Hypertension/high blood pressure
__ DVT/Blood Clot
__ Diabetes
__ arthritis
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__Asthma
__Heart problems
__ diabetes
__ Hypertension
__ emphysema
__Sleep Apnea
__ copd
__ stroke

__ Cancer if yes what kind: _____

__ Other _____

Pulmonology Group LLC
Medication Information

Allergies to any medications

__ Sulfa
__ Pain medication? _____
__ Iodine
__ Penicillin or other antibiotics _____
__ other _____

Medication Name	Dosage (mg, mcg etc..)	Directions	What do you take it for?