PULMONARY AND CRITICAL CARE SPECIALISTS
160 Kingsley Lane, Suite 103
Norfolk, VA 23505
Phone: 757-889-6677 Fax: 757-889-6652

PLEASE PRINT

PATIENT INFORMATION Today's Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Age: _____ Date of birth: _____ ☐ Male ☐ Female SSN: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White

☐ Hawaiian or Pacific Islander ☐ Other ☐ Declined

Email address (please print): _____

Main phone: _____ Alternate phone: _____

Employer: _____ Employer Phone: _____

Occupation: _____

Hospice or Nursing Home patient? □ Yes □No Facility name _____

Primary Care Physician: _____ Phone: _____

Referring Physician(s) to send our reports to: _____

SPOUSE OR RESPONSIBLE PARTY

Name: _____

Address: _____

Age: _____ Date of birth: _____ □Male □Female Marital Status _____

SSN: _____ Home phone: _____

Cell phone: _____ Occupation: _____

Employer: _____ Employer Phone: _____

PRIMARY HEALTH INSURANCE INFORMATION

Company Name _____ Effective Date: _____

Policy Holder Name _____ Policy #: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Patient's relationship to policy holder: □ Self □ Spouse □ Child □ Other Group#: _____

SECONDARY HEALTH INSURANCE INFORMATION

Company Name _____ Effective Date: _____

Policy Holder Name _____ Policy #: _____

Policy Holder DOB: _____ Policy Holder SSN: _____

Patient's relationship to policy holder: □ Self □ Spouse □ Child □ Other Group#: _____

EMERGENCY CONTACT INFORMATION

Name of Contact _____ Relationship _____

Telephone # _____

FINANCIAL POLICY

We are pleased that you have selected us as your care provider. Our mission is to provide you with the highest level of professional medical care with the highest degree of patient satisfaction. An important aspect of optimal patient care is to have an agreement as to financial responsibility to avoid any misunderstandings and to ensure timely payment for services.

PAYMENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services rendered. Payment is expected at time of services for all charges owed for the current visit as well as, any prior balance. You may require additional services beyond the scope of your exam. Therefore, an additional charge may be incurred and you will be asked to pay resulting additional copayments or patient responsibility amounts. Please note that our office is not responsible for any statements received from any other facility.

TYPES OF PAYMENTS

1). **CO-PAYMENTS**. PCCS is required by insurance carriers to collect copayments at the time services are rendered. The patient's appointment will be rescheduled if he/she are not prepared to make this payment.

2). **DEDUCTIBLES**. Some insurance plans require patients to pay a predetermined amount before services will be covered.

3). **CO-INSURANCE**. Some insurance plans require that patients pay a predetermined percentage of the allowed charge amount. If the amount can be determined at time of service, amount will be collected.

4). **UNINSURED PATIENTS (SELF PAY)**. Payment for all services rendered is due at the time of service. A NEW PATIENT TOTAL CHARGE IS $500.00. AN ESTABLISHED PATIENT TOTAL CHARGE IS $100.00. IF YOU ARE HAVING A PROCEDURE (BRONCHOSCOPY) AND ARE UNINSURED, THE TOTAL CHARGE IS $1000.00. This is for Dr. Silva's services ONLY and does not include charges from the hospital. You will be billed separately for those services. In this case, those charges are between the patient and that facility. **In each case, all fees WILL be collected prior to the patient being checked in for his/her appointment.**

INSURANCE. All patients must present their insurance card and proof of identification at every visit. Patients who do not provide current proof of insurance will be billed as a self-pay patient. If at a later time the patient presents his/her insurance card (s), services already rendered may or may not be retroactively billed depending on the insurance's claim filing requirements. The patient's insurance is a contract between him/her and the insurance carrier. PCCS is not a part of this contract. For this reason, we will not waive copays or deductibles.

INSURANCE CLAIMS PROCESSING. PCCS accepts assignment of benefits for many 3rd party carriers. In accordance with the insurance carrier contracts, patients WILL be required to pay co-payments at the time services are rendered. PCCS will submit charges for services to the insurance carrier. The patient or guarantor will be expected to pay the entire amount that is determined to be patient responsibility. These fees are for physician services only and there may be additional bills from laboratory, radiology, or other diagnostic related providers.

Non-Contracted Insurance. If a non-contracted "out of network" insurance (an insurance company with which our providers are not contracted) has not paid within thirty (30) days, the remaining balance, beyond the amount we collect at time of service, is the patient's responsibility and must be paid prior to any additional visits with us.

DEEMED CONSENT. I understand that, in accordance with Section 32.1-45.1 of the Code of Virginia, 1905, as amended, if a Pulmonary and Critical Care Specialists healthcare provider is exposed to my blood or other bodily fluids in a manner which may transmit disease, I may be tested for infection with Human Immunodeficiency Virus (HIV), the virus which causes Acquired Immune Deficiency Syndrome (AIDS) or Hepatitis B or C viruses. I further understand that the results of any such test will be shared with me and the exposed healthcare provider; that the Virginia Department of Health will be notified; and that appropriate counseling shall be provided if the results are positive.

PRESCRIPTION REFILL POLICY. To request a prescription refill, please call your pharmacy and have them send us a fax request. Please allow 48 – 72 hours for us to process your prescription refill request. Prescriptions for narcotics cannot be ordered. Prescriptions for antibiotics are not refilled. If you use the base or a mail order pharmacy, please call the office and allow 48 – 72 hours for us to process your prescription refill request.

RELEASE OF LIABILITY. I understand that Pulmonary and Critical Care Specialists may request additional tests/labs/procedures which are deemed medically necessary at that time. I hereby release Pulmonary and Critical Care Specialists of all liability that may occur as a result of my failure to complete these tests. I also understand that it is my responsibility to notify the office when or if I decide to have the labs/tests/procedures completed. I understand that no results will be given by phone. I understand that if I refuse labs/tests/procedures on a regular basis, I can be discharged from the practice for noncompliance.

INSURANCE REFERRAL REQUIREMENTS. I understand that if my insurance requires a referral for me to be seen and I have not obtained such referral for any and all visits, that I will pay all fees associated with that visit.

OUTSTANDING BALANCES. Any outstanding balance that is due from the patient is payable in full upon receipt of statement. In the event a patient presents for an office visit and has an outstanding balance, a request for payment will be made. If payment is not made, the appointment will be rescheduled to a later date when payment can be made. A patient with unpaid delinquent accounts or accounts which have been sent to collects may not receive additional scheduled services unless special arrangements have been made. The patient may be discharged from the practice.

LATE ARRIVALS, CANCELLATIONS AND NO SHOWS.
LATE ARRIVALS. Patients who arrive late for a scheduled appointment may be asked to reschedule the appointment or wait for an open appointment time on that day's schedule. **CANCELLATIONS**. Patients shall call at least 1 business day in advance if unable to keep a scheduled appointment time or the practice will consider the patient a "no-show." **NO SHOWS**. Patients who do not present for an appointment will be considered a No-show. These patients WILL be charged a $25.00 fee for a missed appointment. I acknowledge that there is a $25.00 charge for NO SHOW APPOINTMENTS, $55 for a NO SHOW for a Methacholine Challenge, $40 for Ultrasound appointment and cancellations less than 24 hours in advance. If a bronchoscopy is scheduled, a $200.00 fee WILL be charged. These charges WILL be collected prior to being checked in for your next appointment. This fee cannot be filed to insurance. In accordance with state guidelines, a patient may be discharged from the medical practice following 3 no-shows in a 1-year period. No-shows will be documented in the practice management system and a history of no-shows may result in refusal to schedule future appointments. First visit appointments that are repeatedly cancelled and new patient no-shows will count toward the patients no-show record and may result in discharge from the practice.

PATIENT AUTHORIZATION
I authorize Pulmonary and Critical Care Specialists to release medical information necessary to submit my health insurance claims. I request that my health insurance claims be paid directly to Pulmonary and Critical Care Specialists.

In consideration of the services rendered, I/we agree and understand that each person signing this document jointly and severable agrees to pay for all services rendered by Pulmonary and Critical Care Specialists. If this account is referred to an outside collection agency or attorney, then the undersigned person(s) agree and promise to pay all collection costs including principal amount due, attorney fees and any all fees being owed when turned over for collection and do further agree to pay interest on the unpaid balance at the legal rate from the date services were last rendered. I authorize photocopies of this form to be valid as the original.

If payment for these services is not made by the insurance company(ies); I agree to pay for said services: for example Code 94762 Home Oxygen **(Some patient's will be charged a copay (by their insurance company) for the reading of the Home Oxygen test, a little blue/black bag you take home with you, typically on the first visit)**, J77674 Methacholine Challenge.

I also hereby authorize release of medical records by any facility that these procedures have been performed at to Pulmonary and Critical Care Specialists, if needed by them for further medical workup. I hereby authorize release of medical records by Pulmonary and Critical Care Specialists for the same reason.

PCCS strives to be considerate to all of our patients. We would appreciate the same in return. If rudeness occurs to any of our staff, this will result in discharge from our practice.

By my signature, I acknowledge that I have read and understood the terms of this agreement.

_____ _____
PATIENT'S SIGNATURE DATE

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the **Notice of Privacy Practices** of Pulmonary and Critical Care Specialists. I understand the contents of the notice and I request the following people be granted permission/restriction concerning the use of my personal medical information:

Person's **permitted** to request medical information:	Person's **restricted** from requesting my medical information:
_____	_____
_____	_____
_____	_____

Patient's signature: _____ Date: _____

If not signed by patient, please indicate relationship to patient. _____

Witnessed By: _____

(Office use only)
Virginia Medical Specialists, PLLC attempted to obtain written acknowledgement of receipt of the Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign
□ An emergency situation prevented us from obtaining acknowledgement
□ Other (please specify)

_____

Employee signature: _____ Date: _____

MEDICATION LIST

Please keep med list on top

Name: _____ **SSN:** _____

DOB: _____

DATE	MEDICATION / STRENGTH