PriCare, P.A.

Patient Registration

Today's Date:___________________

Patient's Name			Date of Birth	SSN	
Address:			City:	State:	Zip Code:
Sex:	Marital status M S D W	Race	Drivers License #	Preferred language	Pharmacy

Home Phone number	Cell Number	E Mail Address
May we contact you by: Home- Email -Mail–Cell ph Work	If unable to speak to you may we leave a message: Yes NO	If we can leave a message, please list names of people we may leave it with:

Employer name:		Employer Address:		
Employer phone number	Occupation	Fulltime	Part-time	student

Emergency Contact

Name	Relationship	Phone Number	Alternate number
Name	Relationship	Phone Number	Alternate Number

Insurance Information

Policy Name		Policy Number	Group number
Subscriber Name on Policy	Subscriber DOB	Subscriber SS#	Relationship

2nd Insurance Information

Policy Name		Policy Number	Group number
Subscriber Name on Policy	Subscriber DOB	Subscriber SS#	Relationship

Responsible party (if other than patient)

Name	SSN	DOB
Address: City	State	Zip
Home Phone	Cell phone	Relationship

FINANCIAL RESPONSIBILITY-CONSENT TO TREATMENT- RELEASE OF MEDICAL INFORMATION

I, the undersigned, consent to treatment necessary for the care of the above patient. I acknowledge full financial responsibility for any services rendered and understand that payment of charges incurred in the office is do at that time of service. I also understand that charges not covered by any insurance remain my responsibility. In the event this account is not paid within 90 days, the undersigned agrees to any and all reasonable costs associated with collection of this debt and I hereby waive all rights of exemption under the Constitution of the State Of Alabama.

Signed:____ Date:____________________________

PRICARE, P.A.
Office Billing Policy

This office accepts assignments of benefit from most insurance companies. Verification of your insurance coverage must be obtained before assignment will be followed. We will need copies of your insurance cards.

It is important to know, however, that your group plan is a relationship between you and your insurance company. **The Ultimate responsibility for payment of services is with you**. Until coverage is verified, you will be responsible for payment of services as rendered.

Generally, most insurance plans have deducible clauses. Therefore any deductible portion of the bill is your responsibility, as well as any co-pay that portion not covered by the plan. **We ask that all co-pays or deductibles be paid each visit**, unless other arrangements are made.

Your carrier will be billed for your services as each billing cycle. If the carrier fails to pay within a reasonable time (45 days of billing) we will bill you for information only. At this time you need to contact your insurance company. Failure of a claim to be paid within 60 days of billing will result in your personal liability for this bill.

At the time that all insurance payments have been received, if there is an overpayment we will either issue you a check or apply that credit to your account. We will be reconciling your account as each payment is made. If there is a balance owed, payment can be made by cash, check, money order or credit card.

AGREEMENT TO PAY: The undersigned accepts the fee charged as a lawful debt and promises to pay said fee as outlined above including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

____ ____________________
Patient Name (print please) Date:

______________________________ _____________________ _____________________
Responsible Party Signature relationship to patient Responsible party SS#

Notice of Privacy Practices Acknowledgement
P**RICARE**, P.A.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I Understand that this information can and will 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 acknowledge that I have received your *Notice of Privacy Practices,* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to health information. 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 any time at, PO Box 789, Alexander City, AL 35011, to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict 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 wish to be contacted in the following manner (check all that apply):

Home: _____ Ok to leave message with detail information
_____Or Leave message with call back number

Work: _____Ok to leave message with detail information
_____Ok to leave message with call back number

Written Communication_____ Ok to mail to home address.

Patient representative
(someone other than patient):______________________________ ______________________________
Print name that we can talk to phone # if different

______________________________ ______________________________
Patients name (print) Relationship to Patient:

______________________________ ______________________________
Patient's / Responsible Party signature Today Date

Patient Pulmonary Evaluation Questionnaire

Name:__________________________________DOB_________________DR______________

Please answer the following questions as they apply to you:

Y – N Have you ever smoked?

Y –N Do you have allergies or currently talking allergy medication?

Y – N Have you ever seemed to be short of breath during normal activity?

Y – N Are you currently taking any form of breathing medication?

Y- N Do you have trouble breathing while participating in athletics?

Y – N Have you worked in Cotton Mills or around Asbestos or other chemicals?

Y – N Have you worked in Rock Quarries, Coal Mines, etc?

Y – N Have you had occupational exposure to dust, pesticides, etc?

Y- N Have you been exposed to second hand smoke?

Y- N Are you on home Oxygen?

Y – N Have you ever seen a Pulmonologist?

Y – N Have you ever had a Pulmonary Function Test?