PULMONARY PHYSICIANS OF SOUTH FLORIDA, LLC

REGISTRATION INFORMATION

(PLEASE PRINT)

Date _____ Cell Phone: _____ Home Phone _____

Patient Name: _____

Street Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Social Security # _____ * Email Address: _____

Employed Full-Time Student Part-Time Student

Patient Employed By _____ Occupational Hazards: _____

Spouse (or responsible party) Name _____ Birthdate _____

Who is responsible for this account? _____ Relationship to Patient _____

Do you have Medical Insurance? No Yes If yes,

Name of Primary Insurer _____

Contract # _____ Group # _____ Subscriber # _____

Name of Secondary Insurer (if any) _____

Contract # _____ Group # _____ Subscriber # _____

In case of emergency, who should be notified?

_____

Phone _____ Relationship to patient _____

Reason for seeing _____

How did you learn of our practice? _____

Whom may we thank for referring you? _____

10139 NW 31st Street Suite 103 Coral Springs, Florida 33065-3908 * Office: 754-702-3247 * Fax: 305-703-4897

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Today's date: _____

Patients Name: _____ Date of Birth: _____

Primary Physician (PCP): _____

Pharmacy Name: _____ **Telephone#:** _____

Pharmacy Address: _____

(If you have a medication list please just provide a copy)

Medications List:

- _____
- _____
- _____
- _____
- _____
- _____
- _____

Medical/Surgery List

- _____
- _____
- _____
- _____
- _____
- _____
- _____

Allergies to medications: _____

History of Smoking: ☐ YES ☐ NO

Age Started_____ Age Quit_____ # Packs _____ #Cigarette_____

Have you received vaccinations for: __ Flu __Pneumococcal __ Covid

Have you Fallen in the last year? __Yes __No If Yes How many times: _____

Recent Travels: ___Out of State ___Out of the Country Where:_____

Animals in the home ___Yes ___No Cats___ Dogs___ Birds____ Others_____

Do you have a Health Care Surrogate: ___Yes ___No Name:_____

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EPWORTH SLEEPINESS SCALE

Fecha: _____

Patient Name: _____ **D.O.B.:** _____

How likely are you to doze off or fall asleep? in the following situations, in contrast to feeling just tired. This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

¿Cuál es la probabilidad que se duerma? en las siguientes situaciones compara a solamente sentirse cansado, esto se refiere a las cosas que se hacen diariamente durante este tiempo. Aunque últimamente no haya hecho algunas de las cosas, trate de imaginar cómo le hubiera afectado. Use las siguientes escalas y escoja en número más apropiado para la situación.

0= would NEVER doze *(Nunca se dormiría)*
1= SLIGHT chance of dozing *(Probabilidad menos moderada de dormirse)*
2= MODERATE chance of dozing *(Probabilidad moderada de dormirse)*
3= HIGH chance of dozing *(Probabilidad alta de dormirse)*

SITUATION (Situación)	**SCALE NUMBER** (Número de escala)
SITTING AND READING (Sentado Leyendo)	
SITTING, INACTIVE IN A PUBLIC PLACE (EG. A THEATER OR A MEETING) (Sentado, inactive en un lugar público (Ejemplo: en el teatro o en una reunión)	
AS A PASSENGER IN A CAR FOR AN HOUR WITHOUT A BREAK (Como pasajero en un carro sin descanso por una hora)	
LYING DOWN TO REST IN THE AFTERNOON WHEN CIRCUNSTANCES PERMIT (Acostarse a descansar en la tarde cuando tiene la oportunidad.)	
SITTING AND TALKING TO SOMEONE (Sentado hablando con alguien)	
SITTING QUIETLY AFTER A LUNCH WITHOUT ALCOHOL (Sentado tranquilo después del almuerzo sin haber tomado bebida alcohólica)	
IN A CAR, WHILE STOPPED FOR A FEW MINUTES IN TRAFFIC (Sentado en un coche mientras espera por el tráfico)	
WATCHING TV (Viendo la televisión)	
TOTAL SCORE:	

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ASSIGMNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____
Name of Insurance Company

And assign directly to Dr. Scott Lieberman and Dr. Ali Chaudhry all medical benefits, if any, otherwise payable to me for services rendered. I understand that am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electric.

_____ _____
Signature of insured/Guardian Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dr. Scott Lieberman and Dr. Ali Chaudhry for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature request that payment be made and authorize the release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 for, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of information to the insurer or agency show. 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, coinsurance, and no covered services. Coinsurance and the deductible are based upon the charge determination of Medicare carrier.

_____ _____
Beneficiary Signature Date

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PATIENT AUTHORIZATION AND FINANCIAL RESPONSIBILITY FORM

CONSENT TO TREATMENT

I hereby voluntarily consent to the rendering of medical treatment by the physicians and medical staff of the Pulmonary Physicians of South Florida. This may include examinations, diagnosis and/or surgical procedures, administration of injections and/or any other such medical treatment deemed necessary for the diagnosis and treatment of the patient's medical condition.

ASSIGNMENT OF THE INSURANCE BENEFITS

I hereby authorize my insurance company to make payments on my behalf of any and all Individual, Group, Worker's Compensation, Liability or PIP benefits directly to the provider, physicians and medical staff of the Pulmonary Physicians of South Florida for medical services rendered to me.

MEDICARE/MEDICAID ASSIGNMENT OF BENEFITS

Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVII or XIX of Social Security Act is correct. I request that Medicare, Medicaid, Medigap and supplementary insurance companies make payments of authorized medical benefits to the physicians and medical staff of the Pulmonary Physicians of South Florida on my behalf.

GUARANTY OF PAYMENT

I understand that I am financially responsible for payment to the physicians and medical staff of the Pulmonary Physicians of South Florida for any charges not covered or allowed by my insurance company and all applicable out of pocket expenses including deductibles, co-insurance and co-payments. I further understand and agree that if this account is placed for collection, I will be responsible for paying the balance owed to the physicians and medical staff of the Pulmonary Physicians of South Florida plus any attorney fees, if applicable.

THIRD PARTY BENEFIT COLLECTIONS

I, hereby authorize the Pulmonary Physicians of South Florida to act on my behalf as attorney in fact in (1) the collection of benefits from any responsible third-party payer through any legal means necessary and (2) in the endorsement of benefits checks made payable to me or the physicians and medical staff of the Pulmonary Physicians of South Florida.

I, _____(PRINT NAME) ACKMOWLEDGE THAT I HAVE READ AND UNDERSTAND EACH OF THE ABOVE PROVISIONS APPERING ON THIS FORM AND THAT BY SIGNING THIS FORM, I CONSENT TO THESE PROVISIONS INDIVIDUALLY AND COLLECTIVELY.

_____ _____

Patient or Legal Guardian Date Witness Date

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Communication by Email, Text Message, and Other Non-Secure Means

It may become useful during the course of treatment to communicate by email, text message (e.g. "SMS") or other electronic methods of communication. These methods in their typical form are not confidential means of communication. If you use these methods to communicate with [PPSF, LLC], there is a reasonable chance that a third party may be able to intercept and eavesdrop on those messages. The kinds of parties that may intercept these messages include, but are not limited to:

- People in your home or other environments who can access your phone, computer, or other devices that you use to read and write messages.
- Your employer, if you use your work email to communicate with [PPSF, LLC]
- Third parties on the Internet such as server administrators and others who monitor Internet traffic

If there are people in your life that you do not want to access these communications, please talk with the office manager about ways to keep your communications safe and confidential.

[PPSF, LLC] also offers other, more secure means of communication. While it cannot be guaranteed that they will prevent 100% of confidentiality breaches, they are designed with the intention of supporting the confidentiality of clinical communications, some examples are listed below.

- Front desk pick-up at a designated time.
- Delivery via Unites States Postal Service.
- Secure E-Mail.

I allow [PPSF, LLC] to use unsecured email and mobile phone text messaging to transmit the following health information:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this consent at any time.

_____ _____

(Signature of Patient) **Date**

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RECORDS RELEASE AUTHORITY

ACTAS DE LIBERACION DEL HISTORIAL MEDICO

I hereby authorize and request _____ to release complete medical records in your possession, concerning my illness and/or treatment on _____, to the physician(s) named above. Incorporated in this release form is my authorization for you to include any and all information relating to (please check as applicable)

Por la presente autorizo y solicito a _____ para liberar los registros médicos completos en su posesión, con respecto a mi enfermedad y / o el tratamiento de _____, al médico(s) nombrado arriba. Incorporadas en esta forma de liberación es mi autorización para que lo incluya toda la información relacionada con (marcar según corresponda)

_____ Physician Office Notes
(Notas de oficina del médico)

_____ Imaging Studies (PET, CT, Chest x-ray, Ultrasound)
Estudios de imagen (PET, CT, radiografía de tórax, ultrasonido)

_____ Sleep Studies, PFTs, Cardiology Diagnostic Studies
Los estudios del sueño, PFT, diagnósticos de cardiología

_____ Labs
Laboratorios

_____ All Medical Records
Todos los registros médicos

SIGNATURE: _____ Date: _____

RELATIONSHIP IF OTHER THAN PATIENT: _____
(Relación si OTRO QUE NO SEA EL PACIENTE)

PRINT PATENT'S NAME: _____
(NOMBRE DEL PACIENTE)

DATE OF BIRTH: _____
(FECHA DE NACIMIENTO)

SOCIAL SECURITY #: XXX-XX-_____
(NUMERO DE SEGURO SOCIAL)

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