RESPIRATORYSPECIALISTS
PULMONARY PHYSICIANS

PATIENT FORM:

New Patient Paperwork

For questions, please call Respiratory Specialists at (727) 725-6128.

+ RESPIRATORYSPECIALISTS
PULMONARY PHYSICIANS

1840 Mease Drive, Suite 307
Safety Harbor, Florida 34695
Phone Number (727) 725-6128
Fax Number (727)725-6168

PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS, PER HIPAA REGULATIONS

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, any plans for future care and/or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, such as referrals,
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided with a "***Notice of Patient Privacy Practices***" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the *"Notice"* Prior to acknowledge this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

PERMISSIONS:
Please tell us with whom we may discuss your protected health information:

_____

_____

May we leave a message at your **home/cell** using doctor's/practice name: Yes [ ] No [ ]

EMERGENCY CONTACT:
If same as above check this box [ ]

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information toanother entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

Signing below confirms that I completely understand and accept the information of this consent.

_____

Patient Name (print)

_____ _____

Patient/ Guardian Signature **Date**

Specify:

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INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS

I request that the payment of authorized Medicare and/or other insurance benefits be made either to me or on my behalf for any services rendered by Respiratory Specialists I authorize any older of medical information about me to release CMS and/or other insurance carriers and there agent any information needed to determine these benefits related to services.

I hereby authorize Respiratory Specialist to provide information to Medicare and/or other insurance carriers concerning medical condition, illness and treatment to determine the benefits for related services. I hereby authorize Medicare and/or my other insurance carriers to make payment directly to respiratory specialist for medical/diagnostics/surgical benefits payable for the services rendered.

I understand that any unpaid balance not covered by this policy will be payable by me. I understand and agree regardless of my insurance status, that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my count is sent to the collection agency and for any return checks. I understand that Medicare and/or other insurance carriers do not cover all office services/procedures and I agreed to take full responsibility for any unpaid balances and that will be made to Respiratory Specialists

Signing below confirms that I completely understand and accept the information of this consent.

_____

Patient Name (print)

_____ _____

Patient/ Guardian Signature **Date**

Specify:

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PATIENT CONSENT

The undersigned consents to the medical care and treatment deemed necessary or advisable in the judgment of my physician and/or other provider, which may include but are not limited to laboratory procedures, radiology examination, medical or surgical treatments and/or procedures, anesthesia or other services rendered to the patient under the general and special instructions of the patient's physician or other provide.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment directly to Respiratory Specialists of any insurance benefits otherwise payable to me for services at a rate not to exceed Respiratory Specialists regular charges for such services.

RELEASING MEDICAL INFORMATION

I understand that respiratory specialist, its business associates, any treating physician/surgeon and/or my insurance company may obtain, use and/or disclose information for the purposes of treatment, payment and normal healthcare operations. The use and disclosure may include collection agencies and credit bureau. Information may include psychiatric, drug abuse, alcohol and or HIV status. I understand that if I do not consent to the release of information for payment purposes, the facility and other healthcare providers be unable to go my insurance company or other party which is an may be responsible for payment for the services documented by the withheld information and I will be billed directly

PERMISSION FOR TREATMENT

Permission is hereby granted for physicians, practitioners, employees and or agents of the practice to render the patient name below such medical and surgical treatment as is deemed necessary

The undersigned certifies that they have read the foregoing, received a copy thereof, and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accept its terms

Signing below confirms that I completely understand and accept the information of this consent.

_____

Patient Name (print)

_____ _____

Patient/ Guardian Signature **Date**

Specify:

Respiratory Specialists have the right to terminate the relationship, if you refuse to sign this consent or at any time you choose to revoke this consent

RESPIRATORYSPECIALISTS
PULMONARY PHYSICIANS

PATIENT FORM:

HIPAA Authorization for Use or Disclosure of Health Information

For questions, please call Respiratory Specialists at (727) 725-6128.

COMPLETE ONLY ITEM INDICATED WITH ARROW

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

I. My Authorization

I authorize the following using or disclosing party:

Patient's Legal Name: _____ Date of Birth: _____
Phone Number: _____

To use or disclose the following health information:

☐ - Office Notes ☐ - Laboratory Results ☐ - Radiology Results ☐ - Other:

The above party may disclose this health information to the following recipient:

Name (or title) and organization _____

Address _____ City _____State _____ Zip_____

Phone _____ Fax _____

The purpose of this authorization is: ☐ - At my request ☐ - Treatment ☐ - Otherhramous

II. My Rights

I understand that the protected health information specified below may include mental health, substance abuse, HIV/AIDS status information, diagnostic and treatment records.

I understand that I have the right to revoke this authorization, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature: _____ **Date:** _____
Patient or Authorized Person: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Executor

Respiratory Specialists 1840 Mease Drive; Suite 307 Safety Harbor, FL 34695

PLEASE FAX RECORDS TO 727-725-6168

RESPIRATORY SPECIALISTS
PULMONARY PHYSICIANS

PATIENT FORM:

Appointment Cancellation Policy

For questions, please call Respiratory Specialists at (727) 725-6128.

+ RESPIRATORYSPECIALISTS
PULMONARY PHYSICIANS

Respiratory Specialists is dedicated to helping our patients breathe easier by providing the highest quality pulmonary service and care in the Tampa area

Appointment Cancellation Policy

Respiratory Specialists has instituted an appointment cancellation policy. A cancellation with less than 24 hour notice significantly limits our ability to make that appointment available for another patient in need

To remain consistent with our mission, we have instituted the following policy:

1. Effective April 1st, 2022, any established patient who fails to show or cancels/reschedules and has not provided our office **at least a 24-hour notice** will be considered a No Show and may be charged a **$25.00 fee**.

2. Any established patient fails to show or cancels/reschedules an appointment without a 24-hour notice a **second** time may be charged a **$50.00 fee**

3. If a third no-show or cancellation/reschedule without a 24-hour notice occurs the practice/patient relationship may be terminated

4. Any new patient who fails to show for their initial visit may not be rescheduled

5. If you are 15 or more minutes late for your appointment, the appointment may be cancelled and rescheduled

6. The fee is charged to the patient, not the insurance company, and is **due prior to rescheduling an additional appointment**

7. As a courtesy, reminder messages for appointments are sent via voice, text or e-mail. If you do not receive a reminder message the above policy remains in effect

I have read and understand the Appointment Cancellation Policy and I acknowledge its terms.

A copy of this policy will be provided to you if requested.

Printed Name Signature Date