NEWPORT MESA PULMONARY

136 Broadway, Costa Mesa, CA 92627 **Tel** (949)873-5537 **Fax** (949)873-5625

DATE: _____/_____/_____

PATIENT INFORMATION		
FIRST NAME **LAST NAME** **M.I.**		
ADDRESS		**SEX** **MARITAL STATUS** **M / F M S W D**
CITY, STATE	**ZIP**	**DATE OF BIRTH** / /
SOCIAL SECURITY NO.	**DRIVER'S LICENSE**	
HOME PHONE	**CELL PHONE**	
E-MAIL ADDRESS:		
PREFERRED LANGUAGE	**RACE / ETHNICITY**	
EMPLOYER	**JOB TITLE**	
EMPLOYER ADDRESS	**WORK PHONE**	

PLEASE BRING YOUR INSURANCE CARD TO YOUR APPOINTMENT. IF YOU DO NOT HAVE PROOF OF INSURANCE, PAYMENT IS REQUIRED AT THE TIME SERVICE IS RENDERED.

EMERGENCY CONTACT / CAREGIVER INFORMATION	
FULL NAME	PHONE NUMBER
ADDRESS	RELATIONSHIP

Forms which need to be filled out by our physicians should be left with front staff; there is a fee associated with this service. Disability request forms must be filled out by your primary care provider.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Newport Mesa Pulmonary to furnish information to insurance carriers on my behalf concerning my illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered to me or my dependents. I understand that I am financially responsible for all charges not covered by my insurance benefits on balances not paid within 90 days.

Patient's Signature: _____

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FINANCIAL POLICY

Thank you for choosing Newport Mesa Pulmonary. We welcome you to our office. We are able to concentrate on the practice of medicine and provide quality of care by having our financial policies understood by our patients and by avoiding confusion or misunderstandings.

Insurance. Filing insurance claims is a courtesy extended to our patients and is not a guarantee of payment. We will bill insurance claims with a maximum of two insurance carriers per patient. It is important to emphasize that your insurance is a contract between you and your insurance carrier. Insurance plans and contracts change constantly. It is your responsibility to contact your insurance carrier, verify your benefits, and verify that your doctor is a contracted provider in your network PRIOR to your visit. You will be financially responsible for the services rendered if we have not been paid by your insurance carrier.

All services rendered by Newport Mesa Pulmonary that are not a covered benefit of your insurance policy are your responsibility to pay. If you are seen or treated without proper authorization from your insurance carrier, you are responsible for the full charge of the services rendered if no payment is authorized retrospectively. All monies that you owe for services (e.g., co-payments, deductibles, required "out-of-pocket" amounts, non-covered services and co-insurance amounts) are due at the time services are rendered.

(Acknowledge that you have read the above) _____ (patient's initials)

Co-payments and Deductibles. All co-payments are due at the time services are rendered. Deductibles are due upon receipt of an explanation of benefits from your insurance carrier. We are legally obligated to collect co-payments and deductibles from patients. Please be sure to pay all co-pays and deductibles as stated above.

(Acknowledge that you have read the above) _____ (patient's initials)

Non-covered Services. Please be aware that some – and perhaps all – of the services you receive may be a noncovered benefit. You must pay for these services at the time services are rendered. Please note that verification of your coverage eligibility is not a guarantee of payment on your behalf from your insurance carrier.

(Acknowledge that you have read the above) _____ (patient's initials)

Coverage Changes. It is your responsibility to notify our office immediately of any changes in your insurance carrier or coverage. Failure to do so will result in Newport Mesa Pulmonary billing you for services rendered.

(Acknowledge that you have read the above) _____ (patient's initials)

Nonpayment. All payments are due immediately and in full. Failure to do so within 90 days may result in your account being sent to an outside collection agency.

(Acknowledge that you have read the above) _____ (patient's initials)

Our practice is committed to providing you with the best treatment possible. By signing below, you are acknowledging you have read and understand all terms that are outlined in this policy. Should you have any questions or concerns, please feel free to address them with us.

Print Name: _____ (Acknowledge that you have read the above)

Signature: _____ Date: ____/____/____

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CANCELLATION / NO SHOW POLICY

Thank you for trusting your medical care to Newport Mesa Pulmonary. When you schedule an appointment with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. A "no show" is someone who misses an appointment without canceling it within 24 hours of the scheduled appointment time. No-shows inconvenience those individuals who need access to medical care in a timely manner.

How To Cancel Your Appointment

If it is necessary to cancel your scheduled appointment, we require that you notify us at least 24 hours in advance. If your appointment is scheduled on a Monday, we require that you call us on the Friday before your appointment by 5:30 p.m. Appointments are high in demand, and your early cancellation will give another person the possibility to have access to timely medical care. To cancel an appointment, please call our office 9:00 am through 5:30 pm at (949) 873-5537 and press option 2 to speak with a receptionist.

- **Effective January 1, 2024 any patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours' notice will be considered a No Show and charged a $50.00 fee. The fee is charged to the patient, not the insurance company.**

- As a courtesy, when time allows, we make reminder calls for appointments. Even if you do not receive a reminder call or message, the above Policy will remain in effect.

I have read and understand the Cancellation/No Show Policy and agree to its terms and conditions.

Print Name: _____

Signature: _____ **Date:** ____/____/____

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PATIENT COMMUNICATION CONSENT

Voicemail, Email, and Text Messaging Program Consent Form
We are happy to provide our patients with the option to participate in our online patient communication system. Some of the features include the ability to:

1. Send or receive email communication from our office
2. Receive text message appointment reminders
3. Receive voicemail appointment reminders
4. Reminders to schedule follow up visits, wellness visits, and other important ordered and recommended tests.

You may choose to discontinue your participation in our online communication system at any time simply by replying "STOP" to a text message from us. Standard text messaging rates may apply.

Cell Phone: _____ (if you wish to receive text messages)
Email: _____(if you wish to receive emails)

We use this information strictly for the purposes of communicating with you more efficiently. Our goal is to provide you with excellent treatment as well as overall service and satisfaction. Please sign below to indicate that you agree to allow us to use this information in providing your services.

Print Name: _____

Signature: _____ **Date:** ____/____/____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I, (patient's name): _____ acknowledge that I have received a copy of Newport Mesa Pulmonary's NOTICE OF PRIVACY PRACTICES or that Newport Mesa Pulmonary's NOTICE OF PRIVACY PRACTICES was made available to me to receive. The Notice of Privacy Practices describes how Newport Mesa Pulmonary may use and disclose my medical information, certain restrictions on the use and disclosure of my medical information, and the rights I have regarding my medical information.

Signature: _____ **Date:** _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE:	INITIALS:	REASON:

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PRESCRIPTION REFILL POLICY

Newport Mesa Pulmonary is committed to providing high-quality care and ensuring patients have continuous access to necessary medications. This policy outlines our policies and procedures regarding prescription refills.

With all prescription refills, each patient must be seen routinely within the past year. Exceptions may be made in emergent circumstances.

If you request a refill but you are overdue for a follow-up visit, your provider may agree to call in enough medication to a local pharmacy to last until we are able to schedule an office visit (up to a one-month supply). It is your responsibility to schedule an appointment before you run out of medication. You should schedule your next visit before you leave our office.

Medication refills will only be addressed during our regular office hours (Monday-Friday 9am to 5:30pm). No prescriptions will be refilled on weekends, holidays, nights or after hours. Please call your pharmacy to verify if you are out of a medication before calling your provider.

Please contact your pharmacy at least three (3) business days before you need a medication refill. Usually, the pharmacist can refill the medication if refills are permitted or the pharmacist will submit a refill request to our office electronically. It is your responsibility to notify the pharmacy in a timely manner when refills are needed.

Approval of your refill may take up to three (3) business days so please be courteous and request early. If you use a mail order pharmacy, please contact the mail order pharmacy at least fourteen (14) days before your medication is due to run out.

Some medications require prior authorization by your insurance. Depending on your insurance this process may involve several steps by both your pharmacy and our staff. The staff and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Sometimes, only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance carrier will approve the medication. Please check with your pharmacy or your insurance carrier for updates. This may take up to 2 weeks.

Note: Our clinic MAY NOT manage or prescribe chronic pain and/or pain and/or Benzodiazepines.

This policy is subject to change. Any exceptions must be approved by your provider. Thank you for choosing NEWPORT MESA PULMONARY. We look forward to providing you with the highest quality of services for your health care needs.

I acknowledge that I have read and I understand this policy:

Print Name: _____

Signature: _____ **Date** ____/____/____

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Patient Authorization for Release of Health Information to External Parties

1. I authorize Newport Mesa Pulmonary and office staff to disclose information from the health records of

   Patient name: _____ **Date of Birth**: _____

   Address: _____ **Phone**: _____

2. **I authorize Newport Mesa Pulmonary to release my protected health information to:**

   _____

   Relationship: Spouse/Parent/Caretaker/Family Member/Other:

   _____

   Address: _____

   Phone/Fax: _____

   I authorize this information to be disclosed in the following ways:
   - ❑ Written/Photocopy/Paper
   - ❑ Verbal/Phone
   - ❑ Fax

3. **Specific reports to be disclosed**:
   - ❑ Progress Notes
   - ❑ Laboratory Reports
   - ❑ Operative Reports
   - ❑ X-ray films or other images
   - ❑ Radiology Reports
   - ❑ Consultation Reports

   Other (Specify):_____

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Newport Mesa Pulmonary in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or California privacy regulations.

Unless revoked earlier, this authorization expires in 12 months after the date I signed this authorization unless I specify another time: _____

I release Newport Mesa Pulmonary from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____

Signature of Patient (or Patient Representative) Date

_____ _____

Printed Name of Patient (or Patient Representative) Authority of Representative to Act for Patient (Relationship to Patient)

PULMONARY ASSESSMENT FORM

Patient Name: _____

Date of Birth: _____

NEWPORT MESA PULMONARY

Referring Provider _____
(If this is a self-referral, please write in "Self")

Reason for visit _____
Please bring all necessary items to your appointments. (i.e., Past medical records, out-of-network imaging CDs, updated medications list, etc.)

Pertinent Illnesses: Please circle if you have had or been told you have any of the diseases below.

Heart Burn/GERD	COPD/Emphysema	Lung Cancer
Diabetes	Pneumonia/ Bronchitis	Pneumothorax
Heart disease	Tuberculosis	Pulmonary Embolism/Blood Clots
Asthma or childhood asthma	Sleep Apnea	Frequent throat clearing

Symptoms:
Do you cough? YES / NO If yes, is it ever bloody? YES / NO

Do you have shortness of breath? YES / NO

Family History: Please circle if any family members have any of the following, write down their relationship to you.

Lung Cancer – Relationship: _____

COPD – Relationship: _____

Asthma – Relationship: _____

Tuberculosis – Relationship: _____

Heart disease – Relationship: _____

Surgical History:

Have you ever undergone **surgery** to your chest, noise/sinuses (e.g., nose job) or abdomen? YES / NO

If yes, why? _____

When? _____

Smoking:
Have you ever smoked? YES / NO

If yes, circle what you smoked: Vape/ Tobacco (Cigars or Cigarettes)/ Hookah/ Marijuana

If yes, circle how many times per day: 1-3 cigs/day / HALF PACK PER DAY / PACK PER DAY / 2 PACK PER DAY / MORE

When did you start (month/year): _____ When did you quit (month/year): _____

PULMONARY ASSESSMENT FORM

Patient Name: _____

Date of Birth: _____

Allergies: Please circle if you have any of the following conditions or symptoms.

Childhood asthma	Postnasal drip
Frequent runny nose	Frequent throat clearing
Grass allergy	Seasonal allergies
Itchy eyes or ears	Sore throat

Sleep Apnea Screen: Please circle if you have any of the following.

Hypertension	Tiredness or non-refreshing sleep	
Snoring	Morning headaches	Waking up in the middle of the night gasping for air
Stopping breathing when sleeping	Dozing off easily	

Pets: Please circle your pets. DOGS / CATS / BIRDS / REPTILES / OTHER _____

Care Team: Please list your primary care provider along with any specialist doctors you are currently seeing.

Primary Care Provider (PCP): _____

Allergist(s): _____

Cardiologist(s): _____

ENT(s): _____

Gastroenterologist(s): _____

Hematologist/Oncologist(s): _____

Infectious Disease(s): _____

Nephrologist(s): _____

Neurologist(s): _____

Rheumatologist(s): _____

Thoracic Surgeon(s):_____

PULMONARY ASSESSMENT FORM

Patient Name: _____

Date of Birth: _____

Pharmacy Information

Name: _____
Address: _____
Phone Number: _____

Medications

Medication Name	Dosage	Frequency

Allergies

Medication Name	Adverse Reaction	Severity of Reaction (Mild/Moderate/Severe)