Charleston Pulmonary Associates, PA
Patient Information Form

Referred by: _____ **Primary Care Physician**: _____

Other Physician(s) involved in your care:_____

Last Name: _____ **First Name:** _____**Prefix** ☐Mr. ☐ Mrs. ☐Miss ☐ Ms. ☐Dr.

Middle Name: _____ **Preferred Name:** _____

Date of Birth: _____ /_____ /_____ **Age:** _____ **SSN:** _____ - _____ - _____

Address: _____ **City:** _____**County:** _____ **State:** _____ **Zip:** _____

Email: _____ **Home:** ( )_____-_____ **Cell:** ( )_____-_____**Work:** ( )_____-_____

May we leave a message about appointments or normal test results on the phone numbers you provided? ☐Yes ☐No

Would you like to receive appointment reminders via text message on your cell phone?☐Yes ☐No

You consent to receive text messages from us that may contain health information or advice. You are not required to provide consent in order to receive such information or advice from your provider. Standard text messaging rates may apply.

Alternate Contact: **If you want us to contact you at an alternate address or telephone number, please provide below:**

Alt. Address: _____ **City:** _____ **State**: ____ **Zip**: _____ **Phone**: ( )_____-_____

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

Ethnicity: ☐ Not Hispanic / Latino ☐Hispanic / Latino ☐Declined to Specify

Race: ☐ White ☐Black / African American ☐Asian ☐ American Indian / Alaska Native ☐Native Hawaiian / Other Pacific Islander ☐Declined to Specify ☐Other Race

Primary Language: ☐English ☐ Spanish ☐ French ☐Other: _____

Birth Sex: ☐Male ☐Female **Gender Identity (optional):** _____

Sexual Orientation (optional): ☐Straight/heterosexual ☐Lesbian ☐Gay/homosexual ☐Bi-sexual ☐Choose not to disclose ☐Other

Student Status: ☐N/A ☐Full-time ☐Part-time **School:**_____

Employment Status: ☐N/A ☐Full-time ☐Part-time ☐Retired ☐Unemployed **Employer:** _____

E**mergency Contact Name**: _____ **Relationship**: _____ **Phone**: ( ) _____-_____

Guarantor/ Person Financially Responsible For the Payment If Other Than The Patient

Last Name: _____ ☐Mr. ☐Mrs. ☐Miss ☐Other: _____ Sex: ☐Male ☐Female

First Name: _____ Date of Birth: ____/____/____ Age: _____ SSN: ____ – ____ -_____

Middle: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Home: ( ) _____-_____ Cell: ( ) _____-_____ Work: ( ) _____-_____

Email Address of Guarantor/ Person Financially Responsible: _____

Primary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID #: _____

Policyholder Date of Birth: _____

Insurance Co. Phone #: _____

Group #: _____

Relationship to Patient: _____

Secondary Insurance

Insurance Company: _____

Policyholder Name: _____

Member or Policyholder ID #: _____

Policyholder Date of Birth: _____

Insurance Co. Phone #: _____

Group #: _____

Relationship to Patient: _____

Consent for Treatment, Authorization, Assignment of Benefits, and Referral Release

CONSENT FOR TREATMENT: I consent and authorize Charleston Pulmonary Associates, PA (CPA) physician or designated qualified assistant to provide me medical treatment and to use and release my protected health information for treatment, payment, and healthcare operations as allowed by HIPAA and as described in the CPA Notice of Privacy Practices, a copy of which has been made available to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION: I understand that my medical information, including complete medical records, test results, and billing information, may be released to my insurance company and to other medical professionals and/or medical care institutions for treatment and payment purposes.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all my rights and allow payment to be made directly to CPA for all medical or surgical benefits otherwise payable to me under terms of my insurance.

PAYMENT GUARANTEE: I understand and agree that I am responsible for paying all co-payments, co-insurance, deductibles, and non-covered services rendered by CPA, including charges for services not covered by my insurance. I consent and authorize CPA and third party agents of CPA to contact me by telephone at any number associated with me, including a wireless number, and to use a pre-recorded and/or an automatic dialing service in connection with any communication made to me or related to my account.

A photocopy of this form shall be considered as effective and as valid as the original.

To the best of my knowledge the information I have given on this form is accurate and true. I know it is my or my legal guardian's responsibility to keep CPA informed of changes to my contact information; a failure to do so may interfere with the ability to contact me concerning my healthcare.

This consent for treatment, authorization, assignments of benefits and referral release is valid for one year from date signed.

Print Patient's Name: _____

Patient's Signature:** _____ Date: _____ /_____ /_____

Print Legal Guardian's Name: _____

Legal Guardian's Signature:** _____ Date: _____ /_____ /_____

Ongoing Communication Regarding Your Healthcare

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL(S) WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITIONS? IF YES, TO WHOM?

By listing an individual and/or entity below, you authorize ALL CPA physicians/ offices to release and/or discuss your health information with the individual and/or entity you have listed.

Authorized Individual or Entity	Phone Number	Relationship	Address
_____	(_____)_____	_____	_____
_____	(_____)_____	_____	_____

Date Range or event of information to be released, select one:

Beginning Date / Event to be Released: _____ End Date / Event to be Released: _____ Or All Healthcare Information _____

*Any revocation or modification to your authorization regarding an individual or organization must be submitted in writing.

Prescriptions

For your convenience, please specify any individuals you authorize to pick up your prescriptions from CPA locations(s). Most prescriptions, including controlled medication, can be electronically sent to your pharmacy. Please list your preferred local pharmacy and mail order pharmacy.

Name of Individual	Phone Number	Relationship	Address
_____	(_____)_____	_____	_____

Preferred Local Pharmacy	Phone Number	Address
_____	(_____)_____	_____

Mail Order Pharmacy	Phone Number	Address
_____	(_____)_____	_____

If filling out the form via electronic format, I understand by typing my full name on the signature line, I do hearby attest that this information is true, accurate and complete to the best of my knowledge, and I understand this will serve as my e-signature of this form and is the same as if it were signed by hand or via electronically signing on the ePad at Charleston Pulmonary Associates' location.