Pulmonary Associates of Fredericksburg, Inc.
521 Park Hill Drive
Fredericksburg, Virginia 22401
(540) 899-1615

Randall B. Currie, M.D.
Richard A. Fiero, M.D.
Mohammed Alattar, M.D.
Rohit Goyal, M.D.
Juan Abril, M.D.

Jeffrey R. Rehm, M.D.
Nicholas Kallay, M.D.
Hazem Ubaissi, M.D.
Jorge Dolojan, M.D.

Patient Name:_____
Doctor:_____
Appt Date:_____
Appt Time:_____

We welcome you to our practice and we will do our utmost to warrant your confidence in us.

Our office hours are Monday – Friday from 9a.m. to 5p.m. with a physician on call after hours for emergencies. Please contact your pharmacist for prescription refills, which are handled daily until 4:00p.m.

Enclosed please find papers necessary to complete your chart. Please have these forms completed in full when you arrive for your appointment. ***Please use black ink only.*** **We will also need your insurance cards and a photo ID. If *your insurance requires a paper referral, you must have it with you when you come in or verify that your PCP has sent it to us.*** This usually applies to Optimum Choice and MDIPA patients. If your insurance requires an authorization number, please have that number with you when you arrive on your PCP or insurance letterhead, unless you have verified with your PCP that it has been sent to us. **Your appointment might be rescheduled if you fail to comply.**

Your copay is due at the time of service at check in. We accept cash, check, Visa, MasterCard, and Discover. If you are a self-pay patient we require a $50.00 minimum payment at the time of the visit and we will schedule payment arrangements for the balance. This also applies to all follow up visits.

Please bring all medicines and all Chest Xray/CT films. The X-ray facility will need at least a 24-hour notice to copy your films.

Your appointment time is reserved exclusively for you. We request that you register at least 15-20 minutes prior to your appointment time. If you arrive late, your appointment will be rescheduled.

Please notify us within 24 hours if you are unable to make this appointment as the physician reserves the right to charge a $50.00 No Call/No Show fee.

For the consideration of our patients and staff, we would appreciate it if you would refrain from using cologne or perfume. The fragrances can cause breathing problems for some of our patients.

Thank you again for your trust in us.

Respectfully,
Pulmonary Associates of Fredericksburg Staff

PULMONARY ASSOCIATES OF FREDERICKSBURG, INC.

PATIENT / RESPONSIBLE PARTY INFORMATION

Patient's Last Name _____ First _____ Middle _____

Address _____
Street City State Zip

Email Address _____

Phone #'s (home) _____ (work) _____ (cell) _____

Date of Birth _____ Gender ☐ Male ☐ Female Marital Status ☐ Married ☐ Single ☐ Divorced Soc. Security # _____

Ethnicity _____ Preferred Language _____ Race _____

Employer _____ Phone # _____

Address _____
Street City State Zip

If patient is a minor, please list responsible party information _____

EMERGENCY CONTACT

Name _____

Phone #'s (home) _____ (work) _____ (cell) _____

INSURANCE	
Primary _____	**Secondary** _____
Address _____	Address _____
Policy # _____	Policy # _____
Group # _____	Group # _____
Subscriber Name _____	Subscriber Name _____
Date of Birth _____	Date of Birth _____
Social Security # _____	Social Security # _____

I hereby authorize Pulmonary Associates of Fredericksburg, Inc. to release such information as may be necessary to any of my physicians or insurance companies that may be pertinent to my case. I also authorize payment directly to Pulmonary Associates of Fredericksburg, Inc. for any benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. Patients not covered by insurance are responsible at the time of service for charges incurred or arrangement for payment may be made at the business office at the time of service.

I also authorized Pulmonary Associates of Fredericksburg, Inc. to release or obtain such information as may be made necessary to assist in my medical treatment. If this account is to be turned over to an attorney/collection agency, the undersigned agrees to pay all costs of collections including attorney fees, interest & court costs. This form will be placed in your chart & be applicable until such information is changed.

SIGNATURE _____ **DATE** _____

Pulmonary Associates of Fredericksburg, Inc.
521 Park Hill Drive
Fredericksburg, VA. 22401

Our financial policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service. We accept Visa and MasterCard.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a copayment at the time of your visit.

4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of patient (or responsible party, if minor) Date

Please print the name of the patient

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Patient Contacts Authorization

I hereby authorize Pulmonary Associates of Fredericksburg, Inc. to discuss my care and/or appointment reminders with the following persons.....

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature _____ Date _____

PULMONARY ASSOCIATES OF FREDERICKSBURG, INC.

NOTICE OF PRIVACY PRACTICES *Effective: April 1, 2003*

1. Pulmonary Associates of Fredericksburg, Inc. may use & disclose protected health information for treatment, payment, health care operations & voluntary clinical research operations. Examples of these include, but are not limited to, referrals to home health agencies & other providers for treatment. Payment examples include but are not limited to, collection agencies, insurance companies for claims and pre-authorizations, including coordination of benefits with other insurers. Health care operations include, but are not limited to, internal quality control & assurance including auditing of records.

2. Pulmonary Associates of Fredericksburg, Inc. is permitted or required to use or disclose protected health information without the individual's written consent in certain circumstances. Two examples of such are for public health requirements or court orders.

3. Pulmonary Associates of Fredericksburg, Inc. will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. Such authorization may be revoked at any time in writing.

4. Pulmonary Associates of Fredericksburg, Inc. will abide by the terms of this notice currently in effect at the time of the disclosure.

5. Pulmonary Associates of Fredericksburg, Inc. reserves the right to change the terms of its notice and to make new notice provisions effective for all protected health information that it maintains. Any revisions will be posted and copies may be obtained at any time at our office.

6. Any patient, guardian or personal representative has the right to inspect & obtain copies of their medical record. A fee will be assessed for copies.

7. Any patient, guardian or personal representative has the right to request amendments to be made to their medical record.

8. Any patient, guardian or personal representative has the right to request a six-year accounting of all disclosures of their medical records from April 2003 henceforth. The history will be provided within 60 days of the request & a reasonable charge will be assessed for any copies after the first requested in a 12-month period.

9. Any patient, guardian or personal representative has the right to request restrictions as to how their health information may be used or disclosed to carry out treatment, payment or health care operations. The practice is not required to agree to the restrictions requested but if the practice does agree, it must abide by those restrictions.

10. Any person/patient may file a complaint to the practice & to the Secretary of Health & Human Services if they believe their privacy rights have been violated. To file a complaint with the practice, please contact the privacy officer at Pulmonary Associates of Fredericksburg, Inc., (540) 899-1615. It is the policy of this practice that no retaliatory action will be made against any individual that submits or conveys a complaint of suspected or actual non-compliance of the privacy standards.

11. A detailed copy of this Notice of Privacy Practices is available upon request.

Name of Patient:_____

Signature:_____ Date: _____