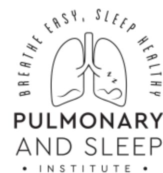


Pulmonary and Sleep Institute PLLC

5109 Brainerd Rd, Chattanooga, TN 37411

New Patient Forms

Patient Name: ____
LAST FIRST MI

Birth Date: _______________________________________

Social Security No: __________________________ Gender: · Male · Female

Address: ____
STREET CITY STATE ZIP

Would you like to create a free online patient account: Yes / No _______________

Email: ____

Home #: _________________ Cell #: _________________ Work #: ___________________

Marital Status: · Married · Single · Divorced · Widowed.

Race: · African American · American Indian/Alaskan Native · Asian · Hispanic
· Native Hawaiian / Pacific Islander · White · Other

Ethnicity: · Hispanic or Latin Descent · Not Hispanic or Latin Descent · Do Not Wish to Report

Reason for today's visit:

____

Referring Physician: ______________________________ Primary Care Physician: __________________

Emergency Contact Information

Name: _____________________ Relationship: _______________ Phone: ______________

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: ____________________ Relationship: ______________ Phone: ______________

Name: ____________________ Relationship: ______________ Phone: ______________

Payment Information

Form of Payment: · Health Insurance · Workers Comp · Self Pay · Other

Primary Insurance:

Primary Company: __________________________ Insured's Name: ______________

Policy #: ______________ Group #: ____________ Insured's Date of Birth: ____________

Secondary Insurance:

Primary Company: __________________________ Insured's Name: ______________

Policy #: ______________ Group #: ____________ Insured's Date of Birth: ____________

Self-Pay Agreement:

I agree to pay for medical services rendered by the Pulmonary and Sleep Institute. I understand that payment must be made before establishing a new patient.

Patient Signature: ________________________________ Date: ______________

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize DR. HARSHA SHANTHA, MD, FCCP. to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in the payment of my medical care.

---------- (Your Initials)

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with DR. HARSHA SHANTHA, MD, FCCP. concerning my medical care. I permit a copy of this authorization to be used in place of the original.

---------- (Your Initials)

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to the affiliated providers of DR. HARSHA SHANTHA, MD, FCCP. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits when my coverage is subject to the coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

---------- (Your Initials)

CONSENT FOR TREATMENT:

I hereby authorize DR. HARSHA SHANTHA, MD, FCCP. to perform a physical examination and to provide any medical treatment deemed necessary. This includes but is not limited to all required medical examinations, testing, x-rays, and/or medical and surgical procedures.

---------- (Your Initials)

PATIENT PAYMENT RESPONSIBILITY:

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered.

---------- (Your Initials)

APPOINTMENT CANCELLATIONS:

I hereby agree to make every attempt to call the office at least 24 hours in advance of any appointment that needs

to be canceled or rescheduled. I understand that I might be charged a "No-Show" fee for not informing the practice.

---------- (Your Initials)

CHANGE OF INFORMATION:

I hereby agree to provide the office with any information regarding changes in my address, phone number, health benefits, or insurance information.

---------- (Your Initials)

NOTICE OF PRIVACY PRACTICES:

DR. HARSHA SHANTHA, MD, FCCP. and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgment of receipt of our office's Notice of Privacy Practices.

---------- (Your Initials)

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that DR. HARSHA SHANTHA, MD, FCCP. reserves the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

Patient Name (Please Print)	Date	Patient Signature

PULMONARY AND SLEEP INSTITUTE
BREATHE EASY, SLEEP HEALTHY

Patient Name: ____________________ DOB: ___________

MEDICAL HISTORY INFORMATION:

Please check if you have had any of these Medical Problems in the PAST:

MAJOR ILLNESS	YES	NO	MAJOR ILLNESS	YES	NO
Anemia			Liver Disease		
Arthritis			Kidney Disease		
Heart Arrhythmia/Palpitations			Loss of Vision		
Asthma			Mitral Valve Prolapse		
Bleeding Problems			Neuropathy		
Blood Clots			Paralysis		
Cancer: Type ___________________			Peripheral Vascular Disease		
Chest pain/Angina			Pneumonia		
Diabetes			Psychiatric Illness		
Gall Bladder Disease			Pulmonary Embolism		
Gastric Ulcers			Reflux		
Glaucoma			Skin Ulcer/Breakdown		
Heart Attack			Steroid Use		
Heart Failure			Stroke		
Heart Murmur			Thyroid Disease		
Hepatitis B			Tuberculosis - TB		
Hepatitis C			Urinary Infections		
High Blood Pressure			Valve Disorders (heart)		
HIV/AIDS			Wound Healing Problems		
Immune Deficiency			OTHER: ___________________		

PULMONARY AND SLEEP INSTITUTE

Please list any Surgery / Hospital Admission you have had:

SURGERY / ADMISSION	YEAR	SURGERY / ADMISSION	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Family Medical History: Please list any major illnesses that affect your immediate family.

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Patient Name: ____________________ DOB: ___________

Medications: Please list any medications you are currently taking:

Do you have any Allergies to any medications/substances? YES NO

If "Yes", please list: ____

MEDICATION	Dose	Freq	Date	Date	Date	Date	Date	Date

Patient Name: ______________________ DOB: ___________

PULMONARY AND SLEEP INSTITUTE
BREATHE EASY, SLEEP HEALTHY

Vaccines: Please list year received. Tetanus _____ Flu Vaccine _____

Pneumovax______ COVID : _____________Other: _____________

Social History:

Employment: · Employed · Unemployed · Retired Occupation: ____________________

Living Situation: · Lives alone · Lives with family

Smoking: · Current Smoker, everyday · Current Smoker, some days · Former Smoker

· Never Smoker ______ pks/day ______ years smoked

Alcohol Use: · YES · NO

· Heavy drinker (1-5 drinks/day) · Moderate Drinker (1-5 drinks/week)

· Occasional Drinker

Recreational Drug Use: · YES · NO

· Heavy User (daily to weekly) · Moderate User (monthly) · Occasional User

List recreational drugs used: ____

TB Exposure: · YES · NO

Animal / Feathers Exposure: · YES · NO

PULMONARY AND SLEEP INSTITUTE
BREATHE EASY, SLEEP HEALTHY

Review of Systems: Please check any of the symptoms that apply to you TODAY:

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Muscle Pain or Swelling		
Cough			Frequent/Easy Bruising		
Shortness of Breath			Cuts that don't stop Bleeding		
Rash			Anxiety		
Wound Healing Problem			Depression		
Fever/Chills			OTHER:		

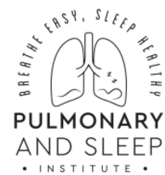
Please list any additional information that might be helpful for your treatment:

____

____

Agreement of Accuracy: The information provided in this history form is true and complete to the best of my knowledge.

Patient Signature:_________________________________ Date: ____________________



Financial and Office Policies

Thank you for choosing Pulmonary and Sleep Institute as your healthcare provider.
We are committed to providing our patients with the best available medical care. Our billing department will be available to discuss our fees and policies with you if you have any questions. We ask that all responsible parties read and sign our financial/office policies form before seeing the physician.

(PLEASE INITIAL BESIDE EACH SECTION INDICATING YOUR UNDERSTANDING AND ACCEPTANCE OF OUR POLICIES.)

______ 1. All co-pays, deductibles, and/or co-insurances are due at the time of service. We do not choose these fees. Your insurance company provides it when we call to verify benefits and/or the terms agreed upon by you (or your employer) and your insurance company. We will collect all co-payments, deductibles, or charges for non-covered services at the time of check-in. If you have a balance on your account, we will ask for that payment in full as well. For your convenience, we accept cash, check, Visa, MasterCard, and Discover.

______ 2. We verify insurance benefits as a courtesy to our patients. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are covered benefit in your medical plan. Some insurance companies select certain services they will not cover. Please contact your insurance company if you have any questions regarding your healthcare coverage. Pulmonary and Sleep Institute provides services that are medically necessary for the patient in the physician's professional opinion. If you are unsure if a procedure, immunization, or injection is covered, please call your insurance company before receiving services. You are ultimately responsible for all charges that are not covered under your health care policy.

*Please remember that your insurance is a contract between you (or your employer) and the insurance company. We are not a party to that contract. We cannot guarantee payment of all claims. If your insurance company pays only a portion of a bill or rejects your claim, the policyholder should contact the insurance company for a detailed explanation. Reduction or rejection of any claim by your insurance company does not relieve you of your obligation. If your insurance company pays us for a claim that you had already paid, and you are due a refund, we will be happy to expedite your refund or credit your account.

______ 3. Please ensure that all personal and insurance information is correct on each visit. We will only bill the insurance company on file. If a claim is rejected or left outstanding due to incorrect

insurance information, you will be responsible for the visit. Please inform the receptionist if your address, phone number, or insurance information has changed (or if you anticipate that it will be changing soon.)

______ 4. Some insurance companies require a referral from your primary care physician before being seen by PSI. If your appointment requires a referral from your primary care physician, that referral will need to be on file with our office before the next appointment day. If you are seen without a referral form on file and the insurance company does not pay, you will be responsible for all charges.

______ 5. We allow 30 days for payment of any balances that are the responsibility of the patient. If we do not receive full payment in 30 days, a late fee of $20 will be incurred monthly. We understand that temporary financial problems may affect the timely payments of your balance. We encourage you to communicate any such problems to us, so that we may assist you to keep your account in good standing. Please ask the receptionist for a payment plan, which doesn't have any cost or interest to you.

______ 6. If your check is returned for insufficient funds, there is a $50.00 charge in addition to the amount of the check. After one instance of a returned check, all further payments will be required to be in the form of credit card, cash, or money order only.

______ 7. There is a $150.00 fee to complete any FMLA, Disability, Extended Work Excuse or any paperwork/forms requiring completion by the provider. Payment is due before the paperwork is completed. Although the paperwork is long, please note that we do our best to complete this paperwork for you in a timely/efficient manner and we ask for your patience. We require 3-5 business days to complete this paperwork.

______ 8. There is a $20.00 fee for copies of medical records for 5 pages or less and $0.50 for each additional page thereafter. Please ask the receptionist for an estimate if you need copies of your records.

______ 9. Appointments not canceled with a 24-hour notice, same-day cancellation/reschedule and any "No Show" appointments will be subject to a fee of $50.00. The patient will not be given a new appointment until the fee is paid. Please note that this fee is not covered by your insurance company. We sincerely hope that we will not need to collect this fee. Rather, it is offered as an incentive to remind all our patients and families to keep their scheduled appointments or, if unable to keep that appointment, to please reschedule more than 24 hours in advance (and we greatly appreciate 48-72 hours advance notice.) When one reschedules their appointment several days ahead of time, it

allows other patients the opportunity to be seen sooner which is often greatly appreciated.

______ 10. If you are more than 15 minutes late for your appointment and have not called the office to inform us, we will reschedule your appointment.

______ 11. After 3 “No Show” appointments we reserve the right to terminate the physician/patient relationship. A notification will be sent to the responsible party and the referring physician.

____

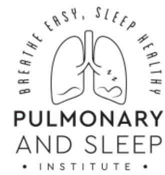
Signature of Patient or Legal Guardian

____

Print Patient’s Name

____

Print Name Legal Guardian Date



Patient Consent for Use and Disclosure of Protected Health Information

- I hereby give my consent to Pulmonary & Sleep Institute PLLC. to use and disclose protected health information (PHI) about me to conduct treatment, payment, and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]
- I have the right to review the Notice of Privacy Practices before signing this consent. Pulmonary & Sleep Institute PLLC. reserves the right to revise its Notice of Privacy Practices at any time. You can get a revised Notice of Privacy Practices by forwarding a written request to the Practice Administrator.
- With this consent, Pulmonary & Sleep Institute PLLC. may call my home or other alternative location and leave a message on voice mail or in person about any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.
- With this consent, Pulmonary & Sleep Institute PLLC. may mail to my home or their alternative location AND/OR email any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request Pulmonary & Sleep Institute PLLC. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.
- By signing this form, I am consenting that Pulmonary & Sleep Institute PLLC. may use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it Pulmonary & Sleep Institute PLLC. may decline to provide treatment to me.

____

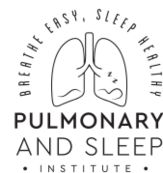
Signature of Patient or Legal Guardian

____

Print Patient's Name

____

Print Name Legal Guardian



Pulmonary and Sleep Institute, PLLC (PSI)

Dr Harsha Shantha, MD, FCCP
5109 Brainerd Rd, Chattanooga, TN 37411
Phone: 423-654-7400 Fax: 423-654-7401
Email: connect@psicha.com

Patient Authorization for Release of Protected Health Information

Patient Name: ______________________________ Date of Birth: ______________________

Address: __________________________________ SS#: ____________________________

I hereby authorize the physician/practice (Disclosing Physician/Practice) listed below to release my Protected Health Information (information obtained in my medical records) to DR. HARSHA SHANTHA, MD, FCCP, and PSI.

Disclosing Physician / Practice: ____________ Phone:__________________

Description of Information to be disclosed:

_____ Complete Medical Record
_____ Chest X-Rays
_____ Echocardiograms
_____ Office Notes
_____ Sleep Study
_____ CT Scan
_____ EKG Test / Results
_____ Hospital Records

Protected Health Information to be disclosed to:

DR. HARSHA SHANTHA, MD, FCCP
Attn: MEDICAL RECORDS
5109 Brainerd Rd Chattanooga, TN 37411
PHONE: (423) 654-7400
FAX: (423) 654-7401

Purpose of Disclosure:

_____ Continuing Care
_____ Referral to Specialist
_____ Change of Doctor
_____ Other: ________________

I understand the following:

1) I may revoke this authorization at any time by providing written notice to Dr. Harsha Shantha, MD, FCCP and PSI.
2) I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3) The information disclosed by this authorization may be subject to re-disclosure by Dr. Harsha Shantha, MD, FCCP and PSI no longer protected by Federal Law.
4) I have reviewed this Authorization and understand its purpose and intent.
5) This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

______________________________ ____________ ______________________________

Patient Signature | Date | Name (if other than Patient)