MESA PULMONARY GROUP

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

DATE: _____/_____/______

PATIENT INFORMATION			HOME PHONE	CELL PHONE
LAST NAME	FIRST NAME	M.I.		
ADDRESS			SEX M / F MARITAL STATUS M S W D AGE	
CITY, STATE	ZIP		DATE OF BIRTH / /	
PATIENT'S EMPLOYMENT NAME/ADDRESS	WORK PHONE NUMBER		SOCIAL SECURITY	
	OCCUPATION		DRIVER'S LICENSE	

SPOUSE	OCCUPATION
SPOUSE'S BUSINESS ADDRESS/NAME	PHONE NUMBER
REFERRED BY (DOCTOR)	PHONE NUMBER

EMERGENCY CONTACT / CAREGIVER INFORMATION	
NAME	PHONE NUMBER
ADDRESS	RELATIONSHIP
NAME OF NEAREST RELATIVE OR FRIEND – NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)	
NAME	PHONE NUMBER
ADDRESS	RELATIONSHIP
NAME OF NEAREST RELATIVE OR FRIEND – NOT LIVING WITH YOU (FOR MEDICAL EMERGENCY)	
NAME	PHONE NUMBER
ADDRESS	RELATIONSHIP

PHARMACY INFORMATION	
NAME	
ADDRESS	PHONE NUMBER

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize the above named doctor 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. 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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PHYSICIANS LIST

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): ____

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RESULTS WAIVER FORM

I understand that the office of **MESA PULMONARY GROUP** does not always receive laboratory results and/or radiology reports automatically. Therefore, I understand that it is ultimately the patient's responsibility to call and follow up with the office regarding any laboratory and/or radiology results.

Patient's Printed Name: ____

Patient's Signature: ____

Date: ____

If patient is unable to provide signature, please fill out the portion below:

Responsible Party's Printed Name: ____

Responsible Party's Signature: ____

Date: ____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Private Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: ____

Patient's Signature: ____

Date: ____

If patient is unable to provide signature, please fill out the portion below:

Responsible Party's Name: ____

Responsible Party's 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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INSURANCE WAIVER FORM

I, ___________________________, wish to receive medical services from Mesa
(PATIENT'S LEGAL NAME)

Pulmonary Group. I understand that if it is determined that I am not

eligible for coverage at the time of service by ____________________________, I
(NAME OF INSURANCE COMPANY)

will be responsible for the services provided.

Patient's Name: ____

Patient's Signature: ____

Date: ____

If patient is unable to provide signature, please fill out the portion below:

Responsible Party's Name: ____

Responsible Party's Signature: ____

Date: ____

MESA PULMONARY GROUP

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

Patient Authorization for Release of Health Information to External Parties

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

   Patient name: ____ **Date of Birth**: ____________________

2. **The information is to be disclosed to**: ____

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

   ____

   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
   - ❑ Discharge Summary
   - ❑ Radiology Reports
   - ❑ Consultation Reports
   - ❑ X-ray films or other images
   - ❑ Photographs/Videotapes
   - ❑ Records from other facilities
   - ❑ Entire Health Records (including, but not limited to, information regarding medical/health treatment, insurance, demographics, referral documents, and records from other facilities.)
   - ❑ 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 Mesa Pulmonary Group 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 one year unless I specify another time: __________________________

I release the individual or organization named in this authorization 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)

Mesa Pulmonary Group, Inc.

136 Broadway
Costa Mesa, CA 92627
Tel: (949) 873-5537 / (949) 548-5111
Fax: (949) 873-5625

Thank you for choosing MESA PULMONARY GROUP, INC. Your health care needs are our top priority. The following information is provided to assist you in planning your office visits:

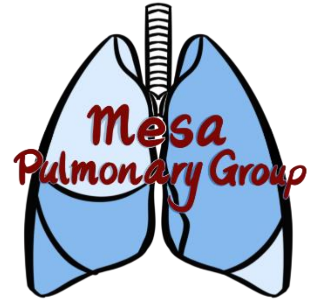
- Office hours are **9:00 am to 6:00 pm, Monday through Friday.**
- Please call **(949) 873-5537 or (949) 548-5111** during regular office hours for appointments
- Please provide our office staff with your email and cell phone number for your appointment reminder prior to your follow-up appointments.
- If you are unable to keep a scheduled appointment, **please inform our office in advance**. There will be a **$50.00 charge** for no-shows or cancellations **made less than 24 hours** of scheduled time.
- Patients are asked to provide a photo ID at the initial visit.
- Please ensure your copay and/or outstanding balance is paid at the time of your visit. We accept cash, checks, and credit card**. There will be a $25 fee for returned checks.**
- It is the responsibility of our patients to inform us of any insurance changes, and to verify whether our office is “in” or “out” of network. Failure to verify may result in unwanted fees.
- If you are a referred to a physician of another specialty by our office, recommendations will be given, but it is the patient’s responsibility to confirm insurance eligibility with that office.
- With a signed medical release form, medical records can be sent electronically to another medical office. If you prefer paper copies, please check with front office, as there is an associated fee.
- Please allow **48 hours for prescription refills.**
- For patients who do not follow-up as recommended, prescription refills will not be sent.
- If a follow-up appointment is needed following your visit, please ensure you schedule this at the end of your visit; otherwise, an appointment at the time needed cannot be guaranteed.
- If you have imaging or labs done at a location other than what was recommended, please ensure you bring copies of the results AND the CD with you to your appointment.
- Please bring all necessary items to your appointments. (i.e., Past medical records, out-of-network imaging CDs, updated medications list, etc.)
- 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.
- **This office does not discuss test results over the phone. However, we will do our best to accommodate you with an appointment to discuss results.**
- Our office maintains strict compliance with federal HIPAA privacy requirements. If you would like any health information released to another person, you must sign a HIPAA release identifying individual(s) to whom you would like your information released. If this information changes, please inform our office for an updated form.

Thank you for choosing MESA PULMONARY GROUP, INC. We look forward to providing you with the highest quality of services for your health care needs.

______________________________________ __________________

Patient Acknowledgement and Signature **Date**

PULMONARY QUESTIONNAIRE FORM



Patient Name: ______________________________________

Date of Birth: ______________________________________

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 QUESTIONNAIRE FORM

Patient Name: ____

Date of Birth: ____

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

Childhood asthma

Frequent runny nose

Grass allergy

Postnasal drip

Frequent throat clearing

Seasonal allergies

Itchy eyes or ears

Sore throat

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

Hypertension

Snoring

Stopping breathing when sleeping

Tiredness or non-refreshing sleep

Morning headaches

Waking up in the middle of the night gasping

Doze off easily

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

Print Legal Name: ____

Date: ____

PULMONARY QUESTIONNAIRE FORM

Mesa Pulmonary Group

Patient Name: ____

Date of Birth: ____

Medications: Please list all your medications including name, dose, frequency of dosing down below. If you have a list with you, please let us know.