1860 Town Center Drive
Suite 270
Reston, VA 20190
Phone: 703-318-8157
Fax: 703-318-7525

19455 Deerfield Ave
Suite 206
Leesburg, VA 20176
Phone: 703-858-9608
Fax: 703-858-9618

Dear Patient,

Your new patient appointment is on _____ at _____arrival time for _____ appointment.

The following is our new patient paperwork. Please fill out the forms completely and bring it to your appointment along with the following items:

-Insurance Card(s) and Photo ID (FOR ALL INSURANCES: IT IS THE RESPONSIBILITY OF THE PATIENT TO CONTACT THEIR INSURANCE TO DETERMINE IF THE DOCTOR YOU ARE SEEING IS IN OR OUT OF NETWORK)

-If your insurance is an HMO, please bring the corresponding referral. NOTE: If you do require a referral, please call the office the business day prior to your appointment to make sure we have received it.

-List of all your medications and dosages as well as any medication allergies and reactions (see attached sheet).

-If you had any recent chest x-rays or chest CAT Scans, please bring the disc or actual film, not just the report.

-If you are being referred, please bring any useful information from your doctor to your appointment or have them fax it to our office. Ex. Office visit notes, labs, radiology, etc

If you have any questions about your new patient appointment, need to cancel, or reschedule please call 703-722-1595. If for any reason you are unable to keep this appointment, we need to have 24 hours in advance notice, or you will be charged a fee up to $80.

Thank you for your time and welcome to our practice. Please take note, if you are 15 minutes late for your appointment you might have to reschedule.

-Pulmonary and Critical Care Associates

Reston Office: 1860 Town Center Dr. #270 Reston, VA 20190
Lansdowne Office: 19455 Deerfield Ave. #206 Leesburg, VA 20176

WELCOME TO PULMONARY AND CRITICAL CARE ASSOCIATES

PATIENT REGISTRATION INFORMATION

Patient's Name: _____ Date of Birth _____
Last First Middle Initial

Address _____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

SSN# _____ □ Male □ Female □ Minor □ Single □ Married □ Divorced □ Widowed □Separated

Email Address (We need for our online portal system)_____

Employer _____ Occupation _____

Address _____ State _____ Zip Code _____

Spouse/Parent _____ Home Phone _____ Cell Phone_____
Circle one

Emergency Contact _____ Relationship _____ Phone_____

□ Same as Spouse/Parent

INSURANCE INFORMATION

Primary Insurance _____ Insured's Name _____
Last First Initial

Relationship to Patient _____ SSN # _____ Date of Birth _____

Secondary Insurance _____ Insured's Name _____
□ I do not have secondary insurance Last First Initial

Relationship to Patient _____ SSN # _____ Date of Birth _____

MEDICAL INFORMATION

Reason for Visit _____

Primary Doctor _____ Referring Doctor _____

Other Doctors Treating You _____

When confirming appointments, would you like a PHONE CALL or TEXT? What number? _____
Please circle one

PATIENT AUTHORIZATION

I authorize my (or my child's) insurance benefits to be paid directly to the physician and I am financially responsible for all charges. I hereby consent to the release and re-disclosure of my medical record to enable or facilitate the collection, verification or settlement of my account for any amounts due from me or any third-party payor, health maintenance organization, insurer or other health benefit plan. This consent applies to Pulmonary & Critical Care Associates, or any of its affiliates or agents, lenders, or any third party servicer acting for Pulmonary & Critical Care Associates, or any of its affiliates.

I agree to promptly pay for services rendered for me or the patient named above. If I fail to meet my financial commitment to Pulmonary & Critical Care Associates and it becomes necessary to take action to collect my account, I agree to pay all costs and expenses incurred in the collection of my account, including attorney and collection agency fees. *I **further** agree to pay for any **missed appointments of which I did not notify the medical office within 24 hours.***

_____ Date _____
Signature of Patient or parent/guardian if minor

PLEASE USE BLACK INK ONLY

1860 Town Center Drive
Suite 270
Reston, VA 20190
Phone: 703-318-8157
Fax: 703-318-7525

19455 Deerfield Ave
Suite 206
Leesburg, VA 20176
Phone: 703-858-9608
Fax: 703-858-9618

PLEASE NOTE OUR OFFICE POLICIES

- When you schedule an appointment with our practice, 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 reserve the right to charge for appointments cancelled or broken without 24 hours' advanced notice.**

  New Patient $100
  Established Patient $50
- **To our patients who have Managed Care Insurance (HMO):**
  All patients requiring a referral **MUST** have a valid referral for each visit. It is the patient's responsibility to make sure we have a valid referral. If we do not have your referral, you will need to reschedule.

  *****If you do not have your referral at the time of your visit, and we must reschedule your appointment, you may be charged the under 24-hour fee.*****
- **Our office checks for eligibility for insurance only.** It is the responsibility of the patient to contact their insurance and determine if the doctor you are seeing is in or out of network. Please note: The out-of-pocket expense is higher if you see an out of network doctor.
- **Co-pays are due at the time of your visit. No Exceptions!**
  - We accept the following forms of payment:
    - Visa, Mastercard, Discover, Personal Checks, Money Orders, and Cash (exact change only)
    - There will be a $10 administration fee added to your statement if you do not pay your co-pay at the time of your visit.
- **Please be advised that if you are more than 15 minutes late for your appointment, you may have to reschedule.**
- **There will be a $30 fee for all returned checks.**

I have read and understand the above policies for Pulmonary and Critical Care Associates.

Signature _____Date_____
(01/05/23)

Specializing in Pulmonary, Critical Care and Sleep Medicine

Pulmonary and Critical Care Associates, PC

Reston: 1860 Town Center Drive, Suite 270, Reston, VA 20190
Leesburg: 19455 Deerfield Ave, Suite 206, Leesburg, VA 20176

PULMONARY HEALTH HISTORY FORM

Name: _____ Birthdate:___/____/_____ Gender: **M / F**

Email address: _____ Occupation: _____

Preferred Pharmacy: _____ _____ _____
Name **Street Address** **Phone**

Primary Language:_____Race:_____ Latino or NOT Latino?
Circle One

GENERAL MEDICAL HISTORY (Please choose as many as necessary)

- ❑ Alcoholism
- ❑ Allergies/Hayfever
- ❑ Anemia
- ❑ Anxiety
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Blood Transfusion
- ❑ CAD
- ❑ Cancer Kind? _____
- ❑ Chemotherapy End _____
- ❑ Radiation Treatment End_____
- ❑ Cardiac Pacer
- ❑ Cardiovascular Disease
- ❑ CHF
- ❑ Chicken Pox
- ❑ Cirrhosis
- ❑ Colitis
- ❑ COPD
- ❑ Chronic Renal Failure
- ❑ Crohn's Disease
- ❑ CVA
- ❑ DVT
- ❑ Depression
- ❑ Diabetes Type 1
- ❑ Diabetes Type 2
- ❑ Epilepsy
- ❑ Fracture
- ❑ Gastric Ulcer
- ❑ Gastrointestinal Disease
- ❑ Gastroesophageal Reflux Disease
- ❑ Gestational Diabetes
- ❑ Glaucoma
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Cholesterol
- ❑ Hyperlipidemia
- ❑ Hypertension
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Insulin Pump
- ❑ Joint Pain
- ❑ Kidney Disease
- ❑ Left Ventricular Systolic Dysfunction
- ❑ Kidney Infection
- ❑ Kidney Stone
- ❑ Migraines
- ❑ Multiple Sclerosis
- ❑ Myocardial Infarction
- ❑ Obesity
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Progressive Neurological Disorder
- ❑ Prostate Cancer
- ❑ Pulmonary Disease
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Shingles
- ❑ Sleep Apnea
- ❑ STD
- ❑ Terminal Illness
- ❑ Thyroid Disease
- ❑ TIA
- ❑ Tuberculosis
- ❑ Valvular Problems

HOSPITALIZATIONS _____
_____
_____

OTHER MEDICAL HISTORY _____

TOBACCO ASSESSMENT

Smoking Status
- □ Current Every Day Smoker
- □ Current Some Day Smoker
- □ Former Smoker
- □ Never Smoked
- □ Smoker- Current Status Unknown
- □ Unknown

Y N Tobacco User

Packs per Day _____ Smoked for how long?_____

Date quit smoking _____

Name: _____

SOCIAL HISTORY

Alcohol Use
- □ Non Drinker
- □ Occassional
- □ Social Drinker
- □ Moderate Consumption
- □ Heavy Consumption
- □ Recovering Alcoholic
- □ Beer Drinker
- □ Wine Drinker
- □ Never Drank Alcohol
- □ Discontinued

Caffeine Use
- □ 0 servings per day
- □ Occassional
- □ 1+ Servings per day
- □ 2+ Servings per day
- □ 3+ Servings per day
- □ 4+ Servings per day

Occupation: _____

Educational level
- □ Grades 9-12
- □ Technical/Vocational School
- □ Junior College
- □ Associates Degree
- □ Bachelor Degree
- □ Master's Degree
- □ PhD
- □ Doctorate

Marital Status
- □ Single
- □ Married
- □ Divorced
- □ Significant Other
- □ Widow
- □ Widower

Exercise Habits
- □ Sedentary
- □ Moderate <3 x/wk
- □ Moderate >3 x/wk
- □ Strenuous <3 x/wk
- □ Strenuous >3 x/wk

SURGICAL / PROCEDURAL

❑ NO PRIOR SURGICAL HISTORY

- ❑ Appendectomy
- ❑ Breast Lumpectomy
- ❑ Cataract Surgery
- ❑ Colectomy
- ❑ Subtotal Colectomy
- ❑ Cone Biopsy
- ❑ D & C
- ❑ Endometrial Ablation
- ❑ Gall Bladder
- ❑ Heart Surgery
- ❑ Hemorrhoids
- ❑ Hernia
- ❑ Hysterectomy
- ❑ Joint Replacement
- ❑ Laparoscopy
- ❑ Mastectomy Right Left Bilateral
- ❑ Myomectomy
- ❑ Oophorectomy
- ❑ Ostomy
- ❑ Splenectomy
- ❑ Tonsil / Adenoidectomy
- ❑ Tubal Ligation

OTHER SURGICAL HISTORY: _____

_____

PREVENTIVE CARE

Flu Vaccine Date_____

Pneumococcal Vaccine _____

Prevnar 13 _____

Zoster _____

Name: _____

Help us care for you better by telling us what prescriptions and over-the-counter medications you take.

Prescriptions					
Name of medicine	**Dose** (Total mg's)	**How Many Times Per Day?**	**When do you take it?** (Am, Pm and/or after meals?)	**Who Prescribed it for you?** (Doctor's Name)	**Do you have any side effects?** (If so, describe them)
Over-the-counter medications, herbal remedies, and vitamins					

Allergies & Reactions (environmental and medications) **Very important**	
ALLERGY	**REACTION**

1860 Town Center Drive
Suite 270
Reston, VA 20190
Phone: 703-318-8157
Fax: 703-318-7525

19455 Deerfield Ave
Suite 206
Leesburg, VA 20176
Phone: 703-858-9608
Fax: 703-858-9618

Pulmonary & Critical Care Associates, PC would like to confirm we have the most current information on file for your protection and convenience. Please complete this form and return it to our staff.

Patient Name_____Date of Birth_____

Primary Phone Number _____ **(circle) Home Mobile Work**
Are we authorized to leave a detailed voicemail? **(circle) Yes No**

Would you like to have access to your patient portal? **(circle) Yes No Already registered**
Email address for access to your patient portal _____
Important Information Regarding the Patient Portal: By accessing this Portal, you, the patient, understand that this Patient Portal is NOT to be used for urgent or emergency situations and should be limited to non-emergency communications and requests. In case of an emergency, call 911 or go to the nearest emergency room.

PLEASE NOTE: *Our preferred method of communication is through our patient portal. Medication refills and exam authorization information will be sent to your portal inbox. For those of you who do not wish to have access to your portal we suggest you allow us to leave a detailed message as indicated above. If you do not wish us to leave a detailed message and you do not wish to use our portal, you must contact our office by telephone for this information.*

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS / FAMILY MEMBERS

In accordance with Federal government policy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

____ I do not authorize the practice to release any or all information concerning my medical care to any individual except as set forth above.

____ I authorize the Practice to verbally release any or all information concerning my medical care to the following individuals.

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Patient Signature_____ Date_____

Witness _____ Date_____

AUTHORIZATION TO RELEASE FINANCIAL INFORMATION TO INDIVIDUALS / FAMILY MEMBERS

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

Patient Signature_____ Date_____

Specializing in Pulmonary, Critical Care and Sleep Medicine

1860 Town Center Drive
Suite 270
Reston, VA 20190
Phone: 703-318-8157
Fax: 703-318-7525

19455 Deerfield Ave
Suite 206
Leesburg, VA 20176
Phone: 703-858-9608
Fax: 703-858-9618

Please sign below acknowledging your receipt of our notice of privacy practices.

_____
Print Name

_____Date_____
Signature

01/05/23

1860 Town Center Drive
Suite 270
Reston, VA 20190
Phone: 703-318-8157
Fax: 703-318-7525

19455 Deerfield Ave
Suite 206
Leesburg, VA 20176
Phone: 703-858-9608
Fax: 703-858-9618

AUTHORIZATION TO OBTAIN OR RELEASE OF MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize Pulmonary & Critical Care Associates (the Practice) to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize the practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize the Practice to release any and all medical records concerning my care to Medicare, Medicaid, any Insurance company, third party administrator, or managed care company.

Patient Signature _____ Date_____

Printed Name_____ Date of Birth_____

(01/05/23)