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

(01/05/23)

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

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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 $80
  Established Patient $40
- **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)

Pulmonary and Critical Care Associates, PC

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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**

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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

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

____
Print Name

____Date____________
Signature

01/05/23

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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)