

**PALMETTO PULMONARY MEDICINE, P.A.**

**Peter N Manos, MD FCCP · Denise Mercier, PA-C**

**Board Certified: Internal Medicine · Pulmonary Disease · Critical Care Medicine · Sleep Medicine**

989 Ribaut Road, Suite 340 · Beaufort, SC 29902 · (843)-521-8484 · Fax (843) 521-8485

Welcome to Palmetto Pulmonary Medicine. **Please complete all forms and bring them with you at the time of your appointment**\_\_\_\_\_. If you are uncertain of how to complete these forms we will be glad to assist you. **\*\* Our practice requires all patients to have a primary care physician\*\*.**

**Uninsured/Cash Paying Patients:** Full payment is **required** at the time of your office visit. If for any reason you are unable to pay the entire amount charged, please call our office to discuss arrangements with our financial representative prior to your appointment.

**Patients with Insurance:** **You are responsible for deductibles, co-pays, non-covered services, coinsurance and items considered “not medically necessary” by your insurance company.** Co-pays and deductible amounts are due at the time of your appointment per your insurance contract. **The remaining balance should be taken care of within one month of notice from the insurance company.** If you cannot meet these requirements, please call our office to discuss arrangements with our financial representative prior to your appointment.

**Note:** It is the patient’s responsibility to determine if Palmetto Pulmonary Medicine is in network with their insurance plan. Any patients with an HMO plan, or whose insurance is out of the network, need to have an authorization from their referring physician before any appointments or procedures are scheduled.

**IMPORTANT:** If you had a chest x-ray or chest CT scan done at a facility other than Beaufort Memorial Hospital or Beaufort Medical Plaza within the last year, please obtain the films and the reports and bring them with you to your appointment (does not pertain to those patients being seen for sleep problems). If you had a sleep study, please obtain those studies along with the initial physician note ordering the sleep study.

We have provided this information so that we may better serve you. However, if you have any questions please feel free to call our office.

**PALMETTO PULMONARY MEDICINE, P.A.**  
**PATIENT INFORMATION SHEET**

When registering, please provide proof of insurance. Full payment is expected at time of service unless special arrangements have been made.

**PLEASE PRINT**

Patient Name: \_\_\_\_\_  
Last First Middle

Mailing Address: \_\_\_\_\_  
City State Zip

Street Address: \_\_\_\_\_  
City State Zip

E-Mail address \_\_\_\_\_

Sex (circle one): M or F      Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_      Social Security #: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Preferred Contact Method: Home \_\_\_\_ Cell \_\_\_\_

Referred By: \_\_\_\_\_ Primary Doctor: \_\_\_\_\_

Name of your Pharmacy for Prescriptions: \_\_\_\_\_ Location: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Marital Status (circle one): S M W D Sep      Spouse's Name: \_\_\_\_\_

Race (check one)

- American Indian    Asian    Black    Hispanic/Latino    Hawaiian    White    Other    Decline to Respond

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 (Relative or friend not living with you)

**INSURANCE INFORMATION**

Primary Insurance Company \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
 (If other than the patient)

Secondary Insurance Company \_\_\_\_\_

Policyholder Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security#: \_\_\_\_\_  
 (If other than the patient)

**PLEASE READ:** I certify that all information is true and correct to the best of my knowledge. I understand that I am responsible for any fees and services regardless of insurance. All charges are due at the time of service. If hospitalization is indicated, the patient is responsible for providing all insurance information prior to admission. If this account is turned over to collections, the undersigned agrees to pay all legally allowed interest, collection and attorney's fees.

Signature of Patient or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**PALMETTO PULMONARY MEDICINE, P.A.  
CONSENT FORM**

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**MEDICARE RELEASE**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers of any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignment.

Initials \_\_\_\_\_

**COMMERCIAL/TRICARE/MEDICAID/INSURANCE AUTHORIZATION STATEMENT**

I authorize any holder of medical or other information about me to release to Palmetto Pulmonary Medicine P.A. any information needed for this or any other related claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to either myself or to the party who accepts assignment.

Initials \_\_\_\_\_

**PRESCRIPTION GUIDELINES**

I authorize Palmetto Pulmonary Medicine, P.A. to use electronic medical records and electronic prescriptions to fill/refill all prescriptions. Under Medicare guidelines, Palmetto Pulmonary Medicine is required to fill/refill via electronic prescription. Therefore, if prescriptions are not filled/refilled at the time of your office visit, you will be required to pick up your prescription from our office. If you would like your prescriptions mailed to you, you will need to provide us with a pre-addressed and pre-stamped envelope or there will be a fee for this courtesy.

Initials \_\_\_\_\_

**CANCELLATION FEE / NO SHOW FEE**

I understand that if I do not cancel my scheduled appointment within 24 hours of my appointment time, or if I do not show for my scheduled appointment, I will be charged a fee of \$20.00. I also understand that I will be responsible for that payment before another appointment will be scheduled for me.

Initials \_\_\_\_\_

**PALMETTO PULMONARY MEDICINE, P.A.**  
**NOTICE OF PRIVACY PRACTICES**

This information describes how medial information about you may be used and disclosed. Please review and sign below. We are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information.

**For Treatment:** We may use your health information to provide you with medical treatment or services. An example of this would include a physical examination. We may also disclose your health information to your physician or another healthcare provider to be sure those parties have all the information necessary to diagnose and treat you.

**For Payment:** We may use and disclose your health information to others so they will pay us or reimburse you for your treatment. For example, a bill may be sent to you, your insurance company or a third party payer. The bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may share your health information with pharmaceutical company assistance programs and patient support organizations in order to assist you in obtaining payment for your care or payment for certain parts of your care.

**Appointment Reminders:** We may use and disclose your health information in order to contact you and remind you of an upcoming appointment for treatment or health care services. Furthermore, this serves as notice that Palmetto Pulmonary/or other party acting on our behalf (such as collection/billing company) may leave messages on my home and/or cell number regarding my medical care, financial responsibility and/or appointments with regards to Palmetto Pulmonary Medicine, P.A. This authorization will remain in effect until written notification from the patient or patient’s representative.

**Individuals Involved In Your Care or Payment for Your Care:** We may release your health information, including information about your condition, to a family member or friend who is involved in your medical care or who helps pay for your care. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers...Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable. You also authorize and consent to us providing your contact information to any third-party for the express purpose of collecting any amounts you may owe. **If you would like us to refrain from releasing your health information to a family member or friend, please notify us.**

**Personal Record Requests:** We will provide a copy of your medical records at your request and may charge an amount that is usual and customary with other practices. We must provide, at your request, an electronic copy of your medical records if you provide the device. We are required to notify you following a breach of your unsecured medical information.

**Other disclosures:** We are also allowed, by law, to use and disclose your health information without your authorization when required to do so by federal, state or local law. We will not use or disclose your genetic information for underwriting purposes. We must get your written authorization to sell your medical information to a third party. Although we do not send you advertisements, we do not need your written authorization to send you communications about health-related products or services as long as the products or services are associated with your coverage or are offered by us. We are required to get your written authorization before we send you other communications about products and services.



I acknowledge that I have reviewed the **Notice of Privacy Practices**.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Name of Personal Representative: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_

You have the right to file a complaint regarding these privacy practices. The address and phone number can be provided to you by our Privacy Officer. A full copy of our Privacy Practices, including how you can get access to this information, is posted in the office.



**PALMETTO PULMONARY MEDICINE, P.A.**  
**MEDICAL HISTORY**

Patient Name \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Name of other **Lung** Specialists you have seen: \_\_\_\_\_

Last X-ray or CT Scan of the **chest**: \_\_\_\_\_ year Facility name \_\_\_\_\_

**TB History:**

Have you ever been exposed to Tuberculosis?  Yes  No

Have you had a PPD placed to check for Tuberculosis?  Yes  No

If yes, was the test positive?  Yes  No Year \_\_\_\_\_

If yes, did you have treatment?  Yes  No Length of Treatment \_\_\_\_\_

**Asbestos History:**

Have you ever been exposed to Asbestos?  Yes  No If yes, years of exposure \_\_\_\_\_

If yes, was it on the job?  Yes  No If yes, Job Description \_\_\_\_\_

Did you wear a respiratory protection device?  Yes  No Type: \_\_\_\_\_

**Occupation History:**

Current/Previous Job Description:  Construction/Demolition  Landscaper  Military  Paper mill  Pilot

Sawmill  Office  Laborer  Professional  Other \_\_\_\_\_

**Social History:**

Do you currently smoke?  Yes  No If no, have you ever smoked?  Yes  No

Avg # of packs per day \_\_\_\_\_ Years Smoked \_\_\_\_\_ Year Quit \_\_\_\_\_

Do you use e-cigarettes or vapor?  Yes  No

Do you drink alcohol?  Never  Occasionally  Daily

**Allergies:**

Do you have allergies to:  Pollen  Dust  Seasonal  Mold  Bees  Ants  Shellfish  Iodine/Contrast

Do you have any allergies to medications and if so please list drug **and** reaction:

Do you have any allergies to foods and if so please list the type of food **and** reaction:

**Family History:**

Is your Mother living  Yes  No If no, age of death \_\_\_\_\_ illnesses \_\_\_\_\_

Is your Father living  Yes  No If no, age of death \_\_\_\_\_ illnesses \_\_\_\_\_

Have you had a flu shot?  Yes  No If yes when? \_\_\_\_\_

Have you had a pneumonia shot?  Yes  No If yes when? \_\_\_\_\_

