PALMETTO PULMONARY MEDICINE, P.A.

Pulmonary Diseases • Asthma • Critical Care • Sleep Disorders

Peter N. Manos, MD, FCCP
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Board Certified:
Internal Medicine
Pulmonary Disease
Critical Care Medicine
Sleep Medicine

Dear Mr./Ms. _____:

We are reminding you in advance of your appointment on _____ at _____ with Dr. Peter Manos. Our office is located at 989 Ribaut Road, Suite 340, Beaufort South Carolina (in the Beaufort Medical Plaza). **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: We participate with the following insurance plans:

1. Medicare (regular type only – we do not participate with any of the PPO's, HMO/s or Advantage plans). Our office will submit your Medicare charges. You are responsible for deductibles, co-pays and any non-covered services.
2. Medicaid (Advacare, Blue Choice, Select Health only). **A copay applies and is due at the time of your appointment.**
3. Tricare (with the appropriate authorization).
4. Blue Cross/Blue Shield Plans (State, Federal, PPO, and BC Choice).

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 these films and the reports and bring them with you to this appointment (does not pertain to those patients being seen for sleep problems).

We have provided this information so that we may better serve you. However, if you have any questions please feel free to ask or 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.
PATIENT MEDICATION SHEET

DATE:_____PATIENT:_____DOB:_____

Drug Allergies: _____

Current Medications (Including over the counter) - Please list dose and frequency
If you are unable to complete this form, please bring your bottles with you to your first office visit.

Medication Name	Dose	Frequency

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?_____

PALMETTO PULMONARY MEDICINE, P.A.
MEDICAL HISTORY CONTINUED

Patient Name_____ DOB: _____ Date: _____

Place a check in the appropriate box if your family member has had the listed illness

Illness	Self	Mother	Father	Sister	Brother	Grandmother	Grandfather	Son	Daughter
A1AT Deficiency									
Asthma									
COPD									
Pulmonary Embolus (PE)									
Sarcoidosis									
Narcolepsy									
Sleep Apnea									
Diabetes									
Hypertension									
Heart Disease									
Congestive Heart Failure									
Coronary Artery Disease									
Myocardial Infarction (Heart Attack)									
Cancer Type:_____									
Lung Cancer									
Prostate Cancer									
Alzheimer's Disease									
Dementia									
Depression									
Stroke									