Pueblo Pulmonary Associates

Patient Information & Authorization of Treatment

Patient Information

Patient Name:_____ Birth Date:___/___/___ Today's Date: ___/___/___
Home Phone:_____ Cell Phone:_____ Work Phone:_____
Email:_____ SSN:_____-_____-_____
Gender: ☐ Male ☐ Female Language:_____ Race:_____
Ethnicity:_____
Address:_____
City:_____ State:_____ Zip:_____ Marital Status: ☐S ☐M ☐W ☐D
Spouse/Guardian:_____ SSN:_____-_____-_____ Phone:_____
Emergency Contact:_____ Relationship:_____ Phone:_____

Pharmacy Information

Pharmacy Name:_____ Phone:_____ Fax:_____
Address:_____City:_____ State:_____ Zip:_____

Referring or Primary Care Physician

Physician Name:_____ Phone:_____ Fax:_____
Address:_____City:_____ State:_____ Zip:_____

Patient Permission to Communicate Medical Information

The patient and/or authorized representative of the patient whose signature is affixed below does herby permit and does not object to the communication of medical information related to my care and condition to the following <u>two</u> individuals.

Name:_____ Relationship:_____ Phone:_____
Name:_____ Relationship:_____ Phone:_____

Signature:_____ Date:_____

Patient Portal

Would you like to be web enabled: ☐ Yes ☐ No

Signature:_____ Date:_____

Authorization to Release Information

I hereby authorize my treating physician to release any information acquired in the course of my examination or treatment.

Signature:_____ Date:_____

Acknowledgment of Financial Obligation

I understand that I am personally responsible for the cost of the services rendered.

Signature:_____ Date:_____

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge receiving and reading a complete copy of the Notice of Privacy Practices of Pueblo Pulmonary Associates. I further acknowledge that, as of today's date, I have no questions regarding the Notice of Privacy Practices of Pueblo Pulmonary Associates.

Signature:_____ Date:_____

FOR OFFICE USE ONLY

Insurance Cards Copied: ☐ YES ☐NO Self Pay: ☐ YES ☐NO

Good faith efforts: The patient presented to the office on _____/_____/_____ and was provided with a copy of Pueblo Pulmonary Associates Notices of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the notice. However, such acknowledgment was not obtained because:

☐ Patient refused to sign
☐ Patient was unable to sign
☐ The patient had a medical emergency and an attempt to obtain the acknowledgment will be made at next available opportunity
☐ Other: _____

Signature:_____ Date:_____