LUNG HEALTH INSTITUTE

Patient Registration

Personal Information

Patient name: _____

Phone number: _____ Alternate phone number: _____

Date of birth: _____ Last 4 SS#: _____ Email: _____

Current address: _____ City: _____ State: _____ ZIP: _____

MARITAL STATUS

- ☐ Single
- ☐ Married (spouse's name):

  _____
- ☐ Widowed
- ☐ Divorced
- ☐ Number of children: _____

RACE/ETHNICITY
(select all that apply)

- ☐ Asian
- ☐ Black or African American
- ☐ Caucasian
- ☐ Hispanic or Latino/a
- ☐ Native American
- ☐ Pacific Islander
- ☐ Prefer not to answer

Emergency Contact Information

Name: _____ Relationship: _____

Cell phone number: _____ Home phone number: _____

Current address: _____

City: _____ State: _____ ZIP: _____

How Did You Hear About Lung Health Institute?

PLEASE SPECIFY THE NAME OF YOUR REFERRAL SOURCE

- ☐ Doctor: _____
- ☐ Internet: _____
- ☐ Magazine: _____
- ☐ Newspaper: _____
- ☐ Television: _____
- ☐ Friend or relative: _____
- ☐ Former patient: _____
- ☐ Medical seminar (location): _____

Authorization to Verbally Discuss Health Information

You may choose to give us permission to discuss information about you with family, friends and others you designate who are involved in your care or concerned about your health status and may ask about your condition or need information when you are not present. You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab and test results, treatment information and billing information. This does not mean that the person will have access to your medical records. Complete this form to let us know to whom we may speak about your information.

HERE ARE SOME EXAMPLES OF WHEN IT MIGHT BE USEFUL FOR YOU TO RELEASE INFORMATION:

- If you want a relative or friend to help you understand medical treatment instructions
- If a relative or friend is helping with billing instructions
- If a relative or friend calls to verify your appointment time
- If a relative or friend comes in and asks if you are here and in or out of the procedure room

Patient name: _____ Date of birth: _____

I hereby authorize Lung Health Institute to discuss and disclose specific health information as selected below to the following entity/individual.

Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone number: _____ Relationship: _____

DESCRIPTION OF SPECIFIC INFORMATION TO BE DISCUSSED AND DISCLOSED (PLEASE CHECK ALL THAT APPLY):

- ☐ All health and treatment information
- ☐ Appointment date/times
- ☐ Lab/test results
- ☐ Billing/payment information
- ☐ Other: _____
- ☐ Medical information (including symptoms, diagnosis, medication, and treatment plan)
- ☐ Procedure status/location (whether I'm waiting to go into procedure or have been released)

I understand the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

EFFECTIVE DATES FOR THIS AUTHORIZATION

Authorization automatically expires 1 year from the date signed below. You have the right to revoke this authorization before the year has passed.

BY SIGNING, I UNDERSTAND THAT:

- I may inspect or copy the protected health information to be used or disclosed.
- I may notify the medical practice in writing if I would like to revoke this authorization.
- This authorization is giving the Lung Health Institute permission to discuss my health information as selected above with entity/individual listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization, and that this authorization is not a condition of treatment or payment.

PATIENT/LEGAL REPRESENTATIVE

_____ _____

Signature Date

_____

Printed name

Authorization of Privacy Information

Authorization to Release or Use Information for Treatment, Payments or Health Care Operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Lung Health Institute in order to carry out treatment, payment or health care operations.

I acknowledge that I have been provided with a copy of Lung Health Institute's Privacy & Security Practices Notice to review a complete description of privacy practices and the potential release and use of my protected health information, and that it is right to review such notice prior to signing this consent form.

I acknowledge that Lung Health Institute reserves the right to change the terms of its privacy practices at any time and that in the event the terms of Lung Health Institute's Privacy & Security Practices Notice change, I will be notified as required by prevailing laws and may also request a current copy of our notice by requesting a copy from our clinic's front desk staff at any time.

I understand that I retain the right to request to change my consent to the below disclosures and that I must do so in writing. I understand I may request that Lung Health Institute further restrict how my protected health information is released or used to carry out care, payment or health care operations. Furthermore, I understand that the practice is not required to agree to such requested restrictions; however, if Lung Health Institute agrees to the requested restriction(s), such restrictions would then be binding.

Please note: Lung Health Institute encourages you to read the privacy practices and standards of your email and phone provider(s) as their privacy policy may differ from those of Lung Health Institute.

In consideration of above, I agree and consent to releasing information to me in the following manners:

VIA EMAIL	CONTACT INFO	DATE
☐ OK to send PHI to email address	_____	_____
☐ OK to send PHI to alternate email	_____	_____
VIA HOME TELEPHONE		
☐ OK to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
VIA CELL PHONE		
☐ OK to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
VIA ALTERNATE COMMUNICATION METHOD		
☐ OK to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
☐ OK to fax PHI to _____		

By signing below, I attest that the information provided above is true and accurate.

_____ _____

Signature Date

Wellness Questionnaire

1. Are you currently following a medically prescribed/recommended diet? If so, which one?

2. Do you have any food allergies, or are there foods that you cannot eat or refuse to eat? If so, which ones?

3. Do you have any medical or health concerns about changing your diet? If so, briefly explain them.

4. Are you prescribed Digoxin or Warfarin (Coumadin)?

5. Do you follow any fluid restrictions?