REGISTRATION: **** Southeast Houston Pulmonology * Louis M Hamer MD ****

==========PATIENT INFORMATION==========

Name _____ **Soc Sec #** _____
Last Name First Name Initial

Address _____
Street City State Zip

Home Phone _____ **Business Phone** _____ **Cell Phone** _____

Sex: M[ ] **F**[ ] **DOB**_____ **Age**____ **Single** [ ] **Married** [ ] **Widowed** [ ] **Separated** [ ] **Divorced** [ ]

Employer _____ **Occupation** _____

Employer Address _____ **Employer Phone** _____

In case of emergency notify_____ **Phone** _____

Referred by _____

==========POLICY HOLDER INFO IF DIFFERENT FROM PATIENT INFO==========

Name _____ **Soc Sec #** _____
Last Name First Name Initial

Address _____
Street City State Zip

Home Phone _____ **Business Phone** _____ **Birth date** _____

Sex: M[ ] **F**[ ] **Age**_____ **Single** [ ] **Married** [ ] **Widowed** [ ] **Separated** [ ] **Divorced** [ ]

Employer _____ **Occupation** _____

Employer Address _____ **Employer Phone** _____

==========CONSENT TO USE AND DISCLOSE PRIVATE HEALTH INFORMATION==========

ASSIGNMENT & RELEASE: I hereby authorize release of any information necessary to process my insurance claims and assign payment directly to Louis Hamer MD; Southeast Houston Pulmonology.

FINANCIAL RESPONSIBILITY: I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions. Billing statements will be sent to the patient's address unless we are informed otherwise.

PRIVATE HEALTH INFORMATION: I hereby authorize *Louis Hamer MD* **,** its physicians and/or staff, to use and disclose my Private Health Information (PHI) for treatment, payment, health care operations, appointment reminders, treatment alternatives, or any of the other purposes described in the *Notice of Privacy Practices*.
I have been shown the *Notice of Privacy Practices* and I understand that I may request a copy now or at any time in the future. I also understand that HIV or substance abuse information will not be disclosed without a specific written authorization in addition to this general consent.

NAME_____ RELATIONSHIP TO PATIENT_____
PLEASE PRINT

SIGNATURE_____ DATE_____
Patient or authorized representative

PATIENT MEDICAL HISTORY: **** SOUTHEAST HOUSTON PULMONOLOGY * LOUIS M HAMER MD ****

Patient Name:_____ Date:_____

Birth Date:_____ Age:_____ Primary Care Physician:_____

Medication Allergies:_____

Previous Surgeries/Hospitalizations:_____

Have you ever smoked? Y / N Are you smoking now? Y / N How much per day?_____

When did you stop?_____ Do you drink Alcohol? Y / N How much per day?_____

Do you have a Family history of heart disease?_____ Father? Y / N Mother? Y / N
Brother? Y / N Sister? Y / N

Do you have a Family history of Diabetes? Y / N _____

CHIEF COMPLAINT: (Reason for your visit today)_____

_____

PLEASE CHECK ALL THAT APPLY TO YOUR MEDICAL HISTORY & CURRENT SYMPTOMS:

CONSTITUTIONAL
____Weight
____Height
____Weakness/Fatigue
____Fever
____Weight Loss/Gain
____Swelling hands/legs/feet
____Other

EYES
____Glaucoma
____Cataracts
____Double Vision
____Blurry Vision
____Floaters/Spots
____Other

EAR/NOSE/THROAT
____Difficulty Hearing
____Ringing in ears
____Difficulty swallowing
____Throat tightness
____Other

ENDOCRINE
____Diabetic
____Hyperthyroid
____Hypothyroid
____Tremors
____Other

CARDIAC
____High blood presssure
____Chest Pain
____Irregular Heart Beats
____Palpitations
____Previous Heart Attack
____Bypass Surgery
____PTCA/Stent
____Pacemaker/Defibrillator
____Other

RESPIRATORY
____Coughing
____Shortness of Breath
____Wheezing
____Asthma
____Bronchitis
____Emphysema
____COPD
____Other

MUSCULOSKELETAL
____Arthritis
____Joint pain
____Muscle pain / cramps
____Swelling
____Use cane or walker
____Use wheelchair
____Other

NEUROLOGICAL
____Stroke/CVA
____Left/Right sided weakness
____Dizziness
____Fainting
____Normal Gait
____Other

GASTROINTESTINAL
____Gallbladder disease
____Diverticulitis
____GERD
____Liver disease
____Constipation/Diarrhea/Vomiting
____Abdominal pain or nausea

GENITOURINARY
____On dialysis
____Prostate disease
____Kidney stones
____Kidney failure
____Discolored urine
____Other

==========**Do not write below this line**==========

For Physician use only**:**_____

_____

_____

_____

Nurse Signature:_____ **Physician Signature:**_____

SOUTHEAST HOUSTON PULMONOLOGY
Louis M. Hamer MD

Our financial policy

We are dedicated to providing the best possible care for you, and we want you to understand our financial policies to avoid any future misunderstandings. Our policy on billing & charity care is also available for your review from the receptionist.

Insurance - You are financially responsible for all charges unless a contract between us and your insurance company prohibits us from billing you. As a service to you we will file your insurance claim if you assign the benefits to us so that your insurance company can pay us directly. We will also follow up for you, but if your insurance company does not pay the claim within a reasonable period, we will have to look to you for payment.

Self-pay - If you do not have insurance, or if we cannot verify your coverage, payment is due at the time of service.

Benefit Verification – We will contact your insurance carrier to verify your benefits when necessary or when you request us to do so. We do this so that you will have an estimate of what your financial responsibility will be, and to determine what portion of your charges should be paid by you at or before the time of service. When we contact your insurance carrier, we are told that *benefits given are not a guarantee of payment.* Therefore when your claim is actually processed by your insurance company, it is possible that your portion of the charges could be different from what we and you were told when we verified your coverage. We cannot guarantee what your insurance company will pay. Therefore you may receive a bill from us if the insurance company denies, changes, or reduces the payment for the services we provided. **Benefit verification is an estimate, not a guarantee of your insurance benefits.**

Co-payments & Deductibles – When your insurance specifies a co-payment and/or when you have a deductible remaining, these payments are due at the time of service.

Prior Authorization – Some *Health Maintenance Organizations* (HMOs) and *Independent Physician Associations* (IPAs) require you to obtain authorization for our services from your primary care provider. It is your responsibility to obtain this authorization before you visit our office, even when the visit is for an urgent problem. Contact your insurance or your primary care provider if you have questions about the need for an authorization.

Returned checks – We will charge a fee of $25.00 for all checks returned unpaid.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____

Signature of patient (or responsible party, if minor) Date

_____

Please print the name of the patient