Panama City Pulmonary, LLC
2426 Jenks Avenue, Panama City, FL 32405
(850) 763-9459 (850) 763-9462 Fax
Angel A. Núñez, M.D., F.C.C.P.,D,ABSM

PATIENT INFORMATION FORM

Date_____

Name_____Home Phone _____ Work Phone_____

Cell Phone _____E-Mail Address_____

Home Address_____City_____St_____Zip_____

Social Security #_____Date of Birth _____ Sex (M) (F)

Employer_____Address_____

Marital Status (M) (S) (D) (W) Spouse's Name_____

Person to contact in case of an emergency_____Phone_____

Who referred you to this office:_____Address:_____

Phone:_____

Who is you primary care physician:_____Address_____

Phone: _____

INSURANCE INFORMATION
(Present Insurance Cards to Receptionist)

Primary Insurance_____

Address _____City_____State_____Zip_____

Telephone Number_____Insurance ID#_____

Date of Birth of Policyholder_____Social Security # of Policyholder_____

Secondary Insurance_____

Address _____City_____State_____Zip_____

Telephone Number_____Insurance ID#_____

Date of Birth of Policyholder_____Social Security # of Policyholder_____

Do you have a Living Will? (Yes) (No)

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance of any professional services rendered. If, for any reason, the account should become delinquent, I agree to pay any billing charges, collection costs, and reasonable legal fees. I have read all the information above and certify this information is true and correct to the best of my knowledge.

Signature of Responsible Party_____Date_____

Name:	Date:	DOB:	Age:

Please help us find out about you by filling out the "Patient" side of this form on pages 1-3. If you don't know the answer(s), ask a family member or one of our staff to assist you.

PATIENT

Why are you here to see a pulmonary (lung) doctor?

_____

_____

_____

Check off any lung or breathing problems or symptoms

- o Unable to catch your breath
- o Wheezing
- o High blood pressure
- o Heart murmur
- o Unable to sleep laying flat or with one (1) pillow
- o Sudden onset of difficulty breathing
- o Night sweats
- o Coughing up blood
- o Chest pains or pressure
- o Shortness of breath
- o Dizziness
- o Swollen legs
- o Heart failure
- o Blue lips or fingernails
- o Leg cramps when you walk

Have you ever had:

- o A pulmonary stress test
- o An electrocardiogram
- o A pulmonary function or spirometry test
- o A bronchoscopy or bronchial/lung biopsy
- o Lung surgery, including complete or partial removal
- o Heart surgery
- o Lung surgery
- o Exposure to tuberculosis or had tuberculosis
- o Pneumonia
- o Blood clot

Are you being treated now of have been treated for any illnesses?

(Please list them)

1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever had any operations? Any injuries?

1. _____
2. _____
3. _____
4. _____

Check if any close family member (parents, brothers and sisters, children) have:

- o Heart problems
- o Diabetes
- o Cancer
- o Heartburn

Are there any other health problems in your family?

_____

_____

Please leave "Clinical" side blank

CLINICAL

CC

HPI

PAST FAMILY SOCIAL

Past Med Hx

Past Surg HX

Family HX

PATIENT

Marital Status S M W D

With whom do you live? _____

What is your occupation? _____

What are your leisure activities? _____

What is your education level? _____

CLINICIAN

Social Hx

Tell us about your risk of lung disease.

Risk Factors

Please check if you have:

- ☐ Worked around toxic chemicals or substances
- ☐ Asthma
- ☐ Ever smoked
- ☐ Lived with someone who smokes
- ☐ Asbestos exposure

Do you exercise (including walking)?

☐ Yes ☐ No

Has a close family member had lung cancer, tuberculosis or emphysema?

☐ Yes ☐ No

Who? _____

If you are a woman, have you passed menopause (change of life)?

☐ Yes ☐ No

At what age? _____

Do you take estrogen replacement?

☐ Yes ☐ No

Please tell us anything else about your lungs: _____

Health Habits:

Do you smoke?

☐ Yes ☐ No

How many packs per day? _____

For how many years? _____

If you no longer smoke, when did you quit? _____

How much alcohol do you drink? _____

Do you use any recreational drugs?

☐ Yes ☐ No

List: _____

Are you allergic to any medications?

Allergies

☐ Yes ☐ No

List medications to which you are allergic & reactions:

1 _____

2 _____

3 _____

4 _____

5 _____

Do you have hay fever?

☐ Yes ☐ No

What kind of symptoms do you experience:

_____

_____

_____

Have you had the following vaccinations?

Vaccinations

- ☐ Influenza ("Flu Shot") Annually
- ☐ Pneumococcal ("Pneumonia") Vaccine

Patient Name

PATIENT	CLINICIAN
Please tell us about your medicines (names, dose or strength, how many times a day). Include over-the-counter medicine that you've recently stopped taking:	Medicines
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	

Please circle any symptom you have, so we can find out more about it:	REVIEW OF SYMP
Lack of energy; daytime sleepiness; trouble sleeping; snoring; loss of appetite; weight changes; fevers	Constitutional
Eye problems, such as double or blurred vision; glaucoma; cataracts	HEENT
Hearing problems; buzzing or ringing in ears	
Allergies; hay fever	
Sinus problems	
Blood pressure or heart problems	Cardiac
Asthma; tuberculosis	Pulmonary
Stomach problems; heartburn; indigestion; change in bowel habits	Digestive
Bloody or tarry stools; jaundice; liver problems; ulcers; gallstones	
Urinary problems: Frequency; infections; stones; bladder	Urinary
Men: Prostate problems; night-time urination	
Women: Abnormal menstrual periods; could you be pregnant?	
Joint pains swelling or redness; arthritis; back pain	Musculoskeletal
Muscle aches or tenderness; gout	
Rash, itching or other skin problems	Dermatological
Women: breast lumps; recent mammogram, pap smear and/or pelvic exam	Female Reproductive
Paralysis (even temporary); stroke; numbness; loss of balance	Neurological
Seizures; loss of memory; headaches	
Unusual thoughts; nervousness; crying or sadness; depression	Psychiatric
Suicide attempts	
Thyroid disorder; diabetes; excess thirst; hunger or urination	Endocrinology
Bleeding; easy bruising; risk factors for HIV; anemia; cancer	Hematological

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CONSENT OF DISCLOSURE

(For the usage and/or disclosure of protected health information)

I hereby give consent to Panama City Pulmonary, LLC to use and disclose my protected health information for the purposes of treatment, payment and healthcare operations.

You may cancel this at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the bottom of this form. This may be delivered in person or by mail, but it will only be effective when we actually receive it. Your cancellation will not be effective to the extent that we or others have acted in reliance upon this consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purpose of treatment, payment, or healthcare operations. We are not required to grant your request, however, if we do, the restriction will be obligatory to us.

Our posted privacy policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our posted privacy policy before you sign this consent.

We reserve the right to amend the terms of our posted privacy policy. You may obtain a copy of the current policy by calling Patty at 850-763-9459.

PRINT NAME OF PATIENT:_____

SIGNATURE:_____Date_____

If you are signing as the patient's representative

Print your name_____
Relationship_____

Address for cancellation: Your cancellation will be effective upon receipt at the following address:
Panama City Pulmonary, LLC
2426 Jenks Ave. Panama City, Florida 32405

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Dr. Angel N`uñez, M.D.

PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I,_____,understand Panama City Pulmonary LLC, is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment or health care operations.
I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Panama City Pulmonary, LLC, or any other individual listed below to disclose my protected health information as described on this form to the recipient(s) listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth above.

IMPORTANT: This notice describes your rights as a patient and how your medical information may be used and disclosed. Please review this notice carefully and acknowledge receipt by your signature on the attached page at the end of this notice.

DESCRIPTION OF THE INFORMATION TO BE USED OR DISCLOSED (check all that apply):

( ) The patient's entire medical record
( ) The patient's demographic information
( ) Medical data/information

Please list any conditions not to be released, if any:_____

Please list the name(s) to whom we can disclose the patient's protected health information:

This authorization is to be used for our own use, and Panama City Pulmonary, LLC will not condition treatment or payment on this authorization. Moreover, the patient has the right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

The patient has the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Panama City Pulmonary, LLC must receive the revocation in writing. The revocation must include:

The patient's name, address, and patient number, if applicable.
The effective date of this authorization, and the recipients of the protected health information according to this authorization
The patient's desire to revoke this authorization, and the date of the revocation and the patient's signature

Panama City Pulmonary, LLC will accept written revocations of this authorization via Certified U.S. Mail or fax to 850-763-9462.
All revocations must be sent to Panama City Pulmonary, LLC to the attention of the Privacy Office, P. Kinard, and are not effective until received by the Privacy Officer.
This authorization shall not expire as long as you are a patient at this office.

I fully understand and accept the terms of this authorization.

_____ _____
Patient's Signature Date

FOR OFFICE USE ONLY
Authorization added to the patient's medical record on:_____ By:_____

TREATMENT AND PAYMENT AGREEMENT

Panama City Pulmonary
2426 Jenks Ave.
Panama City, FL 32405
Phone (850) 763-9459 Fax (850) 763-9462

1. **Treatment Consent and Authorization:** I consent and authorize Panama City Pulmonary to examine me and perform all treatments for this and all following visits, including, without limitation, prescribed medications, performance of diagnostic procedures and laboratory tests as deemed necessary or advisable by the attending physician. This consent and authorization is given in advance of any specific diagnosis or treatment and is continuing until revoked in writing.
2. **Insurance Plan Benefits:** Panama City Pulmonary participates with multiple insurance plans. Each insurance plan has different benefit packages and regulations. I understand, acknowledge and agree that it is my responsibility to be familiar with my insurance benefits and to advise Panama City Pulmonary's staff regarding my insurance coverage. **I understand, acknowledge and agree that I am fully responsible for all charges, including, without limitation, laboratory tests, that are not covered by my insurance policy.**
3. **Payment Agreement and Financial Patient Policies:** Panama City Pulmonary will file the insurance claim(s) with my insurance carrier for services provided to me. I understand, acknowledge, and agree that Panama City Pulmonary must collect my co-payments and deductibles at the time the service is rendered. I am required to present my insurance card at the time of visit. Without a current insurance card, Panama City Pulmonary will not be able to file my claims appropriately and I will be responsible for the payment of all charges. If my insurance coverage changes, I agree to notify Panama City Pulmonary at the time of my visit. Panama City Pulmonary may not be able to re-file claims, and I would be responsible for full payment.
4. **Prescription Refills:** It is our policy that you should take responsibility to know when your medications must be refilled at least a week before you run out. Medications are refilled only at the patient visit or when requested in advance through your pharmacy. This includes all mail-order prescriptions. We cannot take weekend, walk-in, after hours or phone call refill requests.
5. **Patient Fees for Other Services:** Panama City Pulmonary has specific charges for missing appointments without a 24-hour advance notice, filling our medical forms, copying medical records when they are not going to a physician that either referred you to us or that we referred you to, returned checks, prescription refills that are requested over the phone and also for family and patient meetings with the physician outside of your scheduled follow-up appointment. These charges are the patient's responsibility and will not be billed to any insurance company. There will be a 5-10 business day turnaround for all records requests and medical forms.

   Please initial next to each item that you understand, acknowledge and agree that you will be responsible for these charges should they be necessary.

Initial	Description of Service	Description of Billing	Cost of Service to patient
	No-show fee for office visit	Appointment missed without 24-hour advance notice	$25.00 per occurrence
	Returned check fee	Check returned unpaid by bank	$30 per occurrence/must pay using cash or credit for future visits
	Medical Records Medical forms filled out	Medical Records Copy 1-3 pages 4or more pages	$1.00 per page up to 25 pages, .50 each thereafter. $15.00 per form $25.00 per form

Signature of Patient :_____Date:_____