Pulmonary & Critical Care Specialists, Inc

1661 Holland Rd Suite 100

Maumee OH 43537

Name: DOB: / / Sex: M / F SSN: - -

Address: City: State: Zip Code:

Home Phone: ( ) - Cell Phone: ( ) - Marital Status: S M D Se W

Email: @

Primary Care Doctor First & Last Name: Ph#: ( ) -

Preferred Pharmacy Name & City:

Medical Insurance

	Ins. Company Name	Policy No.	Grp. #	Policy Holder Name, DOB & Relationship to patient
Primary				
Secondary				
Tertiary				

Emergency Contact 1:

Name: Relationship: Phone:

Emergency Contact 2:

Name: Relationship: Phone:

Race (Circle)	Ethnicity (Circle)	Language (Circle)
American Indian or Alaska Native	Hispanic or Latino	English
Asian	Not Hispanic or Latino	Chinese
Black or African American	Unknown	Arabic
Hawaiian or Pacific Islander	Declined	French
White		Spanish
Other		Japanese
Unknown		Vietnamese
Declined		

I confirm that the above information is correct.

Signature:

Date:

Privacy Policies

I acknowledge that I have received notice regarding Privacy Practices effective May 20, 2019.

Persons that are allowed to give/receive my private health information:

Name:_____ Relationship:_____ Phone:_____

Method of allowed release: _____ Verbal _____ Written

If needed, is it okay to leave a detailed message? _____ Yes ____ No

Name:_____ Relationship:_____ Phone:_____

Method of allowed release: _____ Verbal _____ Written

If needed, is it okay to leave a detailed message? _____ Yes ____ No

Name:_____ Relationship:_____ Phone:_____

Method of allowed release: _____ Verbal_____ Written

If needed, is it okay to leave a detailed message? _____ Yes ____ No

Name:_____ Relationship:_____ Phone:_____

Method of allowed release: _____ Verbal_____ Written

If needed, is it okay to leave a detailed message? _____ Yes ____ No

Signature of Patient: _____

Printed Name of Patient: _____ Date of Birth: _____

Signature of Parent/Guardian of Minor: _____

Date: _____

Financial Policy

I hereby authorize Pulmonary & Critical Care Specialists INC. to submit to my insurance plan all covered services rendered by the physician(s) and to furnish complete information to my plan regarding services rendered. I understand that in signing this form, PCCS will not release to anyone, including those processing my claim, any information that the law specifically protects and for which a special consent is required. For those records to be released, I will need to sign a separate consent. I authorize and direct my insurance carrier to issue payment check(s) directly to the physician(s) rendering covered services unless otherwise notified.

Authorized Signature

I have read this form, or had it read to me. I understand the above.

Signature of Patient/Authorized Representative: _____

Patient Name: _____

Date of Birth: _____

Relationship (if other than patient): _____

Date of Signature: _____

No-Show Policy

Name: _____ **DOB:** _____ **Date:** _____

Thank you for choosing Pulmonary and Critical Care Specialists for your specialized care. In order for our physicians to provide you with the best service, it is important that you keep all scheduled appointments.

We understand that there may be a need to cancel, change, or reschedule your appointment. We ask that you make any changes **AT LEAST 24 HOURS PRIOR** to your scheduled visit.

Our office makes appointment reminder calls at least 48 hours prior to your appointment. Please make sure that we have the correct contact information on file for you.

Any appointment that is not cancelled within the 24-hour period will be subject to a **$50.00** "no-show" fee.

Our physicians and staff look forward to working with you.

Signature: _____

Date: _____