

# Pulmonary and Medical Associates of Northern Virginia, LTD.

- Steven M. Zimmet, M.D.
- Wilson L. Coudon, M.D.
- M. Anthony Casolaro, M.D.
- Lawrence M. Stein, M.D.

- Robert M. Kruger, M.D.
- David R. Duhamel, M.D.
- Jeff B. Hales, M.D.

- Christopher C. Wyckoff, M.D.
- Michael D. Jacobson, P.A.-C
- Lisa C. Moak, P.A.-C

- New Patient
- Established Pt. / Update

## PATIENT INFORMATION

<b>DATE:</b>			PATIENT'S SOCIAL SECURITY NUMBER		
LAST NAME:		FIRST:	MI:	HOME PHONE: ( )	
ADDRESS:				WORK PHONE: ( )	
CITY:		STATE:	ZIP:	CELL PHONE: ( )	
DATE OF BIRTH: (Mo./Day/Yr.)		SEX(M/F): ____ EMPLOYED(Y/N): ____ STUDENT:(FT/PT) ____		FAX: ( )	
EMPLOYER/SCHOOL NAME:			OCCUPATION:	E-MAIL:	
PERSON TO NOTIFY IN CASE OF EMERGENCY:		RELATIONSHIP TO PT.:		EMERGENCY PHONE NO: ( )	
MARITAL STATUS:	NAME OF SPOUSE:		SPOUSE DATE OF BIRTH	SPOUSE SOC. SEC. #	SPOUSES PHONE NO. ( )
Single / Married / Divorced / Widowed					
RESPONSIBLE PARTY: (If other than Patient)		RELATIONSHIP TO PT.:		RESPONSIBLE PARTY SS #	
				RES. PARTY PHONE NO. ( )	
BILLING ADDRESS: (If different from above)					
REFERRED BY OR REFERRING PHYSICIAN:				ACCIDENT DATE (IF APPLICABLE):	
ANY ALLERGIES:				PHARMACY PHONE NO. ( )	

## INSURANCE INFORMATION

PRIMARY INS. CARRIER			INSURANCE CARRIER PHONE NO.: ( )		
NAME OF POLICYHOLDER (If different than patient)		DATE OF BIRTH (Policy holder)	ID OR SOC. SEC. # OF POLICYHOLDER		
POLICY ID	GROUP #/NAME:	EFFECTIVE DATE:	RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF HUSBAND WFE CHILD OTHER (Please circle appropriate answer).		
SECONDARY INS. CARRIER			INSURANCE CARRIER PHONE NO.: ( )		
NAME OF POLICYHOLDER (If different than patient)		DATE OF BIRTH (Policy holder)	ID OR SOC. SEC. # OF POLICYHOLDER		
POLICY ID	GROUP #/NAME:	EFFECTIVE DATE:	RELATIONSHIP OF PATIENT TO POLICYHOLDER: SELF HUSBAND WFE CHILD OTHER (Please circle appropriate answer).		
PERSON TO BE BILLED AFTER INSURANCE IF OTHER THAN SELF?		SOCIAL SECURITY NUMBER		ADDRESS:	
WILL YOUR VISIT BE COVERED UNDER WORKMAN'S COMPENSATION OR OTHER INSURANCE?		<input type="checkbox"/> YES <input type="checkbox"/> NO		If Yes, please complete below. If No, please continue to insurance authorization.	
EMPLOYER:			EMPLOYERS TELEPHONE NO. ( )		
SUPERVISOR'S NAME:		ACCIDENT DATE:	CASE NO.		

## INSURANCE AUTHORIZATION

I hereby authorize Pulmonary and Medical Associates of Northern VA, Ltd. to apply for benefits on my behalf for covered services rendered me.

I request payment from Blue Cross/Blue Shield of the National Capital Area, Medicare Part B or other insurance carrier be made directly to the provider of services.

I certify that the information I have reported with regard to my insurance is correct and authorize the release of medical information and other necessary information for this or any related claim to my insurance carrier or the above named billing agent(s) or, in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration.

I permit a copy of this authorization to be used in place of the original.

This authorization may be revoked by me, the Blue Cross/Blue Shield of D.C., or the Social Security Administration at any time in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CONSENT FOR MINOR TO BE TREATED: \_\_\_\_\_ Relationship: \_\_\_\_\_

PLEASE SEE REVERSE SIDE

**PULMONARY and MEDICAL ASSOCIATES of NORTHERN VIRGINIA, LTD.**

**PATIENT CONSENT FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION**

I hereby give my consent for Pulmonary and Medical Associates of Northern Virginia, Ltd. (hereafter PMANV) to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (PMANV's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. PMANV reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to PMANV's Privacy Officer at 1400 South Joyce Street, #126, Arlington, Virginia 22202.

With this consent, PMANV may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, PMANV may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, PMANV may E-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that PMANV restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to PMANV's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, PMANV may decline to provide treatment to me.

I have reviewed a notice of privacy practices from Pulmonary and Medical Associates of NVA.

\_\_\_\_\_  
Signature of patient or legal guardian

\_\_\_\_\_  
Patient's name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of patient or legal guardian