We Welcome You To Our Practice

On behalf of Dr. Hull and Edmond Pulmonology, we would like to take the opportunity to welcome you to our practice. We are pleased that you selected us for your pulmonary care.

Enclosed are the forms for you to fill out **IN ADVANCE** of your appointment to assist our office staff and Dr. Hull in making sure that we have all the information necessary to provide you with quality care and treatment. If you have any questions or problems filling out the forms, do not hesitate to call so we may assist you.

Please bring to your appointment, the following:

- A current list of all your medications and dosages, including vitamins and herbal supplements.
- A current copy of your insurance and/or Medicare card and current driver's license.
- Any pertinent medical records if you have been treated by a physician or hospital for the reason you are visiting us. You may have the physician give to you directly, or they can mail or fax them to our office. It is very important that you bring any x-ray films or CT scans with you.
- **If you need a referral or prior authorization, please call your primary care physician to obtain one prior to your appointment. If you do not have a valid referral, you will be required to reschedule until the appropriate referral can be obtained.**

Dr. Hull strives very hard to stay on time with his patients, however, sometimes medical emergencies do occur which can cause him to run behind. You can do your part by showing up on time for your appointment with all the paperwork completed.

Watch for an email from Jackie Fowler, Practice Manager,
Jackie.Fowler@hcahealthcare.com.
It will be identified as M3 Patient Satisfaction Survey.

Please take a few minutes to complete the on-line survey when you receive the email from the clinic asking for your valued opinion. Your comments will be confidential. You may choose to make your response anonymous. Your email address is kept confidential and is not used for any purpose other than to conduct this survey.

THANK YOU!

ATTENTION

As a courtesy to our patients and staff, please do not wear perfume, cologne, or perfume-scented lotions.

Those with allergies suffer greatly.

Thank you for understanding.

Patient Registration Form

PATIENT INFORMATION (Please Print)

☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Jr. ☐ Sr. ☐ Other________

Patient's Name (Last)________ (First)________ (Middle)________

Also Known As Name (Last)________ (First)________

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other

Social Security Number ____-____-____ ☐ Female ☐ Male Date of Birth____/____/____

Race:________ Preferred Language:________ E-Mail Address________

Phone Numbers Work________ ☐ Day ☐ Evening Home________ ☐ Day ☐ Evening

Cellular________ Pager________

Address________

City, State, ZIP (+4)________

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer________ Occupation________

Emergency Contact Name________ Phone Number________

Emergency Contact Relationship to Patient________

Referring Provider Name________ PCP________ Cardiologist________

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last)________ (First)________ (Middle)________

Also Known As Name (Last)________ (First)________

Social Security Number ____-____-____ ☐ Female ☐ Male Date of Birth____/____/____

E-Mail Address________

Phone Numbers Work________ ☐ Day ☐ Evening Home________ ☐ Day ☐ Evening

Address________

City, State, ZIP (+4)________

Employment Status ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐ Retired ☐ Self-Employed ☐ Unemployed

Employer________ Employer Phone Number________

Patient Relationship to Responsible Party________

PRIMARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured________ Patient Relationship to Insured________

Insured Employer Name________

Insurance Company/Phone Number________ (____)________

Subscriber ID (Policy Number)________ Group ID________ Copay Amount________

Effective Date________ Termination Date________ ☐ Female ☐ Male

Insured Date of Birth____/____/____ Insured's Social Security Number ____-____-____

Insurance Company Address________

SECONDARY INSURANCE INFORMATION (provide your insurance card to the front desk at check-in)

Name of Insured________ Patient Relationship to Insured________

Insured Employer Name________

Insurance Company/Phone Number________ (____)________

Subscriber ID (Policy Number)________ Group ID________ Copay Amount________

Effective Date________ Termination Date________ ☐ Female ☐ Male

Insured Date of Birth____/____/____ Insured's Social Security Number ____-____-____

Insurance Company Address________

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature________ ***Date***________

ALLERGIES (include reaction and date):

Name: ______________________

DOB: ______________________

MEDICATION LIST

Date Reviewed
(include your initials)

Medication Name (brand & generic)	**Dosage** (strength & frequency)																						

EDMOND PULMONOLOGY
NEW PATIENT MEDICAL HISTORY FORM

NAME: ____ **DATE OF BIRTH:** ________________
Last First Middle

PRIMARY CARE PHYSICIAN: ______________________ **REFERRED BY:** ______________________

PHARMACY NAME: ______________________ **PHONE #:** ______________________

REASON FOR VISIT: ____

____

____

____

CURRENT MEDICATIONS: ***(Include over-the-counter medications, aspirin, vitamins, herbal supplements)***

Medication Name	*Dosage/Frequency*	*Medication Name*	*Dosage/Frequency*

ALLERGIES: ***(Please list any medication, food, animals, occupational or environmental allergies)***

Name of Allergen	*Type of Reaction*	*Name of Allergen*	*Type of Reaction*

PAST SURGICAL HISTORY:

Year	*Surgery*	*Name of Attending Physician/Hospital*

Use the other side, if needed.

PAST MEDICAL HISTORY: ***(Please list medical problems and hospitalizations)*** ______________________

____

____

____

IMMUNIZATION HISTORY: Have you been immunized against childhood illnesses: Y/N

Date of last influenza vaccination: ______________________ Date of last pneumonia vaccination: ______________________

Have you ever tested positive to a tuberculosis skin test: Y/N
If yes, include date of positive test and name of hospital/clinic where documentation is recorded: ______________________

____

NAME: ______________________ DOB: ______________

SOCIAL HISTORY: Marital Status: ______________ Occupation: ______________

Highest Level of Education Obtained: ______________ Number of Children: ______________

Do you currently smoke: Y/N If yes, age began: ________ Number of packs per day: ________
Have you ever smoked in the past: Y/N If yes, at what age: ____ Number of packs per day: ________
If you quit smoking, at what age? ______

Do you now or have you ever used smokeless tobacco? Y/N If yes, age began: ____ Number of cans per day: ________
If you quit, at what age: ______________

Do you consume alcohol: Y/N Type of alcohol and amount per week: ______________

Do you consume caffeinated beverages: Y/N Type of beverage and cups/cans per day: ______________

How often do you exercise: ______________ Type of exercise: ______________

Hobbies: ______________________________

Are you a member of the military? Yes or No If yes, have you ever been deployed? Yes or No

If yes, please list location of military deployment: ______________________________

____

Have you had any distant travel? Yes or No If yes, please list: ______________________________

____

ENVIRONMENTAL HISTORY: Who lives in your home? ______________________________

____

Do they smoke? Yes or No Are there any pets in the home? Yes or No If yes, please list: ______________

____

FAMILY HISTORY: Do any diseases run in your family? Yes or No If yes, please list: ______________

____

Your immediate family:

Family Member	*Alive/Deceased*	*Current age or Age of Death*	*Health Problems or Cause of Death*
Father			
Mother			
Brother/Sister(s)			
Child(ren)			

REVIEW OF SYSTEMS

In the past 2 months have you had any problems concerning: Checkmark indicates **affirmative** answer.

GENERAL SYMPTOMS	√
Fever	
Chills	
Drenching night sweats	
Weight loss	

EYES	√
Spots before the eyes	
Double vision	
Blindness	
Temporary Blindness	
Itching	
Crusted Matter	
Inflammation	
Dryness	

EARS	√
Ringing in ears	
Poor hearing	
Infection	
Drainage	
Punctured eardrum	
Pain	

NOSE, THROAT, MOUTH	√
Recurrent sore throat	
Hoarseness	
Nose bleeds	
Seasonal hay fever	
Difficulty swallowing	
Frequent Colds	
Year round hay fever	

NECK	√
Thyroid abnormality	
Pain in neck	
Tenderness	
Stiffness	
Enlarged glands	

BREAST	√
Tenderness	
Lumps	
Abscess	
Secretions	

ARMS and LEGS	√
Abnormal sensations	
Numbness	
Weakness	

CHEST	√
Cough	
Pain	
Abnormal Chest Xray	
Tightness	
Coughing blood	
Pneumonia	
Bronchitis	
"Smokers cough"	
Emphysema	
Tenderness	
Shortness of Breath	
Not enough oxygen	
Asthma	
Tuberculosis	
Wheezing	

HEART	√
Murmur	
Fast heartbeat	
Pain on exertion	
Pain without exertion	
Short of breath at night	
Swelling in ankles or legs	
Enlarged heart	
Irregular rhythm	
Smothering spell at night	

ABDOMEN	√
Mucous in throat	
Poor appetite	
Pain	
Intolerant of certain food	
Bloating	
Belching	
Heartburn	
Indigestion	
Cramping	
Nausea	
Vomiting	
Vomiting blood	
Tar-black stools	
Passing blood	
Diarrhea	
Constipation	
Hernia	
Liver trouble	
Inflamed pancreas	
Yellow jaundice	

KIDNEY	√
Infections	
Blood in urine	
Pus in urine	
Painful urination	
Frequent urination	
Night-time urination	
Urinate with coughing	
Change in stream	
Kidney stone	
Empty bladder poorly	
Sugar in urine	
Urinate in bed	

NEUROLOGICAL	√
Recurrent headache	
Spinning dizziness	
Unsteady dizziness	
Blackouts	
Paralysis	
Seizure	
Tremor	
Skull fracture	

MUSCULOSKELETAL	√
Night time burning of feet	
Painful muscles	
Painful bones	
Painful joints	
Swollen joints	
Stiff joints	
Deformed joints	
Back pain	
Cramps when walking	
Cramps when sleeping	

SKIN	√
Rash	
Itching	
Infection	
Lumps	
Abnormal moles	
Jumpy muscles	
Discoloration	
Easy brusing	
Bleeding	
Tumors	
Cancers	

BLOOD	√
Abnormal blood count	
Anemia	
Poor coagulation	
High blood sugar	

DO YOU FREQUENTLY HAVE	√
Trouble going to sleep	
Sleep apnea	
Trouble staying awake	
Sleepiness	
Fatigue	
Weakness	
Irritability	
Nervousness	
Depression	
Trouble concentrating	
Loud Snoring	

OTHER PROBLEMS NOT LISTED

____

____

____

____

____

NAME: ____________________

DOB: ________________

Edmond Physician Services, LLC dba Edmond Pulmonology Patient HIPAA Acknowledgment and Consent Form

Patient Name: ____

Date of Birth: ____

______ **(Patient initials) Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

______ **(Patient initials) Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:
Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.
If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

______ (Patient initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).
The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is______________________________.
The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is______________________________.

OR

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation
I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: ______________________________

Patient/Patient Representative Signature: ______________________________

Date: ____________________ *Time:* ____________________

Consent for Photographing or Other Recording for Security and/or Health Care Operations
____ **(Patient Initials)** I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.
____ **(Patient Initials)** I wish to designate the following family member / friend to pick up an order on my behalf:
Name: ______________________________ Date: ____________________
Name: ______________________________ Date: ____________________

OR

____ (Patient initials) I do not want to designate anyone to pick-up my prescription order.

Patient Signature ______________________________ **Date** ____________________

EDMOND PHYSICIAN SERVICES, LLC dba EDMOND PULMONOLOGY

FINANCIAL STATEMENT

Please check each of the following and sign below:

♡ I authorize medical treatment for myself or my family member. I understand that I am responsible for all charges incurred regardless of insurance status. I understand that Edmond Pulmonology will gladly file my insurance, however, Edmond Pulmonology's association is with me, the patient, not my insurance company, and I am ultimately responsible for my bill. I agree to pay my coinsurance and deductible on the date of service (appointment).

♡ I authorize my insurance company to pay Edmond Pulmonology on my behalf. This assignment will remain in effect until revoked by me in writing.

Patient (or Responsibility Party) Signature ____________________ Date: ____________________

If responsibility party is other than the patient:

♡ Parent

♡ Legal Authority

♡ Spouse

HCA PHYSICIAN SERVICES
EDMOND PHYSICIAN SERVICES, LLC dba EDMOND PULMONOLOGY

PATIENT CONSENT TO TREATMENT

(Please read and sign below)

I, the undersigned, hereby consent to the following treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment and will continue even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that EDMOND PHYSICIAN SERVICES,LLC dba EDMOND PULMONOLOGY may include consent at satellite offices under common ownership.

I, the undersigned, acknowledge that EDMOND PHYSICIAN SERVICES, LLC dba EDMOND PULMONOLOGY will use and disclose my information for the purposes of treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

______________________________ ______________________________

Patient (or Responsibility Party) Signature Date:

EDMOND PHYSICIAN SERVICES, LLC dba EDMOND PULMONOLOGY

PATIENT NAME____**DATE OF BIRTH**______________

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

1. ___________**(Patient or Guardian Initials)**

Financial Agreement.

- I acknowledge, that as a courtesy, EDMOND PULMONOLOGY may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. ___________**(Patient or Guardian Initials)**

Third Party Collection. I acknowledge that EDMOND PULMONOLOGY may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. ___________**(Patient or Guardian Initials)**

Assignment of Benefits. I hereby assign to EDMOND PULMONOLOGY any insurance or other third-party benefits available for health care services provided to me. I understand EDMOND PULMONOLOGY has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to EDMOND PULMONOLOGY, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____________**(Patient or Guardian Initials)**

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to EDMOND PULMONOLOGY by the Medicare or Medicaid program.

5. _____________**(Patient or Guardian Initials)**

Consent to Telephone Calls for Financial Communications. I agree that, in order for EDMOND PULMONOLOGY, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that EDMOND PULMONOLOGY or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or EDMOND PULMONOLOGY or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____________**(Patient or Guardian Initials)**

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

X____Date_______________

If you are not the Patient, please identify your Relationship to the Patient.

(Circle or mark relationship(s) from list below):

Spouse	Guarantor
Parent	Healthcare Power of Attorney
Legal Guardian	Other (please specify)______________________________

EDMOND PULMONARY - PATIENT CONTROLLED SUBSTANCE AGREEMENT

Controlled substances are drugs we prescribe to reduce, but not cure your pain. As doctors, we want to provide the best care for your problem; however, because of the concerns we have when we prescribe controlled substances, we feel it is necessary to notify you of our expectations.

When taking controlled substances, it is important to understand that the medications can lose their effectiveness if not taken as prescribed. Side effects may occur, including constipation, drowsiness and sedation. If this occurs, please notify us. It is also important for you to know that, in rare cases, psychological addiction may occur. We do not want psychological addiction to be a problem for our patients; if this occurs, your controlled substance prescription may be stopped. As doctors, we are under strict regulation by the law, and have guidelines we must follow in prescribing all drugs.

Rules of this Controlled Substance contract are for your comfort and to yield maximum benefit:

1. You agree that if you lose your controlled substances or prescriptions for any reason, you will not get a replacement prescription for your controlled substance.
2. You agree that your prescriptions will be given to you on your appointment day only; do not call the clinic for controlled substance medications.
3. You agree to use only one pharmacy to fill your controlled substance prescriptions.
4. You agree to show up for all your appointments here, and provide notification at least 24 hours in advance if you are unable to come to your appointment.
5. You agree that you will take the controlled substance medications exactly as prescribed and will not take more pills in one day than allowed.
6. You agree that you will obtain controlled substances only from this office. If you have an injury or develop a new pain problem between your clinic visits here (i.e. go to the Emergency Room etc.), and receive controlled substance medications you agree to notify us immediately of the medicine, the dosage, and the number of pills given.
7. You agree that you will not sell or share your controlled substances.
8. You agree to notify this office immediately if you become pregnant.
9. You agree that a drug screen may be performed from time to time without notice.
10. You agree that if any of these rules are broken, controlled substance therapy may stop.
11. You agree that if your doctor gives you a referral to see a Pain Specialist, it is your responsibility to make an appointment with that doctor/group. The Pain Specialist will manage your pain medications form that point forward. After the referral has been completed, we will not refill your pain medications in this office.
12. You agree as a part of your treatment plan to see a specialist as referred. This may include Orthopedist, Physical Medicine specialist, and or Psychiatrist. Non-compliance with these referrals can result in your dismissal from this practice.

You have read and understand all the above expectations and agree to be held to the terms in full. If these terms are not upheld, the physician may decide with proper notice to stop treating you completely.

Patient's Signature____________________________________ Date______________

Physician's Signature__________________________________ Date______________