West Jefferson
PULMONARY ASSOCIATES
Intensivist, Pulmonary & Sleep Medicine
PROUD MEMBER OF LCMC | HEALTH

Patient Information

Primary Care Physician: _____

Patient's Name: _____ Social Security #: _____

Date of Birth: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____

Business Phone: _____

Retired: ○ Yes ○ No Date of Retirement: _____

Patient's Insurance: _____ Effective Date: _____

Policy #: _____ Group #: _____

Spouse's Name: _____ Social Security #: _____

Date of Birth: _____ Email Address: _____

Spouse's Employer: _____ Occupation: _____

Employer's Address: _____

Business Phone: _____

Retired: ○ Yes ○ No Date of Retirement: _____

Any Other Health Insurance? ○ Yes ○ No

Other Insurance: _____ Insured's Name: _____

Policy #: _____ Group #: _____

Person Responsible for Payment: _____

If Worker Compensation, Who Do We Contact? _____

Nearest Relative Not Living With You: _____

Relationship: _____ Phone: _____

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER, THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS ALSO CUSTOMARY TO PAY FOR SERVICE WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I understand my signature requests that payment be made and authorizes releasing of the information necessary to pay the claim. If item 9 of the CMS 1500 claim form is completed, my signature authorizes releasing of the information to the insurer or agency shown

Signature: _____ Date: _____

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Patient History

Any question left blank will be considered a "negative response" and to not be a problem.

Name: _____ Date: _____ Referring MD: _____

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

CHECK OFF ANY LUNG OR BREATHING PROBLEMS/SYMPTOMS

- ○ Unable to catch your breath
- ○ Wheezing
- ○ High Blood Pressure
- ○ Heart Murmur
- ○ Unable to sleep laying flat or with 1 pillow
- ○ Sudden onset of difficulty breathing
- ○ Night Sweats
- ○ Fainting
- ○ Coughed up blood
- ○ Chest pains or pressure
- ○ Shortness of Breath
- ○ Dizziness
- ○ Swollen Legs
- ○ Heart Failure
- ○ Blue lips or fingernails
- ○ Leg cramps when you walk

HAVE YOU EVER HAD:

- ○ Pulmonary Stress Test
- ○ EKG
- ○ Pulmonary Function Test or Spirometry
- ○ Bronchoscopy or Lung Biopsy
- ○ Lung surgery including complete or partial removal of lung
- ○ Heart Surgery
- ○ Lung Cancer
- ○ Exposure to Tuberculosis or Had Tuberculosis

TELL US ABOUT YOUR RISK OF LUNG DISEASE.

Check if you have:

- ○ Worked around toxic chemicals or substances
- ○ Asthma
- ○ Ever smoked
- ○ Lived with someone who smokes

Do you exercise, including walking? ○ Yes ○ No

If you are a woman, have you passed menopause? ○ Yes ○ No

If so, at what age?_____

Do you take estrogen replacement? ○ Yes ○ No

Please tell us anything else about your lungs

Please list any surgeries you have had

What illnesses, if any, are you presently being treated for?

SMOKING HISTORY ○ Often ○ Occasionally ○ Never
○ Present ○ Past
Age started: _____ Age stopped: _____
How may years? _____ Packs per day: _____

ALCOHOL HISTORY ○ Often ○ Occasionally ○ Never
○ Present ○ Past
Age started: _____ Age stopped: _____
How may years?_____ Drinks per day: _____

FAMILY HISTORY

Heart Problems
○ Mother ○ Father ○ Other
If other, explain:_____

High Blood Pressure
○ Mother ○ Father ○ Other
If other, explain:_____

Diabetes
○ Mother ○ Father ○ Other
If other, explain:_____

Cancer
○ Mother ○ Father ○ Other
If other, explain:_____

Any other health problems in your family?

ALLERGIES

List any medication you are allergic to and what reaction you have

The above information is accurate and complete to the best of my knowledge.

Patient's Signature _____

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Patient Medication List

Patient's Name: _____

Allergic To: _____

MEDICATION	DATE STARTED	DATE ENDED	REASON FOR CHANGE

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Policy Regarding Family Members

At no time will this office give out private health information concerning you and your health. We will only talk to your family members with you present in the room and only at your request. If you need for any of your information to be discussed with anyone other than yourself, you may give written authorization now by signing the person whom we are allowed by you to talk to and then date and sign your name.

MY INFORMATION CAN ONLY BE DISCUSSED WITH:

Name: _____

Relationship to You: _____

Name: _____

Relationship to You: _____

Signature of Consent

Patient: _____

Date: _____

PLEASE BE ABSOLUTELY SURE THAT YOU WANT US TO DISCUSS YOUR INFORMATION WITH THE ABOVE NAMED PEOPLE.

ANY CHANGES TO THE ABOVE WILL HAVE TO BE IN WRITING AND CAN ONLY BE CHANGED BY THE PATIENT.

William Borron, MD • Judy Kang, MD • Michel LeBrun, MD
1111 Medical Center Blvd. • Suite N-504 • Marrero, LA 70072
504.349.6705 • wjmc.org/pulmonary

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Release of Information

I hereby authorize West Jefferson Pulmonary Associates to release any medical information necessary to process any insurance claims which may be in the form of copies of medical records or information conveyed via telephone or telefax to my insurance company and/or any referral provider and/or any other necessary third party and/or its agents (collectively referred to as "The Plan"). I also authorize this facility to disclose any medical information necessary for The Plan to verify services, conduct quality chart, site, or utilization reviews or investigate grievances.

This authorization also authorizes release to the Health Care Financing Administration (HCFA) or its medical claims agencies any information needed to administer Title XVII (the Medical Program) of the Social Security Act. A photographic copy of this authorization shall be as valid as the original. This authorization is valid until revoked by me in writing.

Patient's Signature

Date

William Borron, MD • Judy Kang, MD • LeBrun, MD
1111 Medical Center Blvd. • Suite N-504 • Marrero, LA 70072
504.349.6705 • wjmc.org/pulmonary

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Pharmacy Release of Information

I, hereby, authorize West Jefferson Pulmonary Associates to view my RX history prescription records provided by Community Pharmacies and Pharmacy Benefits Managers (PBM's). A photographic copy of this authorization shall be valid as the original. This authorization is valid until revoked by me in writing.

Patient's Signature

Date

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IQ Health Patient Portal

IQ Health is a webpage that is the basis for provider to patient interaction. It is the physical site that patients can access to view their medical record and send messages to their provider.

Patients will be able to view portions of their chart. They will also be able to send in medication refill request, send message, schedule or cancel appointments.

Patients will also have the ability to update their personal information, such as an address change or insurance changes.

If interested in getting access to the patient portal, please provide your email address to our receptionist. An invitation will be sent to your email by the end of the day. You will then click on the link to accept the invitation and set up an account. A request for this service must be submitted within 4 business days of your office visit.

If you have any problems setting up your account, you can contract Cerner Client Care at 877-621-8014.

Patient Name: _____

Email: _____

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:

Information about you is considered Protected Health Information and we will take reasonable efforts and make reasonable safeguards to ensure that your information is protected from unauthorized use and disclosure. We will use and disclose your Protected Health Information in accordance with the requirements of federal and state laws and regulations.

Your Privacy Rights - You Have the Right to:

- Receive a copy of our Notice of Privacy Practices.
- Request access to your Protected Health Information and/or a copy of your information.
- Request that we amend your Protected Health Information.
- Request a restriction on our use and disclosure of your Protected Health Information. We do not have to agree to the restriction.
- Request an accounting of the uses and disclosures of your Protected Health Information. You can ask for an accounting for a period up to six years.
- Request accommodations regarding our communications to you. We will accommodate your request if we can reasonably do so.
- Opt out of a facility directory and restrict information about you that we may disclose to family, friends, caregivers, and others.
- Revoke an authorization for specific use and disclosure.

Our Obligations for Privacy

- We will provide you with our Notice of Privacy Practices and get your written acknowledgment that you received it.
- We will use and disclose your Protected Health Information only for treatment, payment and health care operations (with the exceptions listed below) without getting your written authorization allowing a specific use and disclosure.

Exceptions to the Requirement for an Authorization Are:

- Disclosures required by law, for Public Health or Food and Drug Administration purposes, and for law enforcement purposes.
- Certain other disclosures may be made for health oversight activities, for deceased persons, for Workers Compensation purposes, and to the Secretary of Department of Health and Human Services.

We have a process where you can tell us your concerns and we can help resolve them.

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Acknowledgement of Receipt of Notice

Patient Name:	First Service Date:
Social Security Number:	Medical Record Number:
Print Staff Name and Title:	Name:

This acknowledges that I was given a copy of West Jefferson Pulmonary Associates' Notice of Privacy Practices. I have read the Notice or had the information in the Notice explained to me. At any time, I may request another copy of the Notice by contacting this office. The Notice of Privacy Practices explains how West Jefferson Pulmonary Associates will use and/or disclose my health information.

Patient's Signature:	*Date:*
Signature of Employee:	

FOR OFFICE USE ONLY:
If the patient does not sign this acknowledgment, give the reason and document your good faith efforts to obtain the written acknowledgment.

Signature:	*Date:*

Please fill out the forms, print them, and bring them with you to your appointment. PRINT FORM