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Welcome to our office:

As a new patient, you are being seen at the request of your physician. We will keep your physician informed as to our consultation and subsequent follow-up treatment. It is important that you continue to contact your primary care physician or specialist for medical care outside of our specialty.

Pulmonary Consultants, PLLC is a group of physicians who are board certified in Pulmonary Disease, Critical Care Medicine, and Sleep Medicine. Patients being referred will be seen at one of the following locations:

- □ Tacoma – 1708 S. Yakima Ave, Suite #300 (St. Joseph Medical Clinic Bldg)
- □ Federal Way – 34509 9th Ave South, Suite #104 (St. Francis Medical Building "B")
- □ Gig Harbor – 11511 Canterwood Blvd NW, Suite #300 (Milgard Medical Pavilion at St. Anthony)
- □ Puyallup – 2920 S. Meridian Ave, Suite #100 (Rainier Hematology/Oncology Building)

Please complete the enclosed information and bring it to your scheduled appointment. Your insurance card(s) and photo ID must be presented at the time of your visit, in order to verify your coverage, co-pay amount, and current address.

Please refrain from using after-shave, colognes, or perfumes when visiting our office. These products may cause breathing difficulties for other patients.

1708 S. Yakima Ave, Suite 300 · Tacoma, WA 98405 · Tel: (253) 572-5140
34509 9th Ave. S, Suite 104 · Federal Way, WA 98003 · Tel: 1 (877) 572-1004
11511 Canterwood Blvd. NW, Suite 300 · Gig Harbor, WA 98332 · Tel: (253) 572-5140
2920 South Meridian, Suite 100 · Puyallup, WA 98373 · Tel: (253) 572-5140

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APPOINTMENT DETAILS

Date: Time:

Location

- ○ **1708 S. Yakima Ave, Suite #300, Tacoma, WA 98405**
- ○ **11511 Canterwood Blvd NW, Suite #300, Gig Harbor, WA 98332**

Please do not smoke, use your inhalers, or consume caffeine products 4 hours prior to your breathing tests.

If you must use your rescue inhaler before this appointment please note the time and medication and inform the respiratory therapist/technician at the time of your appointment.

Call 253-572-5140 with any questions

If you must reschedule or cancel your appointment, we require you to notify us at least 1 business day in advance. If you do not provide that notice, we will consider you to have cancelled without notice, which may lead to your discharge from our practice.

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PFT Screening Questionnaire

What Provider sent you here for testing today? ____

What is the **main reason** you are having breathing testing done:

☐ Shortness of breath

☐ Cough

☐ Taking Amiodarone

☐ Other____

Have you ever had pulmonary function testing before?

☐ NO

☐ Yes Where/When____

Have you used any inhalers in the past 4 hours?

☐ NO

☐ Yes Type/When____

Patient Name____

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FEE PAYMENT POLICY

The care rendered to you at Pulmonary Consultants, PLLC will result in fees for our services. While it is our intention to assist in the billing of your insurance, the responsibility for payment is yours. There are many different insurance plans and it is impossible for us to know all the covered benefits, co-pays, and deductibles for each one. In addition, your insurance company will not guarantee payment to us.

Upon arrival, you will be asked for a photo ID and current health insurance card(s).

Contracted Insurances:

We are contracted with most of the large insurance plans. Co-pays must be paid at the time of service, as required by your own plan. Patient portions due after your insurance has determined benefits are expected to be paid within 30 days.

If your insurance coverage is through a **managed care plan** a written primary care physician referral is required before your appointment and all subsequent appointments and for any tests that are ordered. We cannot be responsible for obtaining these referrals. Your own involvement in this process is required and appreciated.

Medicare

Our physicians are participating providers with Medicare. Your supplement will be billed after Medicare pays their portion. We will submit to only **one** supplemental policy per each individual account. Patient portions are expected to be paid within 30 days.

Medicaid

Patients with Medicaid coverage are required to present a current ProviderOne card. If you are in the status of applying for Medicaid, you will be required to provide a case manager's name and phone number for verification. Payment will be required until approval has been granted. Upon approval of Medicaid coverage and payment, we will reimburse you for any payments that we received, according to state guidelines.

Patients without insurance coverage:

Payment at the time of service is required. We offer a 40% discount to patients who pay by cash/check for their services, or 35% if paid by credit card in full at the time of their visit.

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Notice of Privacy Practices Acknowledgment

Pulmonary Consultants has a responsibility to protect the privacy of your health care information and to provide a Notice of Privacy Practices that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have questions, concerns, or complaints.

We may change the Notice of Privacy Practices at any time, and you may contact Susan Delaurier at 253-572-5140 to obtain a current copy of the Notice of Privacy Practices or to ask questions.

By my signature below, I agree that I have received the Notice of Privacy Practices of Pulmonary Consultants, PLLC.

____

Printed name of patient

____

Patient or legally authorized individual's signature Date Time

____

Printed name if signed on behalf of the patient Date Time

In addition to my health care professionals, I authorize Pulmonary Consultants to disclose my personal health information to:

Name (please print legibly)	**Relationship to Patient**

For Office Use Only

Office staff complete below:

I have attempted to obtain the patient's signature on this form, but was not able to obtain it for the reason(s) listed below:

Date: ____________________ Staff member initials: ______________________

Reasons:

____

PATIENT INFORMATION

Name: ______________________________
(Last) (First) (Middle Initial)

Address: ______________________________

Email: ______________________________

Phone: ( ) -

Mobile: ( ) -

SSN: - -

Birthdate: / /

Gender: ☐ Female ☐ Male

Language: ______________________________

Marital Status: ______________________________

Race:
☐ American Indian/AK Native ☐ Asian
☐ Black/African American ☐ Hawaiian/Pacific Islander
☐ White/Caucasian ☐ Decline to answer

Primary Care Physician: ______________________________

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino
☐ Decline to answer

Phone: ( ) -

Primary Insurance: ______________________________

ID #: ______________ Group #: ______________

Secondary (Supplemental)
Insurance: ______________________________

ID #: ______________ Group #: ______________

Other Party Insurance: ______________________________

ID #: ______________ Group #: ______________

Name of
Insured: ______________ SSN# - -

Birthdate: / / Employer:

Emergency Contact: ______________________________

Relationship: ______________ Phone: ( ) -

Alternate Contact: ______________________________

Relationship: Phone: ( ) -

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any services rendered. I attest that this information is true and accurate to the best of my knowledge. I will notify this office of any changes in my health status or the above information. I also authorize payment of medical benefits to be paid directly to the physician and I authorize release of medical records to my insurance carrier(s) and my referring physician. I further permit a copy of this authorization to be used in place of the original.

Signature: Date: / /