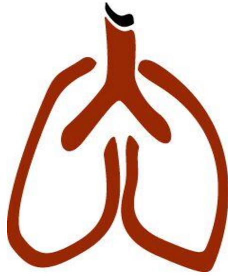


3121 CITRUS TOWER BLVD.
CLERMONT, FL 34711
352-404-5968

2762 DORA AVENUE
TAVARES, FL 32778
352-508-1727

PATIENT DEMOGRAPHICS SHEET

NAME: ________________________ **DOB**: ___________ **MARITAL STATUS**: _________ M ___ F ___

PRIMARY ADDRESS: ____
(Street) (City) (State) (Zip Code)

SECONDARY ADDRESS: ____
(mailing address) P.O. Box

PHONE NUMBER: __________________________ **CELL NUMBER**: ________________________

PATIENT'S EMPLOYER: __________________________________ **WORK PHONE**: _________________

SPOUSE'S NAME: _______________________ PHONE NUMBER: _______________________
PERSON RESPONSIBLE FOR BILL (IF OTHER THAN ABOVE): __________________ PH NUMBER: ________________

ADDRESS: ____
(Street) (City) (State) (Zip Code)

NEAREST RELATIVE: ______________________________ **PHONE NUMBER**: ___________________

Were you referred by another physician? If so whom? __________________________

Who is your Primary Care Physician? _______________________ Phone number: __________________

REASON FOR VISIT TODAY:
____
____

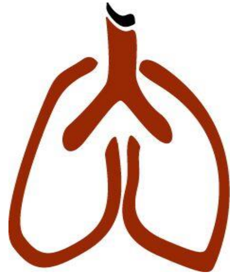
PRIMARY INSURANCE COMPANY: ____

SECONDARY INSURANCE COMPANY: ____

SELF PAY: ___________________

Authorization to Release Information and to Pay Benefits:
I hereby authorize any physician who has treated or attended me or my dependent to furnish any medical information requested. In consideration of services rendered, I hereby transfer and assign to Pulmonary Critical Care & Sleep Specialist of Lake County, who has treated me or my dependent, any benefits of my insurance that I may have. A photocopy of this authorization shall be considered as effective and valid as the original.

Patient's Social Security Number: ____________________ Email: ____________________________________
Signature: __________________________________ Date: ________________________________



PULMONARY & SLEEP
SPECIALISTS

HIPAA POLICY AND PRACTICES

This form is used to confirm the direction of an individual that we use or disclose protected health information for a purpose.

SECTION A: The individual (or the individual's Personal Representative) confirming the authorization.
Name: _____________________, yes you may leave a message on my answering machine or cell phone confirming appointments or other information.

SECTION B: Please list organizations we may disclose to: Primary Care Physician, Specialists Hospitals and other facilities.

__________________________________ ____________________________________

__________________________________ ____________________________________

SECTION C: Please list individuals we may disclose to: Family members, neighbors, close friends, etc.

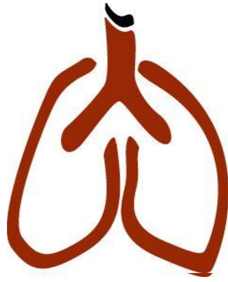
_________________________________ _____________________________________

__________________________________ _____________________________________

SECTION D: Signatures for Acknowledgement and confirmation

I, ______________________, have had full opportunity to read and consider the contents of this authorization, and confirm that the contents are consistent with my direction to you. I understand that, by signing this form, I am confirming my authorization that you may use and/or disclose to the persons and/or organizations named in this form the protected health information described in this form.

Signature: ____________________________ Date: _____________________________



PULMONARY & SLEEP
SPECIALISTS

I,___________________________am authorizing and hereby give consent for the medical staff of Pulmonary, Critical Care and Sleep Specialist of Lake county to examine and render care

To: _______________________________. This consent form will remain in effect until revoked in writing.

Signature: ______________________________ Date: __________________________

Upon check-in, we will collect your deductible, co-pay, uncovered services, or percent of your responsibility. Please be prepared to pay **BEFORE** you are seen by the doctor.

Please be thorough with your insurance information if you expect us to file for you. Bring your card with you and your driver's license WITHOUT THESE WE WILL BE UNABLE TO SEE YOU!

As a courtesy, we will file your insurance. It is YOUR responsibility to make sure they are paying as they should.

If your insurance denies payment on your account, you will be asked to pay by check, cash, or charge. If you do not pay in a timely fashion, your account may be subject to a monthly finance charge and turned over to collections. If you do not agree with the denial it is YOUR responsibility to pay services and take it up to your insurance company.

TO ALL MEDICARE PATIENTS: We will continue to participate as Medicare providers. We will bill your Medicare as well as secondary insurance, bit if payment is not received by your secondary insurance within 45 days you will be notified and must pay our office the balance due. You must then contact your secondary insurance to pay you for the balance you paid our office.

SELF PAY PATIENTS: This category includes those people with no insurance and patients who have and indemnity plan and wish to file their own insurance. Payment for medical services is expected on the day the services are rendered. We accept Visa, MasterCard, checks and money orders. If you will not be able to pay for our services in full you must contact the office to make a payment before coming to see the doctor.

If your insurance is out of state (except PPO insurance), you must pay for your visit at the time of service. 95% out of state insurance companies pay the patient and will not pay us directly (even if they tell you they will).

If you have any questions regarding this policy, please ask prior to being seen by the physician.

____

(Print Name)

____

Print Guarantor – (if different from patient name)

____ Date: ______________

Signature of Patient or Guardian/Parent

Dear Patient,

Due to the increased number of NO CALL NO SHOW to our office, we are now implementing a charge for missed appointments. We are asking EVERYONE to give a 24-hour notice when CANCELING or RESCHEDULING appointments.

You may not be aware that we are responsible for the care of many different diagnosis and some patients with very critical needs. The office staff works diligently on setting up the appropriate appointments in a timely manner per the needs of each patient. Some of these appointments are set up with a TIME line in which diagnostic testing (example-PFT, Overnight Oximetry, 6 Minute Walk Study, Home Sleep Study, in office Sleep Study) and the face to face with the Dr. or ARNP is needed per insurance guidelines. We offer many Diagnostic studies in our office to best serve our customers without delay.

We understand emergencies. Please note, Hospital stays are an emergency. Care accidents ae an emergency. We also understand delay due to weather. Please call and inform us of your current circumstance and we will try to provide you with the best choice in that current time frame. We will be rescheduling to later or another date due to the Doctors busy schedule.

List of Charges

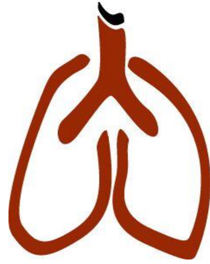
- All Physician appointments $ 50.00
- Pulmonary Function Test $ 50.00
- Home Sleep Study (HST) $ 75.00
- In office Sleep Study $150.00

By signing below, you acknowledge, understand and will adhere to our policy to help best serve ALL our patient’s needs.

Print Patient Name: _________________________ Email: ____________________________

Patient Signature: _____________________________ Date: __________________________

Thank you for choosing us to serve your medical needs!



PULMONARY & SLEEP
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Ahmad Jalloul, MD

3121 Citrus Tower Blvd
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Client's Name: ____________________________________ **DOB:** ___________________

Florida law requires that information in medical records be held in strict confidence and not be released without your written authorizations. The authorizations you sign on this page will remain in effect until you request in writing that your authorization be withdrawn, which you may do at any time. You have a right to receive a copy of your authorization upon your request.

I, ___________________________________ authorize ___________________________________

(Name of patient/legal representative) (Agency/Individual in possession of record)

to release (**initial,** by the following, any or all that apply):

______ A. The general medical record created at the medical facility
______ B. The following information from the medical or case management record:
____
______ C. Records obtain from the following providers:
____
______ D. STD Records
______ E. TB Records
______ F. HIV/AIDS Records
______ G. Drug/Alcohol treatment records
______ H. Psychiatric/Psychological information
______ I. Adult and child abuse information

For the purpose of: ____

Signature of Patient/Legal Guardian: ______________________________ Date: _____________

Witness: ___________________________________ ___________________________________

(Legal guardian's relationship to patient)

Dr.Name: _____________________________ Phone Number: ____________________________

Address: _____________________________ Fax Number: ____________________________

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Medication List

(DO NOT fill this section out if you have handed the staff your medication list)

Patient Name: ______________________________ **DOB:** ____________________

Medication	Strength	Quantity	Frequency