Florida Chest Care
Pulmonary & Sleep Clinic

Rana Kanaan, MD
Medical Director
370 34th Street, S.
St. Petersburg, FL 33711

Phone 727.353.3530
Fax 727.353.3313
www.FloridaChestCare.com

"Breathing better shouldn't be a luxury."

PLEASE PRINT- PATIENT INFORMATION

Last Name_____ First Name_____Date of Birth_____

Social Security #_____Sex (Please Circle) M F Race_____Marital Status _____

Street Address_____City_____ State_____ Zip_____

Home Phone_____ Cell Phone _____ Work Phone _____

Occupation_____ Employer_____ Email _____

Emergency Contact (Name/ Relationship) _____ Phone #_____

Hispanic, Latino or Spanish Origin? Yes_____ No_____ **DME Company:** _____

PRIMARY CARE PHYSICIAN_____TELEPHONE_____

PHARMACY_____ PHONE_____

LOCATION _____ FAX _____

INSURANCE INFORMATION:

Insurance Carrier: _____ Insurance Policy#: _____

WHO IS THE SUBSCRIBER OF YOUR INSURANCE? _____

If (Husband, Wife, Parent, etc) is Subscriber of insurance we need their:

Name: _____ SS#: _____ DOB: _____

INSURANCE INFORMATION – **SECONDARY**

Insurance Carrier: _____ Insurance Policy#: _____

Insurance Information of Subscriber ***IF NOT*** SELF INSURED (Husband, Wife, Parent, etc…)

Name: _____ SS#: _____ DOB: _____

ALL PATIENTS – LIFETIME AUTHORIZATION

I HEREBY AUTHORIZE "FLORIDA CHEST CARE" TO REQUEST MY MEDICAL RECORDS FROM ALL PHYSICIAN'S OR MEDICAL FACILITY THEY DEEM NECESSARY FOR MY CONTINUITY OF CARE.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

INSURANCE AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF PAYMENTS:
NON-MEDICARE PATIENTS & MEDICARE PATIENTS WITH A SECONDARY INSURANCE

I HERBY AUTHORIZE "FLORIDA CHEST CARE" TO RELEASE ANY INFORMATION TO MY INSURANCE COMPANY(S), THAT IS NECESSARY TO PROCESS MY MEDICAL CLAIMS. I FURTHER AUTHORIZE ALL INSURANCE PAYMENTS BE MADE DIRECTLY TO "FLORIDA CHEST CARE". I UNDERSTAND THAT I WILL BE HELD FINANCIALLY RESPONSIBLE FOR ANY CHARGES THAT ARE NOT PAID BY THE INSURANCE COMPANY.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

MEDICARE PATIENTS – LIFETIME AUTHORIZATION

I HERBY AUTHORIZE "FLORIDA CHEST CARE" TO RELEASE ANY INFORMATION THAT IS NECESSARY TO PROCESS MY MEDICAL CLAIMS. I FURTHER AUTHORIZE ALL MEDICARE PAYMENTS BE MADE DIRECTLY TO "FLORIDA CHEST CARE". I UNDERSTAND THAT I WILL BE HELD FINACIALLY RESPONSIBLE FOR MY DEDUCTIBLE AND ANY BALANCE NOT PAID BY MY INSURACNE CARRIER.

PATIENT/GUARDIAN SIGNATURE _____ DATE_____

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MEDICAL APPOINTMENT CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to FLORIDA CHEST CARE. When you schedule an appointment with Florida Chest Care we set aside enough time to provide you with the highest quality care. Should you need to cancel or rescheduled an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective June 16, 2021 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a No Show and may be charged a **$25.00 fee**.
- Any established patient who fails to show or cancels/reschedules an appointment without a 24 hour notice a **second** time may be charged a **$50.00 fee**.
- If a **third** No Show or cancellation/reschedule with no 24-hour notice occurs, the patient may be **dismissed** from Florida Chest Care.
- Any new patient who fails to show for their initial visit may not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit**.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our Office Manager so she may be able to waive the No Show fee. You may contact FLORIDA CHEST CARE 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Thursday, or a weekend, you may leave a message.

FLORIDA CHEST CARE (727) 353-3530

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS, PER HIPAA REGULATIONS

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the health professionals who contribute to my care, such as referrals,
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually rendered
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided with a "***Notice of Patient Privacy Practices***" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the *" Notice"* Prior to acknowledge this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

Please Print

RESTRICTIONS:
Please tell us with whom we may NOT discuss your protected health information: [I would NOT like my information shared with the following family or friends.]

_____

_____

PERMISSIONS:
Please tell us with whom we may discuss your protected health information: [I would like to share my information with the following family and friends.]

_____

_____

May we leave a message at your **home/cell** using doctor's/practice name: Yes [ ] No [ ]
May we leave a message at your **work** using doctor's/practice name: Yes [ ] No [ ]
(Messages will be of a non-sensitive nature, such as, appointment reminders.)

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

Signing below confirms that I completely understand and accept the information of this consent.

_____
Patient Name (print)

_____ _____
Patient/ Guardian Signature **Date**

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A MESSAGE TO OUR PATIENTS

Dear Patient,

It is necessary from time to time to verify critical billing data. This can include copies of insurance cards to ensure accurate addresses and often may include social security numbers and dates of birth for the insured party. **IF YOUR INSURANCE REQUIRES A REFERRAL OR AUTHORIZATION, IT IS YOUR RESPONSIBILITY TO OBTAIN OR PROVIDE US THIS INFORMATION.**

Florida Chest Care understands and supports the protection of this information under HIPAA guidelines. Failure to provide the necessary information may result in the need to bill you directly.

As it continues to be our goal to provide you with quality medical care, including the filing of your claims, we will anticipate with appreciation your full cooperation. **Your signature and date below indicates you have read this message and understand fully the policy of FLORIDA CHEST CARE.**

_____ _____
Patient Signature Date

_____
Patient Name Printed