Mukesh Patel, MD FCCP

Diplomate American Board of Pulmonary, Critical Care and Internal Medicine

PATIENT INTRODUCTION

DATE ______________________ PATIENT ____ AGE _____________

BIRTH DATE: ____________________________ SEX: ________________________ SOCIAL SECURITY # _______________________________________

PHONE # ____________________________________ CELL#________________________________ EMAIL:_____________________________________

MARTIAL STATUS: __________ RACE: ______________ ETHNICITY [HISPANIC OR NON-HISPANIC] : _______________________________________

FLORIDA ADDRESS: ____

OUT OF STATE ADDRESS: ____

OUT OF STATE PHONE# ____ EMAIL ADDRESS:____

MAY WE LEAVE A MESSAGE ON YOUR ANSWERING MACHINE: _____________________ PREFERRED LANGUAGE:__________________________

PRIMARY PHYSICIAN: ____PHONE:____

WHOM MAY WE THANK FOR REFERRING YOU :____ DO YOU HAVE A LIVING WILL? ____________

EMPLOYMENT INFORMATION

EMPLOYMENT STATUS: _______________________________ EMPLOYER NAME: ____

WORK# ______________________________________ EXT __________ OCCUPATION: ____

ADDRESS ____

MAY WE CONTACT YOU AT YOUR WORK NUMBER LISTED ABOVE: _______________________

INSURED INFORMATION [IF OTHER THAN PATIENT]

INSURED:____ RELATIONSHIP TO PATIENT ___________________________

DATE OF BIRTH___________________________ SOCIAL SECURITY# _________________________________ HOME PHONE ____________________

HOME ADDRESS ____

EMPLOYER NAME: ____ WORK#____

DESIGNATED EMERGENCY CONTACTS

Please list the family members or significant others, if any, whom we may inform about your medical condition, in case of an emergency: I authorize discussion of my General Medical Condition and Diagnosis (including treatment, payment and healthcare operations) with:

NAME ____ RELATIONSHIP_____________________ PHONE _______________________________

NAME ____ RELATIONSHIP_____________________ PHONE _______________________________

OVER ➔

Mukesh Patel, MD FCCP

Diplomate American Board of Pulmonary, Critical Care and Internal Medicine

PERMISSION FOR TREATMENT

I hereby voluntarily consent to medical care/diagnostic treatment and or minor surgical treatment by Mukesh Patel, MD deemed advisable and necessary in the diagnosis and treatment of my condition.

AUTHORIZATION AND ASSIGNMENT

I hereby authorize payment to be made to Mukesh Patel, MD, PA and benefits otherwise payable to me.
As a courtesy to our patients, our office will file all insurances to the best of our efforts. In order for us to continue this courtesy, we must receive payment in full within 60 days from the service date or when the balance becomes patient responsibility. We require payment at time of service when the insurance assigns copays, coinsurances, deductibles or pays the patient directly.

I understand and agree that (regardless of my insurance status); I am ultimately responsible for the balance due on my account. Furthermore, it is my understanding that if any portion of my balance remains unpaid over 60 days from the date of service, a **late charge of 1.5% may be assessed monthly** against the outstanding balance on my account. If my account remains unpaid, I will also be responsible for any and all collection costs and attorneys' fees incurred to collect this debt. There will be a **returned checks charge of $30.00** for returned checks.

I agree to give at least ***24 hours notice*** if I am unable to keep my appointment. I understand that there ***may be a charge*** for cancelled or rescheduled appointments in less than 24 hours of appointment time. A *No Show* charge of **$25.00** will be billed for more than ***2 consecutive missed appointments.***

Please be advised that you will receive a separate bill for any outside diagnostic and/or laboratory tests.

RELEASE OF INFORMATION

I hereby authorize any information about me to be released to determine the benefits for services provided and to process any medical claims.

PRIVACY NOTICE

Signature below is an acknowledgment that I have received the Notice of our privacy practices as required by HIPPA.

I have read and completed each of the above sections. I have presented my current insurance card(s) to be scanned and attached to my file. I certify that all information is true and correct to the best of my knowledge. It is my responsibility to notify this office of any and all changes in my health status, insurance or any of the information given above.

Signature: ____ **Date:** _________________________

Mukesh Patel, MD FCCP

Diplomate American Board of Pulmonary, Critical Care and Internal Medicine

PRE-REGISTRATION & INSURANCE VERIFICATION

DATE: ____/_____/_____ STAFF: _________________

APPT MADE BY(PT/RF DR): ______________ STAFF:____________ APPT GIVEN ___/___/_____@__________

PATIENT NAME: _______________________________ DOB: ____/____/_____ SS#: _____/____/________

ADDRESS: ______________________________________ CITY: _______________ STATE:_____ ZIP:_________

EMAIL: ____

HOME PHONE: _____________________ ALT PHONE:_________________________ LIVING WILL: [] YES []NO

DX: ____ FU HOSP: ______ HOSPITAL: _______________________

LABS <6 MONTHS: ______ WHERE: _____________________ PT TO BRING _______ RF DR TO FAX _______

PFT <6 MONTHS: ______ WHERE: _____________________ PT TO BRING ______ RF DR TO FAX _______

CHEST <1 YEAR: XRAY/CT _______ WHERE: _________________ PT TO BRING _____ NEED TO ORDER ____

REF DR: _____________ PHONE: ________________ PRIM DR: _______________ PHONE: ___________________

*REQUEST LAST OFFICE NOTES, REPORTS RELATED TO CONDITION & AUTH TO BE FAXED TO OFFICE.
*REMIND PT TO BRING ACTUAL MEDICATION BOTTLES, PHOTO ID, INSURANCE CARDS & LIVING WILL.

PRIMARY INSURANCE

INS: _____________________ PH: ______________ ID#________________________GRP# ____________________

POLICY HOLDER: ______________ RELATION: ________ DOB _____/_____/______ SSN: _____/_____/______

EFF: ___/___/____ DED$_______ MET$______ COPAY$______ COINS% ______ OOP$ ________ MET$ _______

PFT COV _____ AUTH REQ _____ COPAY$ _______ COINS % _______ AUTH#_______________________

CLAIMS ADDRESS: ____

REFERENCE# _________________________________ VERIFIED _____/_____/_____ BY ____________________

SECONDARY INSURANCE

INS: _____________________ PH: ______________ ID#________________________GRP# ____________________

POLICY HOLDER: _________________ RELATION: __________ DOB ____/____/_____ SSN: _____/_____/______

EFF : ____/____/____ MG: _____ COVERS PRIMARY INS DED: ______ 2NDRY DED$_______ MET$______

COPAY$________ COINS% _________ OOP$ _________ MET$ ________ ROUTINE OV COV ____________

PFT COV _______ AUTH REQ _______ COPAY$ ________ COINS % ________________________________

CLAIMS ADDRESS: ____

REFERENCE# ______________________________ VERIFIED _____/_____/______ BY _____________________

Mukesh Patel, MD FCCP

Diplomate American Board of Pulmonary, Critical Care and Internal Medicine

PATIENT HISTORY

NAME: ____ **DOCTOR:** ____
DATE OF BIRTH: ___________________ **PHONE:** (____) ___________________ **DATE:** ___________________
LOCAL PHARMACY: ____**PHONE:** ____________________
MAIL ORDER PHARMACY: ____**PHONE:** ____________________
LIST OF ALLERGIES:____
CAN WE ACCESS YOUR Rx HISTORY: ________

PAST HISTORY:

____ASTHMA
____EMPHYSEMA
____CHR BRONCHITIS
____ HAY FEVER
____ SINUS INFECTION
____ LUNG CANCER
____HYPERTENSION
____ANGINA

____PACEMAKER
____DIABETES
____THYROID PROBLEM
____KIDNEY PROBLEM
____LIVER PROBLEM
____PEPTIC ULCER
____GOUT

FAMILY HISTORY:

____CANCER
____DIABETES
____HYPERTENSION
____HEART ATTACK
____ASTHMA
____EMPHYSEMA

SMOKING:

____NEVER
____QUIT_____PACKS/DAY_____YRS
____YES _____PACKS/DAY _____YRS

ALCOHOL:
____SOCIAL
____QUIT ____YRS
____NEVER

REVIEW OF SYSTEMS

PLEASE CHECK ("X") IF YOU HAVE HAD ANY OF THE FOLLOWING SYMPTOMS OR CONDITIONS IN THE PAST YEAR.

1. HEAD AND NECK
____FREQUENT HEADACHES
____MIGRAINE
____INJURY
____NECK PAINS
____NECK LUMPS

2. EYES
____RECENT CHANGE IN VISION

3. EARS
____HEARING DIFFICULTY
____RINGING/BUZZING
____EARACHES
____DISCHARGE FROM EARS
____MOTION SICKNESS

4. NOSE AND THROAT (X ONLY IF FREQUENT)
____CONGESTED NOSE
____RUNNY NOSE
____NOSE BLEEDS
____SORE THROAT
____TONSILLITIS
____HOARSE VOICE

5. MOUTH
____SORES
____SORENESS
____DENTAL PROBLEMS
____CHANGES IN TASTE

6. RESPIRATORY
____SHORT OF BREATH
____WHEEZING
____CHRONIC COUGH
____COUGH UP PHLEGM
____COUGH UP BLOOD
____FREQUENT CHEST COLDS
____PAIN ON DEEP BREATH

7. CARDIOVASCULAR
____IRREGULAR HEARTBEAT
____RACING HEART
____CHEST PAIN
____SHORT OF BREATH LYING DOWN
____SWOLLEN FEET OR ANKLES
____LEG CRAMPS
____COLD HANDS/FEET

8. GASTROINTESTINAL
____APPETITE LOSS
____TROUBLE SWALLOWING
____NAUSEA/VOMITING
____VOMIT BLOOD
____HEARTBURN
____RECENT CHANGE IN BOWEL HABITS
____ABDOMINAL PAIN
____EXCESS "BELCHING"
____BLACK STOOLS
____RECTAL PAIN
____RECTAL BLEEDING
____BLOATING

9. URINARY
____FREQUENT URINATION
____URGENCY
____BURNING ON URINATION
____BROWN/BLACK/BLOODY URINE
____PASSAGE OF STONES
____DRIBBLING
____BED WETTING

10. GENITAL
A. FEMALE
____LUMPS IN BREAST
____ABNORMAL PAP SMEAR
____MENSTRUAL TROUBLE
____POST-MENOPAUSAL BLEEDING
____VAGINAL DISCHARGE
____NO. OF PREGNANCIES
____NO. OF PREMATURE BIRTHS
____NO.OF STILL BIRTHS
____NO. OF MISCARRIAGES OR ABORTIONS
____CESAREANS
____NO. OF LIVE CHILDREN
____IUD
____BIRTH CONTROL PILL
____OTHER CONTRACEPTION
____HORMONES MENOPAUSE

B. MALE
____PROSTATE TROUBLE
____BURNING/DISCHARGE
____PAINFUL TESTICLES
____WEAK URINE STREAM
____ABNORMAL LUMPS IN SCROTUM

11. MUSCULOSKELETAL
____FRACTURES
____ACHING MUSCLES/JOINTS
____MUSCLE WEAKNESS
____HANDICAPPED
____SWOLLEN JOINTS

12. SKIN
____ITCHING
____SCALING
____RASHES
____BRUISE OR BLEED EASILY
____CHANGE IN MOLES

13. ENDOCRINE
____WEIGHT CHANGE
____ALWAYS HUNGRY
____IMPOTENCE
____STERILITY
____TENDENCY TO FEEL HOT
____TENDENCY TO FEEL COLD
____DRYNESS OF SKIN/HAIR
____DRINK A LOT OF FLUIDS
____CHANGE OF SKIN PIGMENTATION
____CHANGE IN SIZE OF SHOE/HAT/GLOVES SINCE ADULT

14. NERVOUS SYSTEM
____ TROUBLE SMELLING
____WEAKNESS
____SHAKING
____SPEECH DIFFICULTY
____CONVULSION
____FAINTNESS
____CHANGE IN HANDWRITING

15. MOOD
____NERVOUS WITH STRANGERS
____TROUBLE WITH DECISIONS
____TROUBLE WITH MEMORY
____TROUBLE SLEEPING
____TROUBLE RELAXING
____DEPRESSION
____SHY
____STRANGE DREAMS/THOUGHTS
____WORRY A LOT
____LOSE TEMPER
____WORK/FAMILY PROBLEMS
____SEXUAL DIFFICULTY
____CONSIDERED SUICIDE
____DESIRE PSYCHIATRIC HELP

Mukesh Patel, MD, FCCP

Diplomate American Board of Pulmonary, Critical Care and Internal Medicine

13740 Office Park Ct. Suite A
Hudson, FL 34667 – 7145
(727) 863 - 7487

4738 Grand Blvd. Suite H
New Port Richey, FL 34652 – 5170
(727) 848 -0994

PATIENT MEDICATION HISTORY

NAME: ____ DATE OF BIRTH: ________________________

ALLERGIES: ____

____

MEDICATIONS

NAME OF MEDICATIONS	DOSE / STRENGTH	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

NON-PRESCRIPTION MEDICATIONS

1.		
2.		
3.		
4.		
5.		
6.		
7.		

When was your last Pneumonia vaccination? Date: _____________________ [ ] Unknown

When was your last Flu vaccination? Date: ______________________ [ ] Unknown

Patient Signature: ____ Date: _____________________

Mukesh Patel, MD, FCCP

Diplomate American Board of Pulmonary, Critical Care and Internal Medicine

13740 Office Park Ct. Suite A
Hudson, FL 34667 – 7145
(727) 863 - 7487

4738 Grand Blvd. Suite H
New Port Richey, FL 34652 – 5170
(727) 848 -0994

OUR FINANCIAL POLICY:

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. We believe that clear understanding of our financial policy is important to our professional relationship.

Any changes in insurance coverage, address, and telephone or other demographics must be given to the front desk representative when you check in for your appointment.

To setup your account with our practice please provide the following:

A> Complete the Patient Registration Form

1. Complete Demographic Information
2. Current Primary and Secondary Insurance information
3. Complete Insured Information if Insured is other than the Patient
4. Complete Name and Phone number of the Designated Relative(s)
5. Read and Sign the Patient Consent

B> Complete the Patient Medical History Form

C> Be prepared to present your Current Insurance Cards and your ID card at Check-In

D> Be prepared to pay your Copays, Coinsurance, or Deductibles at Check-In

E> You will be required to pay any outstanding patient balance on your account at Check-In

OUR COLLECTION POLICY:

Account balances must be paid in full within 30 days from the statement date. If any portion of the account balance remains unpaid over 60 days from the statement date, a late charge of 1.5% monthly may be assessed. If the account remains unpaid, patient will also be responsible for any and all collection costs and attorneys' fees incurred to collect this debt.

Payment plans are available for those who are experiencing the financial hardship but the arrangements must be made in advance with our Practice Billing Department. We accept cash, personal checks, and credit cards (Visa, MasterCard). **There will be a returned check charge of $30.00 for a returned check.**

Mukesh Patel, MD, FCCP

Diplomate American Board of Pulmonary, Critical Care and Internal Medicine

13740 Office Park Ct. Suite A
Hudson, FL 34667 – 7145
(727) 863 - 7487

4738 Grand Blvd. Suite H
New Port Richey, FL 34652 – 5170
(727) 848 -0994

OUR INSURANCE POLICY:

Insurance is a contract between you and your insurance company.

Our office will file all insurances to the best of our efforts. We will not become involved in disputes with your insurance company regarding your deductibles, non-covered/covered expenses, co-insurance or "reasonable and customary" charges other than to supply factual information as necessary. Patient is ultimately responsible for the balance due on his or her account.

Medicare:

We are a participating provider with Medicare. We will also file with your secondary or supplementary policy. Please make sure that you provide our Medical Receptionist with your Medicare and supplementary cards at Check-In.

HMO Plans:

We work with your PCP (Primary care Provider) to acquire the authorization required to treat you. In case when we are not able to obtain the authorization in time for your appointment, we may reschedule your appointment. We encourage you to contact your PCP to request the authorization or the referral for your upcoming appointment to avoid any delay. Most HMO plans require patient to pay copay at the time of visit. We will require you to pay at Check-In.

Other Insurance Plans:

As a courtesy to our patients we file with your insurance. If you have not met your annual deductible or if you are required to pay coinsurance, you will be asked to pay at Check-In.

Self-pay:

Our practice does not accept patients without insurance.

Notice of Privacy Practices for Protected Health Information (HIPAA)

Mukesh R Patel MD, PA

13740 Office Park Court, Suite A
Hudson, FL 34667
(727) 863-7487

4738 Grand BLVD, Suite H
New Port Richey, FL 34652
(727) 848-0994

"This Notice Describes How Medical Information About You May Be Used and Disclosed & How You May Get Access To This Information". Please Review It Carefully!

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations for other purposes that are permitted or required by law. This notice also describes your rights to access and control your protected health information. "Protected Health Information: is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services."

We Safeguard Information about Your Health and Person:

We collect information from you and store it in a medical record chart as well as on a computer. Charts are stored in a secure area and available only to designated staff and only for designated reasons. Housekeeping, maintenance, and other non-office personnel should have no access to the charts and have signed *Business Associate Agreement*. Service technicians may have access to the computer, but only for service of computer operations and also sign a *Business Associate Agreement.*

Typical Uses and Disclosures of Medical Information/Protected Health Information:

Uses: Your protected health information may be used and disclosed by your physician and our office staff for treatment and care, payment to insurers, and for healthcare operations. Outside our office, we restrict the disclosure to those people, entities and agencies for which you authorize disclosure such as other healthcare providers (doctors, nurses, and extended care facilities), insurance companies, billing agencies, hospitals and surgery sites, or those agencies and entities for whom legal and administrative requirements demand disclosure such as:

1] Required by Law [Secretary of the Department of Health and Human Services .. section 164.500]
2] Public Health Issues (abuse or neglect, violence, problems with products & product recalls)
3] Health Oversight Activities (audits, investigations & inspections)
4] Judicial and Administrative Proceedings (court order)
5] Law Enforcement Requests for Criminal Activity
6] Deceased Person Information (corners, medical examiners & funeral directors)
7] Organ and Tissue Donation
8] Research, provided authorization is IRB-approved or privacy board-approved
9] Disaster Relief, Emergencies or to Avert Serious Threat to Health or Safety
10] Specialized Government Function and National Security (military, inmates)
11] Worker's compensation

Treatment: We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. This includes the coordination or management of your health care with third parties. *For example*:

1] We would disclose your protected health information, as necessary, to an oxygen supply company that provides care to you.
2] Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services (obtaining approval for hospital outpatient procedure).

Healthcare Operations: We may use or disclose, as needed, your Protected Health Information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of new staff, licensing, and conducting or arrangement for other business activities. *For example*:
1] We may use a sign-in sheet at the registration desk where you will be asked to sign your name.
2] We may also call you by name in the waiting room when your physician is ready to see you.
3] We may contact you as a reminder about follow-up appointments.

Other Permitted and Required Uses and Disclosures: Will be made only with your consent, authorization or opportunity to object unless required by law.

You May Revoke this Authorization: We will not use or disclose your medical information for any purpose not listed without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

You Have the Right To: Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in a reasonable anticipation of, or use in: a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
1] Inspect and copy medical information from your chart. You may submit a written request to our office and pay the copy fee and receive a copy of your record. We must respond within 30 days if the record is readily available and within 60 days if it is not readily available. You may also get an electronic copy if we have one available.
2] Amend medical information in your chart. You may identify inaccurate or incomplete information in your chart. You can do this with a written request to amend your chart directed to our office. We must respond within 60 days.
3] Receive an accounting of any disclosures made from your record over the last seven years, starting April 14, 2003. You can get this with a written request directed to our office. We must respond within 60 days.
4] Request restrictions as the amount of medical information we disclose. This is limited as noted above, and your request may not supercede the typical disclosures noted above. You may revoke or restrict the consent. You may also request that any part of the protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. You may ask us not to use or disclose any part of your self-pay services. Your request must state the specific restriction request and to whom you want the restriction to apply. ***Note: Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted.***
5] Request confidential communications. All communications in our office are confidential.
. 6] Receive a copy of this notice by printing it or with a written request directed to this office, and a copy of this notice will be given with all new patient packets.

Our Responsibilities under HIPPA: We are required by Law to maintain the privacy of your personal health information, and to provide you notice of our legal duties and privacy practices and adhere to this notice. We reserve the right to make changes to this notice. We will post a notice that this HIPPA notice has been changed, the effective date of the change, and copies will be made available. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number (727) 863-7487. You can submit a complaint about our privacy policy or its execution either verbally or in writing to our Privacy officer at our office. We will not retaliate against you for filing a complaint.

Effective Date of Notice: April 14, 2003 Amended Date: June 15, 2012

Mukesh Patel, MD, FCCP

Diplomate American Board of Pulmonary, Critical Care and Internal Medicine

13740 Office Park Ct. Suite A
Hudson, FL 34667 – 7145
(727) 863 - 7487

4738 Grand Blvd. Suite H
New Port Richey, FL 34652 – 5170
(727) 848 -0994

DISCLAIMER

Do not use the Website if you do not agree to the following terms and conditions.

www.mukeshpatelmd.com and www.lungsdoc.com is intended for patients of Mukesh Patel, MD PA and provided 'as is' for general information purposes only. Do not rely on this information as a substitute for personal medical diagnosis or treatment. Please consult your healthcare provider immediately if you are concerned about your health. Any links to other web pages are provided for informational purposes and cannot be guaranteed since they are not under our control.

www.mukeshpatelmd.com and www.lungsdoc.com ("the Website"), is provided by Mukesh Patel, MD PA free of charge to users of the World Wide Web, with the express condition that users agree to be bound by the terms and conditions set forth in this disclaimer, subject to change without notice. Furthermore, you acknowledge that the information on the Website is provided 'as is' for general information only with no Warranty and is not intended to be relied upon as a substitute for face to face consultation, hands-on evaluation and medical advice from qualified health professionals.

You will hold Mukesh Patel, MD, PA and employees harmless from any and all claims arising out of or related to your access or inability to access or use this Website or the information contained therein or on other websites to which it is linked. In no event will Mukesh Patel, MD PA nor any contributors be liable to you or anyone else for any decision made or actions taken or not taken by you in reliance on such information. We cannot and do not guarantee or warrant that files available for downloading through the Website will be free of infection or viruses, worms, Trojan horses or other code that manifest contaminating or destructive properties.

Links on the Website to other websites are provided for your convenience only and are not intended as an endorsement of the entity operating the website or a warranty of any type. All information contained within this Website, unless otherwise stated, is copyrighted materials of Mukesh Patel, MD PA.

You may provide links to this Website on another website, provided that you agree that any links to this Website must be first approved in writing by Mukesh Patel, MD PA.