**PULMONARY ASSOCIATES**

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LAWRENCE A.COSKEY, M.D.
ROBERT M. JASMER, M.D.
CHARLES K. EVERETT, M.D.
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LISA L.CHEN, NP

1750 El Camino Real, Suite 307
Burlingame, CA.94010
P (650)-697-5367
F (650)-697-3843

Patient Name _____
Last Name First Name Middle Initial

Birthdate ___/___/___ Age _____ Sex Male / Female
Mo Day Year

Address _____ Apt.# _____ City _____

State _____ Zip _____ Social Security # _____

Home Phone (___) _____ Cell Phone (___) _____ Marital Status S( ) M ( ) W ( ) D ( )

Email _____

Patient Employed By _____ Occupation _____

Business Address _____ Business Phone (___) _____

Spouse's Name _____ Spouse's Birthdate ___/___/___
Mo Day Year

Spouse Employed By _____ Business Phone (___) _____

Emergency Contact _____ Phone (___) _____

Preferred Pharmacy _____ City _____

Primary Physician _____ Which Dr. will you see today? _____

* Ethnicity (___) Hispanic or Latino (___) Not Hispanic or Latino

* Race (___) American Indian or Alaska Native (___) Asian (___) Black or African American

(___) Hispanic or Latino (___) Multiracial (___) Native America (___) Native Hawaiian or other Pacific Islander

(___) Other (___) White

*Preferred Language _____

* The US Government is mandating that the information is collected from our patients.

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## *RELEASE OF INFORMATION / FINANCIAL AGREEMENT / PRIVACY POLICY*

- *I authorize Pulmonary Associates to release all information necessary to secure the payment of benefits. I understand claims are submitted electronically.*
- *I hereby give authorization for payment of insurance benefits, otherwise payable to me, to be made directly to Pulmonary Associates physicians for professional services rendered.*
- *I understand that I am financially responsible for all charges, co-pays, co-insurance amounts, out of pocket expenses, or any charges not covered by my insurance, administrative charges, prescription drug pre-authorizations, special reports, letters, fees to process forms, telemedicine: video visits, telephone visits and email through MHO-My Health Online charges.*
- *I understand that it is my responsibility to verify that Pulmonary Associates physicians are providers of my insurance company and to pay any collection recovery fees for delinquent balances.*
- *A photocopy of this agreement shall be as valid as the original.*
- *I have received copy of the HIPAA notice of Privacy Policies and Practices.*
- *For appointment cancellation: I understand I am financially responsible for a cancellation fee for an unkept appointment or for failure to provide cancellation notice of at least 24 hours.*
- *Telemedicine consent- I agree to receive health care services as telemedicine service.*
- *I understand that the healthcare practitioner is at a different location than me. I hereby consent to use of telemedicine services: video visits, telephone visits and email through MHO.*
- *Video visit or Audio during consultation will NOT be recorded.*
- *The same confidentiality protections that apply to my other medical care also apply to telemedicine services.*

Signature _____ Date _____