Reason For Visit: _____

Primary Care Provider: _____

Referring Physician: _____

PSI INSTITUTE, PA Pulmonary & Sleep

Patient Name: _____ **Birth Date:** _____
LAST FIRST MI

Social Security No: _____ **Gender:** ☐ Male ☐ Female

Address: _____
STREET ADDRESS CITY STATE ZIP

Home #:: _____ **Cell #:** _____ **Work #:** _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed **Preferred Language:** _____

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic
☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latin Decent ☐ Not Hispanic or Latin Decent ☐ Do Not Wish to Report

Emergency Contact Information

Name: _____ **Relationship:** _____ **Phone:** _____

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: _____ **Relationship:** _____ **Phone:** _____

Name: _____ **Relationship:** _____ **Phone:** _____

Payment Information

Form of Payment: ☐ Health Insurance ☐ Auto Insurance ☐ Workers Comp ☐ Self Pay ☐ Other

Primary Insurance:

Primary Company: _____ **Insured's Name:** _____

Policy #: _____ **Group #:** _____ **Insured's Date of Birth:** _____

Secondary Insurance:

Primary Company: _____ **Insured's Name:** _____

Policy #: _____ **Group #:** _____ **Insured's Date of Birth:** _____

Self-Pay Agreement:

I agree to pay for medical services rendered from David A. Marks MD PA. I understand that payment must be made prior to establishing a new patient.

Patient Signature: _____ **Date:** _____

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize DAVID A. MARKS, M.D., P.A. and affiliated providers to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with DAVID A. MARKS, M.D., P.A. and affiliated providers with respect to my medical care. I permit a copy of this authorization to be used in place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to the affiliated providers of DAVID A. MARKS, M.D., P.A. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the DAVID A. MARKS, M.D., P.A. and affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, echocardiograms, EKG, nuclear scans, x-rays, and/or medical and surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered.

APPOINTMENT CANCELLATIONS:

I hereby agree to make every attempt to call the office at least 24 hours in advance of any appointment that needs to be cancelled or rescheduled.

CHANGE OF INFORMATION:

I hereby agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

NOTICE OF PRIVACY PRACTICES:

DAVID A. MARKS, M.D., P.A. and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgment of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that DAVID A. MARKS, M.D., P.A. and affiliated providers reserve the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

Patient Name (Please Print)	**Date**	**Patient Signature**

Patient Name: _____ **DOB:** _____

MEDICAL HISTORY INFORMATION:

Please check if you have had any of these Medical Problems in the PAST:

MAJOR ILLNESS	YES	NO	MAJOR ILLNESS	YES	NO
Anemia			Liver Disease		
Arthritis			Kidney Disease		
Heart Arrhythmia/Palpitations			Loss of Vision		
Asthma			Mitral Valve Prolapse		
Bleeding Problems			Neuropathy		
Blood Clots			Paralysis		
Cancer: Type _____			Peripheral Vascular Disease		
Chest pain/Angina			Pneumonia		
Diabetes			Psychiatric Illness		
Gall Bladder Disease			Pulmonary Embolism		
Gastric Ulcers			Reflux		
Glaucoma			Skin Ulcer/Breakdown		
Heart Attack			Steroid Use		
Heart Failure			Stroke		
Heart Murmur			Thyroid Disease		
Hepatitis B			Tuberculosis - TB		
Hepatitis C			Urinary Infections		
High Blood Pressure			Valve Disorders (heart)		
HIV/AIDS			Wound Healing Problems		
Immune Deficiency			OTHER: _____		

Please list any Surgery / Hospital Admission you have had:

SURGERY / ADMISSION	YEAR	SURGERY / ADMISSION	YEAR
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Family Medical History: **Please list any major illnesses that affect immediate family**

MEDICAL ILLNESS	RELATION	MEDICAL ILLNESS	RELATION
1)		5)	
2)		6)	
3)		7)	
4)		8)	

Patient Name: ______________________ **DOB:** ____________

Medications: **Please list any medications you are currently taking:**

Do you have any Allergies to any medications / substances? YES NO

If "Yes", please list: ____

MEDICATION	Dose	Freq	Date	Date	Date	Date	Date	Date

Patient Name:_____ **DOB:**_____

Vaccines: **Please list year received.** **Tetanus**_____ **Flu Vaccine**_____ **Pneumovax**____

Social History:

Employment: ☐ **Employed** ☐ **Unemployed** ☐ **Retired** **Occupation:**_____

Living Situation: ☐ **Lives alone** ☐ **Lives with family**

Smoking: ☐ **Current Smoker, everyday** ☐ **Current Smoker, some days** ☐ **Former Smoker**

☐ **Never Smoker** _____ **pks/day** _____ **years smoked**

Alcohol Use: ☐ **YES** ☐ **NO**

☐ **Heavy drinker (1-5 drinks/day)** ☐ **Moderate Drinker (1-5 drinks/week)**

☐ **Occasional Drinker**

Recreational Drug Use: ☐ **YES** ☐ **NO**

☐ **Heavy User (daily to weekly)** ☐ **Moderate User (monthly)** ☐ **Occasional User**

List recreational drugs used:_____

TB Exposure: ☐ **YES** ☐ **NO**

Animal / Feathers Exposure: ☐ **YES** ☐ **NO**

Review of Systems: **Please check any of the symptoms that apply to you TODAY:**

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Tarry Stools			Frequent Urination		
Vomiting			Urgent Urination		
Abdominal Pain			Painful Urination		
Chest Pain			Muscular Weakness		
Irregular Heart Beat			Numbness or Tingling		
Rapid Heart Beat			Joint Pain or Swelling		
Swelling of Legs			Muscle Pain or Swelling		
Cough			Frequent/Easy Bruising		
Shortness of Breath			Cuts that don't stop Bleeding		
Rash			Anxiety		
Wound Healing Problem			Depression		
Fever/Chills			OTHER:		

Please list any additional information that might be helpful for your treatment:

_____

_____

Agreement of Accuracy: The information provided in this history form is true and complete to the best of my knowledge.

Patient Signature:_____ **Date:**_____

Our Financial and Office Policies

Thank you for choosing Pulmonary and Sleep Institute as your healthcare provider. We are committed to providing our patients with the best available medical care. Our billing department will be available to discuss our fees and policies with you if you have any questions. We ask that all responsible parties read and sign our financial/office policies from prior to seeing the physician.

(PLEASE INITIAL BESIDE EACH SECTION INDICATING YOUR UNDERSTANDING AND ACCEPTABLE OF OUR POLICIES.)

_____ 1. All co-pays, deductible, and/or co-insurances are due at the time of service. We do not choose these fees. They are provided to our office by your insurance company when we call to verify benefits and/or the terms agreed upon by you (or your employer) and your insurance company. We will collect all co-payments, deductibles or charges for non-covered services at the time upon check-in. If you have a balance on your account we will ask for that payment in full as well. For you convenience, we accept cash, check, Visa, MasterCard, American Express and Discover.

_____ 2. We verify insurance benefits as a courtesy to our patients. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in your medical plan. Some insurance companies select certain services they will not cover. Please contact your insurance company if you have any questions regarding your health care coverage. Pulmonary and Sleep Institute provides services that are medically necessary in the physician's professional opinion. If you are unsure if a procedure, immunization or injection is covered, please call your insurance company prior to receiving services. You are ultimately responsible for all charges that are not covered under your health care policy.

***Please remember that your insurance is a contract between you (or your employer) and the insurance company. We are not a party of that contract. If it is very important that you understand the provisions of your healthcare policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of a bill or rejects your claim, the policy holder should contact the insurance company for a detailed explanation. Reduction of rejection of any claim by your insurance company does not relieve you of your obligation. In the event that your insurance company pays us for a claim that you had already paid and you are due a refund, we will be happy to expedite your refund or credit your account**

_____ 3. Please ensure that all personal and insurance information is correct at each visit. We will only bill the insurance company on file. If a claim is rejected or left outstanding due to incorrect insurance information, you will be responsible for visit. It is not uncommon for someone to change their phone number or address and forget to inform us. This leads to fragmented communication. Please inform the receptionist if your address, phone number, or insurance information has changed (or if you anticipate that it will be changing in the near future.)

_____ 4. Some insurance companies require a referral from your primary care physician before being seen by PSI. If your appointment requires a referral from your primary care physician, that referral will need to be on file with our office before the next appointment day. If you are seen without a referral form on file and the insurance company does not pay, you will be responsible for all charges.

_____ 5. We allow 30 days for payment of any balances that are the responsibility of the patient. If we do not receive full payment in 30 days, a late fee of $20 will be incurred monthly. We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to us, so that we may assist you to keep your account in good standing.

_____ 6. If your personal check is returned for insufficient funds, there is a $50.00 charge in addition to the amount of the check. After one instance of a returned check, all further payment will be required to be in the for of credit card, cash or money order only.

_____ 7. There is a $150.00 fee to complete any FMLA, Disability, Extended Work Excuse or any paperwork/forms requiring the completion by provider. Payment is due before the paperwork will be completed. Although the paperwork is long, please note that we do our best to complete this paperwork for you in a timely/efficient manner and we ask for your patience. We require 3-5 business days to complete this paperwork.

_____ 8. There is a $50.00 fee for copies of medical records up to 40 pages, $1.50 for each additional page thereafter. Please ask the receptionist for an estimate if you need copies of your records. We can fax records free of charge to another provider after we have received Release of Medical Records Form.

_____ 9. Appointments not canceled with a 24 hour notice, same day cancellation/reschedule and any "No Show" appointments will be subject to a fee of $75.00. Patient will not be given a new appointment until fee is paid. Please note that this fee is not covered by your insurance company. We sincerely hope that we will not need to collect this fee. Rather, it is offered as an incentive to remind all of our patients and families to keep their scheduled appointments or, if unable to keep that appointment, to please reschedule with more than a 24 hours in advance (and we greatly appreciate 48-72 hours advance notice.) When you reschedule your appointment several days ahead of time, this allows other patient the opportunity to be seen sooner... which they often greatly appreciate.

_____ 10. If you are more than 15 minutes late for your appointment and have not called the office to inform us, we will reschedule your appointment.

_____ 11. After 3 "No Show" appointments we reserve the right to terminate the physician/patient relationship. A notification will be sent to the responsible party and to the referring physician.

_____ 12. ALL prescription refills MUST be called to your pharmacy. You can have your pharmacy submit the refill request electronically, or they may fax the request to 210-494-4227. We DO NOT accept calls directly from patients for refills. Please do not wait until you are out of medication to ask your pharmacy for a refill. We require 2 business days to respond to a refill request. Please note that we do not process refill requests on weekends or holidays. The patient must have a follow-up appointment scheduled or have been seen within the last 6 months in order to have any prescription refilled.

_____ 13. Due to Texas state laws, we have adopted the following policies regarding Triplicate prescriptions (Triplicate prescriptions are for Schedule II controlled substances): W will not mail Triplicate prescriptions. All expired Triplicate prescriptions that are not filled must be returned to our office. Triplicate prescriptions must be filled with 21 days. There is a $25.00 fee for each triplicate prescription that is expired or not picked-up in a timely manner.

_____14. By initialing, you are giving PSI consent to sent text (SMS) messages to the mobile number you have provided.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of DAVID A. MARKS, M.D., P.A. and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of DAVID A. MARKS, M.D., P.A. and affiliated providers reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of DAVID A. MARKS, M.D., P.A. and affiliated providers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of DAVID A. MARKS, M.D., P.A. and affiliated providers may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of DAVID A. MARKS, M.D., P.A. and affiliated providers may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of DAVID A. MARKS, M.D., P.A. and affiliated providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of DAVID A. MARKS, M.D., P.A. and affiliated providers may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except tot he extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of DAVID A. MARKS, M.D., P.A. and affiliated providers may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Print Patient's Name

_____

Print Name Legal Guardian

_____

Date

PSI Pulmonary & Sleep INSTITUTE, PA

Office Information:
115 Gallery Circle, Suite 102
San Antonio, Texas 78285
P: (210) 494-4220
F: (210) 494-4227

Patient Authorization for Release of Protected Health Information

Patient Name: _____ **Date of Birth:** _____

Address: _____ **SS#:** _____

I hereby authorize the physician / practice (Disclosing Physician/Practice) listed below to release my Protected Health Information (information obtained in my medical records) to DAVID A. MARKS, M.D., P.A. and affiliated healthcare providers.

Disclosing Physician / Practice: _____ **Phone:** _____

Description of Information to be disclosed:

_____ Complete Medical Record
_____ Chest X-Rays
_____ Echocardiograms
_____ Office Notes
_____ Complete Medical Record
_____ Chest X-Rays
_____ EKG Test / Results
_____ Holter Monitor Results

Protected Health Information to be disclosed to:

DAVID A. MARKS, M.D., P.A.
Attn: MEDICAL RECORDS
115 GALLERY CIRCLE, SUITE 102
SAN ANTONIO, TX 78258
PHONE: (210) 494-4220 FAX: (210) 494-4227

Purpose of Disclosure:

_____ Continuing Care
_____ Referral to Specialist
_____ Change of Doctor
_____ Other: _____

I understand the following:

1) I may revoke this authorization at any time by providing written notice to David A. Marks, M.D., P.A.
2) I may not be able to revoke this authorization once the office has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage.
3) DAVID A. MARKS, M.D., P.A. will not condition treatment or payment based upon my signing of this Authoriztion.
4) The information disclosed by this authorization may be subject to re-disclosure by David A. Marks, M.D., P.A. no longer protected by Federal Law.
5) I have reviewed this Authorization and understand its purpose and intent.
6) This Authorization is valid until or unless I submit in writing a request of revocation to the practice.

Patient Signature	Date	Name (if other than Patient)