LUNG HEALTH INSTITUTE

Patient Registration

Personal Information

Patient name: _____

Phone number: _____ Alternate phone number: _____

Date of birth: _____ Last 4 SS#: _____ Email: _____

Current address: _____ City: _____ State: _____ ZIP: _____

MARITAL STATUS

- ☐ Single
- ☐ Married (spouse's name):

  _____
- ☐ Widowed
- ☐ Divorced
- ☐ Number of children: _____

RACE/ETHNICITY
(select all that apply)

- ☐ Asian
- ☐ Black or African American
- ☐ Caucasian
- ☐ Hispanic or Latino/a
- ☐ Native American
- ☐ Pacific Islander
- ☐ Prefer not to answer

Emergency Contact Information

Name: _____ Relationship: _____

Cell phone number: _____ Home phone number: _____

Current address: _____

City: _____ State: _____ ZIP: _____

How Did You Hear About Lung Health Institute?

PLEASE SPECIFY THE NAME OF YOUR REFERRAL SOURCE

- ☐ Doctor: _____
- ☐ Internet: _____
- ☐ Magazine: _____
- ☐ Newspaper: _____
- ☐ Television: _____
- ☐ Friend or relative: _____
- ☐ Former patient: _____
- ☐ Medical seminar (location): _____

Authorization of Privacy Information

Authorization to Release or Use Information for Treatment, Payments or Health Care Operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by Lung Health Institute in order to carry out treatment, payment or health care operations.

I acknowledge that I have been provided with a copy of Lung Health Institute's Privacy & Security Practices Notice to review a complete description of privacy practices and the potential release and use of my protected health information, and that it is right to review such notice prior to signing this consent form.

I acknowledge that Lung Health Institute reserves the right to change the terms of its privacy practices at any time and that in the event the terms of Lung Health Institute's Privacy & Security Practices Notice change, I will be notified as required by prevailing laws and may also request a current copy of our notice by requesting a copy from our clinic's front desk staff at any time.

I understand that I retain the right to request to change my consent to the below disclosures and that I must do so in writing. I understand I may request that Lung Health Institute further restrict how my protected health information is released or used to carry out care, payment or health care operations. Furthermore, I understand that the practice is not required to agree to such requested restrictions; however, if Lung Health Institute agrees to the requested restriction(s), such restrictions would then be binding.

Please note: Lung Health Institute encourages you to read the privacy practices and standards of your email and phone provider(s) as their privacy policy may differ from those of Lung Health Institute.

In consideration of above, I agree and consent to releasing information to me in the following manners:

VIA EMAIL	**CONTACT INFO**	**DATE**
☐ OK to send PHI to email address	_____	_____
☐ OK to send PHI to alternate email	_____	_____
VIA HOME TELEPHONE		
☐ OK to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
VIA CELL PHONE		
☐ OK to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
VIA ALTERNATE COMMUNICATION METHOD		
☐ OK to leave detailed message	_____	_____
☐ Leave call back number only	_____	_____
☐ OK to fax PHI to _____		

By signing below, I attest that the information provided above is true and accurate.

_____ _____

Signature Date

Authorization to Verbally Discuss Health Information

You may choose to give us permission to discuss information about you with family, friends and others you designate who are involved in your care or concerned about your health status and may ask about your condition or need information when you are not present. You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab and test results, treatment information and billing information. This does not mean that the person will have access to your medical records. Complete this form to let us know to whom we may speak about your information.

HERE ARE SOME EXAMPLES OF WHEN IT MIGHT BE USEFUL FOR YOU TO RELEASE INFORMATION:

- If you want a relative or friend to help you understand medical treatment instructions
- If a relative or friend is helping with billing instructions
- If a relative or friend calls to verify your appointment time
- If a relative or friend comes in and asks if you are here and in or out of the procedure room

Patient name: _____ Date of birth: _____

I hereby authorize Lung Health Institute to discuss and disclose specific health information as selected below to the following entity/individual.

Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone number: _____ Relationship: _____

DESCRIPTION OF SPECIFIC INFORMATION TO BE DISCUSSED AND DISCLOSED (PLEASE CHECK ALL THAT APPLY):

- ☐ All health and treatment information
- ☐ Appointment date/times
- ☐ Lab/test results
- ☐ Billing/payment information
- ☐ Other: _____
- ☐ Medical information (including symptoms, diagnosis, medication, and treatment plan)
- ☐ Procedure status/location (whether I'm waiting to go into procedure or have been released)

I understand the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

EFFECTIVE DATES FOR THIS AUTHORIZATION

Authorization automatically expires 1 year from the date signed below. You have the right to revoke this authorization before the year has passed.

BY SIGNING, I UNDERSTAND THAT:

- I may inspect or copy the protected health information to be used or disclosed.
- I may notify the medical practice in writing if I would like to revoke this authorization.
- This authorization is giving the Lung Health Institute permission to discuss my health information as selected above with entity/individual listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization, and that this authorization is not a condition of treatment or payment.

PATIENT/LEGAL REPRESENTATIVE

_____ _____

Signature Date

_____

Printed name

Authorization to Verbally Discuss Health Information

You may choose to give us permission to discuss information about you with family, friends and others you designate who are involved in your care or concerned about your health status and may ask about your condition or need information when you are not present. You can tell us who we may talk with about your medical care, including your appointment and scheduling information, lab and test results, treatment information and billing information. This does not mean that the person will have access to your medical records. Complete this form to let us know to whom we may speak about your information.

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Patient name: _____ Date of birth: _____

I hereby authorize Lung Health Institute to discuss and disclose specific health information as selected below to the following entity/individual.

Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone number: _____ Relationship: _____

DESCRIPTION OF SPECIFIC INFORMATION TO BE DISCUSSED AND DISCLOSED (PLEASE CHECK ALL THAT APPLY):

- ☐ All health and treatment information
- ☐ Appointment date/times
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- ☐ Billing/payment information
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PATIENT/LEGAL REPRESENTATIVE

_____ _____

Signature Date

_____

Printed name

LUNG HEALTH INSTITUTE

Privacy & Security Practices Notice

This notice describes how your medical information is protected under the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act, as well as how your information may be used, disclosed and accessed. Please review it carefully.

Understanding Your Protected Health Information (PHI)

As a patient, each time you visit a Lung Health Institute office or see a Lung Health Institute provider in any patient care setting, a record of your visit is made. This record contains information about your symptoms, examinations, test results, medications you take, your allergies and the plan for your care. This information we refer to as your health or medical record and is an essential part of the health care we provide for you. Your health record contains protected health information (PHI) and there are state and federal laws to protect the privacy of your health information.

USES AND DISCLOSURES OF PHI

Lung Health Institute is required by law to maintain the privacy of protected health information, to provide notice of its legal duties and privacy practices with respect to protected health information, to abide by the terms of this notice and to notify affected individuals following a breach of unsecured protected health information.

Lung Health Institute reserves the right to amend or change the terms of this notice. Should provisions of our Privacy Practices be revised, Lung Health Institute will notify affected individuals in writing by redistributing the new notice effective for all protected health information we maintain.

Disclosures not described in this notice will be made only with your prior written authorization.

WE MAY DISCLOSE YOUR PHI WITH OTHER PROFESSIONALS

We may also disclose PHI to other medical institutions or medical professionals who are involved in the delivery of services to you.

WE WILL USE YOUR PHI FOR TREATMENT

All the physicians, nurses and clinical staff involved in your care will document in your record about your examination and the care planned for you. If you were referred to us from another provider, your Lung Health Institute provider may send copies of your medical record to the provider who referred you to us so your provider will have updated treatment information about your care.

WE MAY USE YOUR PHI FOR CONTACT PURPOSES

We may also use your PHI to call you or send you a written reminder about an appointment, to follow up with diagnostic tests results or to provide you with information about other treatment and care that could benefit your health.

WE WILL USE YOUR PHI FOR PAYMENT

We may use your PHI to generate a bill or invoice for services provided and to process payment for those services.

WE WILL USE YOUR PHI FOR REGULAR HEALTHCARE OPERATIONS

Lung Health Institute physicians, nurses, managers and staff may access and use your PHI to conduct daily operations and to complete quality reviews to assess care and results in your case and other cases like yours.

Privacy & Security Practices Notice

Other Disclosures

BUSINESS ASSOCIATES

There are some services provided in our organization through contacts with business associates. Examples include compounding pharmacies. To protect your health information, however, we require the business associate to protect your PHI.

COMMUNICATION WITH OTHERS

We may disclose to a family member, close personal friend or any other person you identify, PHI relevant to that person's involvement in your care or payment related to your care.

The disclosure will only be made if you agree, or are silent when given the opportunity to disagree or

if we believe, based on the circumstances and our professional judgment, that you do not object.

If you are incapacitated or in an emergency, we may disclose to a family member, other relative, close personal friend or any other person accompanying you, PHI directly relevant to the person's involvement in your care or payment for your care.

RESEARCH

Under certain circumstances, we may use and disclose medical information about you for research purposes. All research projects, however, are subject to special approval processes which are designed to maintain the required privacy and security standards for your protected health information.

You Have the Right To

REQUEST RESTRICTIONS OR TO REVOKE

You have the right to request restrictions on certain uses and disclosures of your protected health information and the right to revoke an authorization at any time, provided that the request is made in writing. Lung Health Institute is not required to agree to a requested restriction.

RECEIVE CONFIDENTIAL COMMUNICATIONS

You have the right to request to receive communications of protected health information by alternative means or at alternative locations.

ACCESS YOUR PHI

You have the right to inspect and copy your protected health information as required by law.

AMEND YOUR PHI

You have the right to request to amend your protected health information or your record as specified by law.

RECEIVE AN ACCOUNTING OF DISCLOSURES

You have the right to receive an accounting of disclosures of protected health information as required by law.

RECEIVE A PAPER COPY OF THIS PRIVACY NOTICE

You have the right to obtain a paper copy of the notice upon request, regardless if you have agreed to receive the notice electronically.

Privacy & Security Practices Notice

As Required by Law

WE MAY ALSO DISCLOSE PROTECTED HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION TO THE FOLLOWING TYPES OF ENTITIES BUT NOT LIMITED TO:

- Food and Drug Administration
- Public health or legal authorities charged with disease prevention
- Correctional institutions
- Workers compensation agents
- Organ and tissue donation organizations
- Military command authorities
- Health oversight agencies
- Funeral directors, coroners and medical examiners
- National security and intelligence agencies
- Law enforcement as required by law or in accordance with a valid subpoena
- To avoid a serious threat to the health and safety of a person or the public

Marketing

We will not use information in your records for marketing.

For More Information or to Report a Problem

If you have any questions about your rights, our duties or our practices and procedures regarding protected health information, please call Lung Health Institute's Privacy Officer at the number below. You may also obtain a copy of this notice on our web site at theLungHealthInstitute.com.

If you believe your privacy rights have been or are being violated, you may complain to Lung Health Institute and to the Secretary of the Department of Health and Human Services. Complaints to the Secretary must be filed in writing on paper or electronically and must be made within 180 days of when you became aware of, or should have been aware of, the incidents giving rise to your complaint.

At Lung Health Institute, you may contact one of our privacy officers at 888-372-4827. By law, you cannot be penalized for filing a complaint.