

Athens Pulmonary

Pulmonary, Critical Care & Sleep Medicine

3320 Old Jefferson Road
Building 200, Suite A
Athens, GA 30607
phone(706-549-5560)

Please arrive a few minutes before your appointment. It is important that you bring your **photo ID, insurance cards, and completed paperwork**. We collect all co-pays, co-insurances, and deductibles at the time of service. Please call, 706-549-5560 ext.231 prior to your appointment if you need to make financial arrangements.

In addition, please bring:

- All medications (including eye drops or ear drops, creams, and inhalers).
- CT scans and Chest x-rays- Actual films/CD and Reports! EXCEPT FILMS taken at Athens Regional Medical Center.
- Records from your referring doctor.
- If you are having a PFT, DO NOT use an inhaler or nebulizer 4hours prior to your appointment. DO take all other medications.
- Your initial appointment could take up to 2 hours. Please be prepared for this amount of time.

Please call within 48 hours if you are unable to keep this appointment! If you do not call to cancel or re-schedule your appointment, you will be billed a \$50.00 no show fee. Same day cancellations will have a \$50.00 cancellation fee. This is to better service our new patient availability.

We look forward to seeing you!

Athens Pulmonary

Pulmonary, Critical Care & Sleep Medicine

3320 Old Jefferson Road
Building 200, Suite A
Athens, GA 30607
phone(706-549-5560)

From GA10 (the Loop around Athens)

Take Exit 14 Prince Ave/Jefferson Hwy.

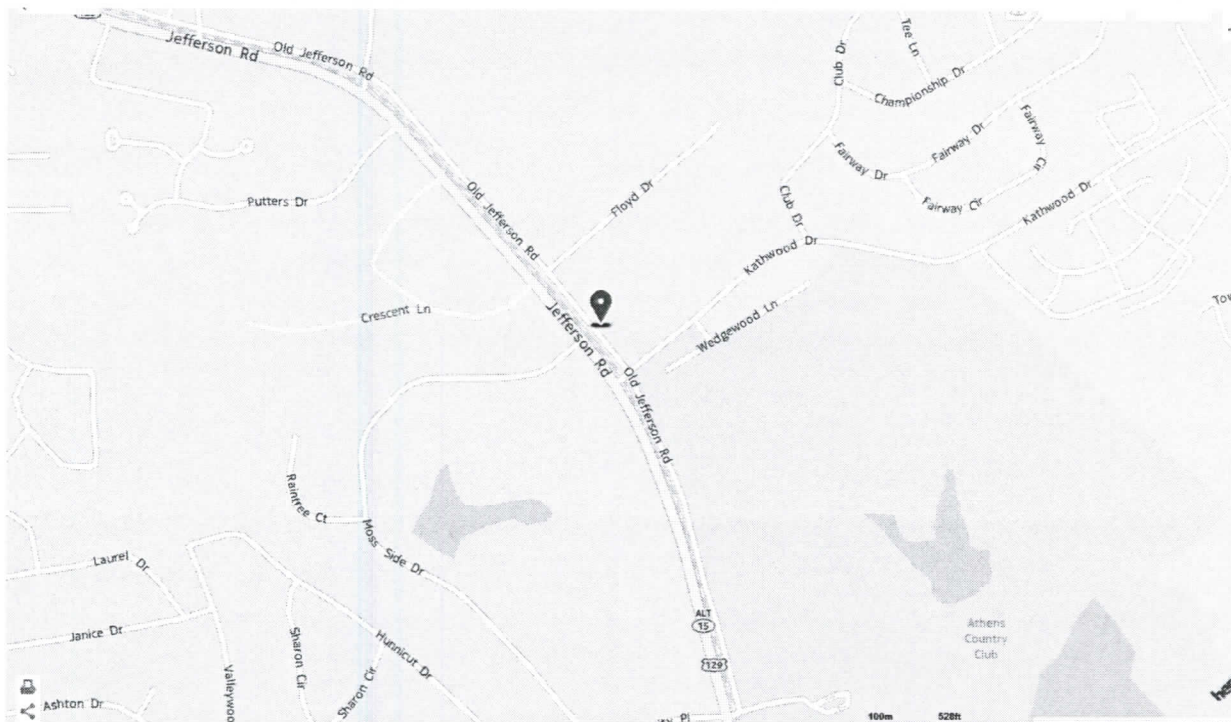
Turn Right onto Jefferson Hwy

Turn Right onto Kathwood Dr. (one traffic light after Athens Country Club)

Take an IMMEDIATE Left onto Old Jefferson Rd

Turn Right into Athens Medical Specialty Park

Athens Pulmonary is the 2nd building on the Left (Building 200A)



PULMONARY FUNCTION TEST

What is a Pulmonary Function test?

This is a series of breathing test that measure both the capacity and effectiveness of your lungs as well as the forcefulness of your breathing. The Pulmonary Function test will take about 40 minutes to complete. Do not use any inhalers four (4) hours prior to this test.

Before the test begins, you will be asked several questions about your history of smoking, shortness of breath, coughing, asthma, and so forth. A technician will be present through all the procedures and will instruct you throughout the test. You should let the technician know if, at any time during the test, you experience discomfort or trouble breathing. There are 5 parts to the Pulmonary Function Test.

PATIENT INFORMATION

General Information:

- Cigarettes, coffee, tea, carbonated beverages (e.g. Coke, Pepsi, etc), and alcohol should be avoided 4 hours prior to testing. All other beverages are fine.
- Avoid eating a heavy meal 1 hour prior to the test. If you are a diabetic or have low blood sugar, please bring a snack.
- Heavy exercise should not be performed on the same day of the test.
- DO NOT USE proventil, Ventolin, Atrovent, Combivent, Maxair, Albuterol, ProAir, Advair, etc. within four (4) hours prior to testing
- Take your other medications as usual
- DO NOT WEAR COLOGNE OR PERFUME. Many other patients suffer respiratory distress around strong aromas.
- DO NOT WEAR LIPSTICK

PATIENT REGISTRATION

Patient Name: _____ Date Of Birth: _____

SS#: _____

Circle One: MALE/FEMALE Marital Status: S/ M /W /SEP/ DIV

Street Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Telephone Number: (Home) _____ (Cell) : _____ (Work): _____

What is the BEST way to contact you? _____

Emergency Contact: _____ Relationship: _____ DOB _____

Contact Tel#: _____

PATIENT EMPLOYER INFORMATION

Employer Name: _____ Telephone #: _____

Employer Address: _____ City/State: _____ Zip: _____

Patient's Occupation: _____

INSURED PERSON (IF NOT PATIENT)

Name: _____ Telephone Number: _____

Street Address: _____ City/State _____ Zip: _____

INSURANCE

Primary Ins. Co. Name: _____

ID#: _____ Group#: _____ Phone #: _____

Secondary Ins. Co. Name: _____

ID#: _____ Group#: _____ Phone #: _____

Additional Information

Referring Doctor: _____ Primary Care Doctor: _____

Athens Pulmonary and Sleep Medicine

3320 Old Jefferson Rd
Building 200, Suite A
Athens, GA 30607
706-549-5560

Athens Pulmonary Notice of Privacy Practice

I agree that I have been given the opportunity to read and/or receive a copy of Athens Pulmonary Notice of Privacy Practice.

Release of Information: Athens Pulmonary may disclose all or any part of my medical record and/or financial ledger, to any person or corporation (1) which is or may be liable or under contract to Athens Pulmonary for reimbursement for services rendered and (2) any health care provider for continued patient care. Athens Pulmonary may also disclose, on an anonymous basis, any information concerning my case, which is necessary or appropriate for the advancement of medical science, medical education, medical research, for the collection of statistical data or pursuant to State or Federal law, status, or regulation.

Patient or Guardian/Beneficiary Print

Patient Date of Birth

Patient or Guardian/Beneficiary Signature

Date

**AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION
AND PRIVACY PRACTICES ACKNOWLEDGEMENT**

I give my authorization to use or disclose my protected health information to any health care provider who is involved with my medical treatment or services, my health insurance plan and/or medical billing clearing house who is involved with my insurance claims fulfillment.

I authorize you to release information to the following people:

Name _____ **Phone** _____

Relation _____

What specific information to disclose _____

Name _____ **Phone** _____

Relation _____

What specific information to disclose _____

I authorize the office to contact me in the following manner:

- _____ **Home Phone**
- _____ **Leave detailed information**
- _____ **Leave call back number only**
- _____ **Work Phone**

I have reviewed and I understand this Authorization. I also understand that my health information will be used or disclosed to certain business associates who are part of the health care process. These business associates will also keep your health information confidential. I also have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Print Name

Date of Birth

Signature

Date

Athens Pulmonary and Sleep Medicine

3320 Old Jefferson Rd
Building 200 Suite A
Athens, GA 30607
706-549-5560

Financial Responsibility Agreement Form

Please read each line below and sign to acknowledge that you have read and understand our payment policy regarding patient responsibility.

Financial Responsibility

For patients with no insurance coverage, payment is due at time of service. As a self paying patient you will receive a discounted rate on your visit as long as the payment is made in full on the date of service. If other arrangements have to be made, the office visit will not be discounted. Please call the office prior to your appointment to discuss the financials of your appointment. We accept cash, checks, and all Visa or Master cards. If you need further assistance please call 706-549-5560 prior to your visit.

As a courtesy to you, we will bill your insurance carrier for all covered services. You will be required to pay all co-payments, deductibles and coinsurances at the time of your visit. All services not paid by your insurance company will become your responsibility. It is the patient's responsibility to check their own insurance benefits and coverage. If for any reason your insurance company becomes insolvent, any balance is the patient's responsibility.

As our patient, we will provide the best possible care for you. Services we provide to you may or may not be covered by your insurance due to routine or non-covered, or "deemed medically unnecessary" by your insurance company. In the event your insurance company does not cover your services, you will be responsible. We will make every effort to let you know if we feel your insurance company may not cover your services. As a courtesy, we will obtain pre-certification for any procedures or treatments we schedule for you. Please understand pre-certification does not guarantee payment from your insurance company.

It is the patient's responsibility to notify us of any change in insurance, mailing address, or contact information.

Cancellation Policy and No Show Policy

It is your responsibility to call within 24 hours of your scheduled appointment time if you need to reschedule your appointment. If you have not called within 24 hours of your appointment or you are a No Show for your appointment, you will be charged a **\$25 Cancellation/No Show fee. New Patient appointments have a \$50 charge for No Show/same day cancellations.**

I acknowledge that I have read and understand the above information.

Patient Signature: _____ **Date:** _____