Coastal Pulmonary of Newport
320 Superior Ave #270, Newport Beach, CA 92663
Phone (949) 287-6182 Fax (949) 287-8058

Welcome! Thank you for choosing Coastal Pulmonary of Newport. ***Your healthcare need is our most important priority.*** Our goal is to be available and responsive to your needs. The following information is provided to introduce you to our practice and to help you plan your office visits. Please feel free to call for any questions or for additional information.

- Office hours are 830 am to 5 pm Monday through Friday.
- Please call 949-287-6182 during regular office hours to schedule an appointment.
- Our office staff will call you 1 week prior to your appointment to confirm the date and time of your appointment.
- If you are unable to keep an appointment, please call the office at least 2 working days in advance. After hours, you may leave a message with our exchange service.

- **(There will be a $50.00 charge for no shows and cancelations less than 48 hours in advance)**
- If you need to contact the physician after hours, your call will be answered by our exchange service. The on-call physician will be notified and respond to your call.
- Parking, including handicap parking, is available in the parking lot in front of the building.
- You will be asked to provide a photo ID at your first visit. This is part of our privacy/identify theft program.
- Our office maintains strict compliance with federal HIPAA privacy requirements. If you would like any health information released to another person, you must sign a HIPAA release identifying the individual to whom you want information released.
- We accept cash, checks, credit cards, and debit cards. There will be a $25 fee for any returned checks.
- Co-pays are due at the time of the appointment.
- Bills are payable within 30 days of receipt. We bill insurance on your behalf; however, the balance due is your responsibility.
- This office does not discuss test results over the phone. However, we will do our best to accommodate you with an appointment to discuss results.
- Prescriptions will not be refilled if you have not been seen in the previous 12 months.
- Our practice offers HIPAA compliant email through our patient portal.

Thank you for choosing Coastal Pulmonary of Newport. We look forward to providing you with the highest quality of services to support your health care needs. Wishing you the best of health!

Sincerely,

Coastal Pulmonary of Newport

Patient Signature _____ Date _____

PATIENT ACCOUNT INFORMATION

I. PATIENT

PATIENT NAME:_____ ☐ MALE ☐ FEMALE

LAST FIRST M.I

PATIENT'S ADDRESS:_____

STREET CITY STATE ZIP CODE

HOME PHONE: (____) _____ CELL PHONE: (____) _____

LEAVE MESSAGE: (____) _____

PRIMARY CARE
PHYSICIAN:_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH:_____

EMAIL ADDRESS: _____

ETHNICITY: _____ PREFERRED LANGUAGE: _____

EMPLOYER NAME: _____ OCCUPATION: _____

EMPLOYER ADDRESS: _____ EMPLOYER PHONE: (___) _____

II. RESPONSIBLE PARTY

PATIENT NAME:_____ ☐ MALE ☐ FEMALE

LAST FIRST M.I

PATIENT'S ADDRESS:_____

STREET CITY STATE ZIP CODE

HOME PHONE: (___) _____ CELL PHONE: (___) _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED DATE OF BIRTH:_____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE: (___) _____

III. ACKNOWLEDGEMENT OF NOTICE OF PRIVACY

By signing this form you acknowledge you were advised of the Notice of Privacy Practices for Coastal Pulmonary of Newport. Our Notice of Privacy Practices provides information about how we may use and disclose your protected information. We encourage you to read it in full. Our Notice of Privacy Practices is subject to change. The Notice of Privacy is available on our website at www. and in our office. You may request a copy of the Notice of Privacy.

_____ _____

Signature of Patient/Patient Representative DATE

IV. EMERGENCY CONTACT

NAME OF CONTACT PERSON: _____ RELATIONSHIP: _____

ADDRESS: _____

STREET CITY STATE ZIPCODE

HOME PHONE: (____) _____ CELL PHONE: (____) _____

LEAVE MESSAGE: (____) _____

V. APPOINTMENT POLICY

If you are unable to keep an appointment, please call the office in advance. After hours, you may leave a message with our exchange service. There will be a $50.00 charge for no shows and cancelations less than 24 hours in advance.

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest and understand that I am responsible for knowing my benefits/coverage and tests ordered by my doctor may NOT be covered. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for medical services and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. All charges are the direct responsibility of the patient. We cannot render services on the assumption that out charges will be paid by the Insurance Company. Insurance is an agreement between you and you insurance company. If we have problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I hereby acknowledge that I have read, understand and agree to hereby give consent for treatment.

PATIENT SIGNATURE: _____ DATE: _____

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_____

_____

Signature of Patient /Patient Representative Date Date

_____

Name of Patient/ Patient Representative (please print) Relationship to Patient

Authorization for Disclosure of Medical Information

Patient Name:

_____

Last First MI Other Name

Date of Birth: ____-_____-____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

I **authorize** the disclosure of my protected health information and give permission to communicate any and all information to those listed below:

Name:_____ Relationship: _____ Phone Number: _____

Name:_____ Relationship: _____ Phone Number: _____

Name:_____ Relationship: _____ Phone Number: _____

This authorization shall remain in effect until it is revoked by a request in writing.
You have the right to receive a copy of this authorization.