🩺 Coastal Pulmonary of Newport

Mubina Gaffar, MD
320 Superior Ave, Suite 270
Newport Beach, CA 92663
Phone: (949) 287-6182 Fax: (949) 287-8058

Welcome to Coastal Pulmonary of Newport

Your healthcare is our top priority.
Our goal is to provide exceptional, responsive care. Please review the following information to help you plan your visits and understand our office policies.

🕓 Office Hours

- Monday–Friday: **8:30 AM – 5:00 PM**
- To schedule or change an appointment, please call **(949) 287-6182** during office hours.
- Our staff will call you **one week prior** to confirm your appointment.

🗓️ Appointments & Cancellations

- Please call at least **48 hours in advance** to cancel or reschedule.
- **No-shows or cancellations within 48 hours** will be charged a **$50 fee.**
- After hours, you may leave a message with our exchange service.

📞 After-Hours Calls

- After hours, calls are answered by our exchange service.
- The **on-call physician** will be notified and respond as needed.

🚗 Parking & Check-In

- Parking (including handicap parking) is available in front of the building.
- Please bring a **photo ID and Insurance Card** to your first visit for privacy and identity verification.

💳 Payments & Insurance

- We accept **cash, checks, credit, and debit cards.**
- There is a **$25 fee** for returned checks.
- **Co-pays are due at the time of service.**
- Balances are payable within **30 days** of billing.
- We bill insurance on your behalf; however, any remaining balance is your responsibility.

🔐 Privacy & Records

- Our office follows all **HIPAA privacy laws** to protect your medical information.
- To release your health information to another person, please sign a **HIPAA release form.**
- Secure, HIPAA-compliant email communication is available through our **patient portal.**

⚕️ Test Results & Prescriptions

- **Test results** are not discussed over the phone. Please schedule an appointment if you wish to review results.

- **Prescription refills** require that you have been seen within the **past 12 months.**

CONSENT FOR TREATMENT & HIPAA ACKNOWLEDGMENT

I, the undersigned, authorize **COASTAL PULMONOLOGY OF NEWPORT** and its healthcare providers to provide medical evaluation and treatment as deemed necessary. I understand that:

- I am financially responsible for all charges not covered by insurance.
- I authorize the release of medical information necessary to process insurance claims.
- I acknowledge receipt of the **Notice of Privacy Practices (HIPAA)** and understand my rights regarding my protected health information.

Signature of Patient (or Legal Guardian): _____
Date: _____

OFFICE POLICIES

Welcome to **COASTAL PULMONOLOGY OF NEWPORT**! We're committed to providing excellent care. Please review our office policies:

Appointments:

- Please arrive **10–15 minutes early** to complete any paperwork.
- If you are more than **15 minutes late**, your appointment may be rescheduled.

Payments:

- Payment or copay is due at the time of service.
- We accept cash, credit/debit, and most major insurance plans.
- Unpaid balances over 60 days may be subject to collections.

Prescription Refills:

- Please request refills **at least 48 hours in advance**.
- We do not refill medications after hours or on weekends.

Forms & Paperwork:

- Allow **3–5 business days** for completion of forms (e.g., FMLA, disability).
  A fee of $25 will be charged for any doctor Signature

Communication:

- Non-urgent messages will be returned within **1–2 business days**.
- For medical emergencies, call **911** or go to the nearest ER.

Privacy & Confidentiality:

- Your personal and medical information is kept strictly confidential in accordance with HIPAA regulations.

💙 Thank You

Thank you for choosing **Coastal Pulmonary of Newport.**
We look forward to providing you with the highest quality of care and service.
Wishing you good health!

Patient Acknowledgment
I have read and understand the above office policies.

Patient Name: _____
Signature: _____ **Date:** _____

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🏥 COASTAL PULMONOLOGY OF NEWPORT

New Patient Packet

1. PATIENT REGISTRATION FORM

Patient Information

- Full Name: _____
- Date of Birth: _____ Sex: ☐ M ☐ F ☐ Other
- Address: _____
- City: _____ State: _____ ZIP: _____
- Phone (Home): _____ Cell: _____
- Email: _____

Emergency Contact

- Name: _____
- Relationship: _____ Phone: _____

Insurance Information

- Primary Insurance Company: _____
- Policy Number: _____ Group #: _____
- Subscriber Name: _____ DOB: _____
- Secondary Insurance (if any): _____

Preferred Pharmacy

- Name: _____ Phone: _____
- Address/Location: _____

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2. MEDICAL HISTORY FORM

Primary Care Provider: _____
Referring Provider: _____

Current Medications:

Allergies (including drug, food, or environmental):

Past Medical History:
☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Asthma
☐ Cancer ☐ Stroke ☐ Depression ☐ Other: _____

Past Surgeries:

Family History (Check if applicable):
☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ Other: _____

Lifestyle:

- Tobacco use: ☐ Yes ☐ No — If yes, packs/day: ____
- Alcohol use: ☐ Yes ☐ No — If yes, drinks/week: ____
- Exercise: ☐ Regularly ☐ Occasionally ☐ Rarely

Patient Acknowledgment:
I have read and understand the above office policies.

Signature: _____ Date: _____