PALOUSE PULMONOLOGY & SLEEP MEDICINE
PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

Vinod Mehta, MD
840 SE Bishop Blvd. Suite 103
Pullman WA 99163-5517
Office (509) 338-6000
Fax (509) 338-6001

PATIENT REGISTRATION

Patient's Legal Name: _____ Last 4 Digits S.S. #: _____
(First) (Middle Initial) (Last)

Preferred Name: _____ Marital Status: _____

Due to updated Federal guidelines, we are required to obtain specific patient information. Please make sure you answer questions 1-6. Thank you.

(1) Patient's Birthdate: _____ **(2) Patient's Age:** _____ **(3) Patient's Gender**: _____

(4) Race (Check One)
□ American Indian/Alaska Native □ White
□ Asian □ Other Race
□ African American □ Declined

(5) Ethnicity (Check One)
□ Not Hispanic or Latino
□ Hispanic or Latino
□ Declined

(6) Primary Language (Please List)
□ English
□ _____
□ Declined

Home Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

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

Email: _____ Occupation: _____

Employer Name & Address: _____

SPOUSE OR SIGNIFICANT OTHER INFORMATION

Name: _____ DOB:_____ Last 4 Digits S.S. #: _____
(First) (Middle Initial) (Last)

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

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

Email: _____ Occupation: _____

Employer: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relation: _____

Address: _____ City: _____ State: ____ Zip Code: _____

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

PHYSICIAN INFORMATION

Referring Provider: _____ Phone #: _____

Primary Care Provider (If Different): _____ Phone #: _____

Other: _____ Phone #: _____

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PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone #: _____

Preferred Mail Order Pharmacy: _____ Phone #: _____

INSURANCE INFORMATION

Primary Insurance:_____ Effective Date: _____

Subscriber's Name: _____ Birthdate: _____

Policy/ID # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: ___

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

Customer Service Phone #: _____ Relationship to Patient: _____

Secondary Insurance *(If Applicable):* _____ Effective Date: _____

Subscriber's Name: _____ Birthdate: _____

Policy/ID # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: ___

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

Customer Service Phone #: _____ Relationship to Patient: _____

Tertiary Insurance *(If Applicable :* _____ Effective Date: _____

Subscriber's Name: _____ Birthdate: _____

Policy / ID # (Include Alpha Prefix, if applicable): _____ Group #: _____ Copay: ___

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

Customer Service Phone #: _____ Relationship to Patient: _____

Notice of Privacy Practices Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Clinic Administrator and Privacy Officer at 509-332-6139.

Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information. **By my signature below, I acknowledge receipt of Notice of Privacy Practices.**

_____

Patient or legally authorized individual signature Date

_____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian)

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Patient's Name: _____ Date of Birth: _____

CONSENT FOR ELECTRONIC COMMUNICATIONS

E-mail, Text or Other Electronic Communications. To provide the best care possible, Pullman Regional Hospital Clinic Network, LLC and its affiliates seek to communicate with its patients in a convenient and effective manner, including e-mail, text or other electronic means if requested by the patient and deemed appropriate by Pullman Regional Hospital Clinic Network, LLC. Please note that such communications sent through the internet or over phone systems may not be encrypted or secure, and could result in unauthorized persons accessing your information. If you would like Pullman Regional Hospital Clinic Network, LLC to communicate with you electronically despite these concerns, please indicate your preferred method of communication and sign below.

☐ **E-mail.** Use this e-mail address: _____

☐ **Text.** Use this text number: (_____) _____- _____

☐ **Other Means** (subject to Pullman Regional Hospital Clinic Network, LLC's approval):

_____

Patient or legally authorized individual signature: _____

PALOUSE PULMONOLOGY & SLEEP MEDICINE

PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

MEDICAL HISTORY INFORMATION SHEET

TODAY'S DATE: _____/_____/_____

NAME: _____ AGE: _____ Birth Date: (M / D / Y) _____/_____/_____

Height ____ ft ____inches Weight _____ lbs BMI _____

REASON FOR TODAY'S EXAM: _____

PAST MEDICAL HISTORY: Please check any illnesses/conditions which YOU have had.

	High Blood Pressure		DVT		Lung Disease		Stroke
	High Cholesterol		Pulmonary Embolus		Asthma		Diabetes
	Anxiety/Depression		Tuberculosis		Heart Trouble		Pneumonia
	Kidney Disease		Nervous Disorder		Seasonal Allergies		HIV
	Thyroid Problems		Sinus		Arthritis		Hepatitis
	Drug Abuse/Alcoholism		Sleep Apnea		Gastrointestinal		Hepatitis
	Insomnia/Hypersomnia		Bleeding Tendencies				

Cancer: If Yes, What Type _____

Other: _____

History of Serious Injuries / Illnesses? YES NO If yes, please describe below.

SURGICAL HISTORY and or SURGICAL COMPLICATIONS? Please list

FAMILY MEDICAL HISTORY: Please check any illnesses/conditions immediate FAMILY has had.

	High Blood Pressure		DVT		Lung Disease		Stroke
	High Cholesterol		Pulmonary Embolus		Asthma		Diabetes
	Anxiety/Depression		Tuberculosis		Heart Trouble		Pneumonia
	Kidney Disease		Nervous Disorder		Seasonal Allergies		HIV
	Liver Disease		Seizures		Arthritis		Sinus
	Drug Abuse/Alcoholism		Thyroid Problems		Gastrointestinal		
	Insomnia/Hypersomnia		Sleep Apnea				Osteoporosis

Other: _____

SOCIAL HISTORY:

Occupation: _____ Marital Status: _____ Children: Yes No Live Alone: Yes No

Tobacco Use: Never In the Past Presently How Much? _____ How Long? _____

Alcohol Use: Daily Occasional None Other substance use or abuse? Yes No

SYSTEM REVIEW: Please describe any active problem or symptom.

General Symptoms (i.e. fever, weight gain/loss, fatigue)

Eyes / Ears / Nose / Throat _____ Heart _____ Lung _____

Allergies / Rashes _____ Muscles/Bones/Joints _____ Psychiatric _____

Endocrine (Diabetes/Thyroid) _____ Bleeding/Lymph Nodes _____ Nerves _____

Skin and / or Breasts _____ OB/Genital/Urinary _____ Abdomen _____

ALLERGIC TO LATEX: Yes No **ALLERGIC TO MEDICATIONS: Yes No**

PLEASE LIST:_____

CURRENT MEDICATIONS:

PALOUSE PULMONOLOGY & SLEEP MEDICINE

PULLMAN REGIONAL HOSPITAL CLINIC NETWORK

– Financial Policy–

Palouse Heart Center is committed to providing the highest level of quality medical care and personal service to our patients. We do not discriminate in the provision of services because of inability to pay or based upon race, color, sex, national origin, disability, religion, age or sexual orientation. For every commitment, there is an obligation. We feel it is the patient or guardians' responsibility to meet their financial obligations. We see patients from many different insurance plans; as such, it is impossible for us to know all the covered benefits, co-pays, and deductibles for each plan. In addition, your insurance company will not guarantee payment to us. While it is our intention to assist you, it is still your responsibility to ensure that all services rendered or referred by Palouse Heart Center on your behalf are paid in full. In order to clarify Pullman Regional Hospital Clinic Network, LLC DBA Palouse Heart Center's Financial Policy, we have listed our financial requirements below:

Patients without Insurance Coverage

Upon check in, patients will be asked to pay $75 dollars up front and the remainder at the end of the visit. Payment in full at the time of service is expected. We offer a **20% discount** to patients who pay for their services in full at the time of their visit. If absolutely necessary short-term payment plans are available, but must be requested prior to the services being performed. Patients on payment plans will be expected to pay at least ½ on the date of service and then the remainder may be split into equal monthly payments, not to exceed six months.

Contracted, PPO & HMO Patients that have a Co-payment or Deductible

We will bill your insurance for you. If your insurance plan has an annual out-of-pocket deductible, you will be expected to pay at time of service until that deductible is met. Co-pays must be paid at the time of service, as required by your insurance company. If the Co-pay is not paid within the same day of appointment, then a $10 fee will be assessed. Once your claim is processed by your insurance, any additional co-insurance, deductibles, or non-covered services will be due upon receipt. If you are unable to pay the balance in full, payment arrangements may be available by contacting the billing office directly at (509) 332-6139.

Medicare Patients

We will bill Medicare for you. You will receive a statement after Medicare has paid their portion of the charges or applied them to your deductible. If you have supplemental insurance to Medicare, we will also bill your Medicare Supplement for you. You will receive a statement from our office after Medicare and your secondary insurance has paid their portion of the charges or applied them to your deductible. Occasionally, your insurance may pay the payment directly to you. In this case, please notify our office billing office so that we can keep your account current.

Medicaid Patients

We accept patients on the Washington State and Idaho State Medicaid Programs. A referral from your PCP is required on most plans in order to be seen at Palouse Heart Center. Patients on Medicaid and affiliated health plans are required to present a current medical identification card and other insurance information upon arrival at each visit. If you do not have all of your current insurance cards, you may be asked to reschedule your appointment. **Medicaid patients being seen for non-covered medical services will be expected to pay in full at time of service**.

Non-contracted Insurance/Private Insurances

Upon check in, patients will be asked to pay $75 dollars up front and the remainder at the end of the visit. As a courtesy to all our patients, we will bill your primary insurance for you; however, you are responsible for full payment of your account.

Auto Accidents, Civil Suits, Home or Business Owners Claims

Due to the often-lengthy resolution of these claims, you are expected to pay in full for any charges that are not paid in full within 60 days. We will bill your third party insurance one time as a courtesy if you supply all of the necessary billing and contact information. Please be aware if you intend to bill your medical insurance for any portion of your visit, you will need documentation from your third party payer stating the reason for denial of payment.

Worker's Compensation Claims

If you are seeing one of our providers for an injury that occurred during the course of your employment, please be sure to notify the receptionist that your injury is "work-related" so we can make sure we get the appropriate paperwork filled out. We have the paperwork for the State of Washington Labor & Industries here in our office for you to fill out. If your employer is self-insured with another carrier please bring the appropriate paperwork with you from your employer and notify the receptionist that it is a different carrier. Please be advised that our office is required by law to report all work-related injuries. We cannot choose not to report the accident if we have knowledge that it is work-related. If your employer or their insurance carrier denies the claim, you will be held financially responsible for all charges. We are contracted with WA Department of Labor & Industries and the Idaho State Insurance Fund. If your employer is not covered by either of these carriers, please check with them in regards to any restrictions in who you may see for your claim.

Services Provided to Minors

A "minor" is defined as someone under the age of eighteen years of age, who is not considered legally emancipated from his or her parent or guardian. We realize that there may be an arrangement regarding who is responsible when paying for medical services provided to a minor. However, it is our policy that the parent or guardian who requests medical care for the minor is the financially responsible party.

Laboratory and Other Ancillary Services

Palouse Heart Center provides some lab services in the office. In addition, several test specimens are drawn or collected here and then sent to an outside laboratory or pathologist for processing. In addition, ultrasounds are often sent to an outside radiologist for the interpretation and report. You will receive a separate statement of charges for services provided outside our office. An example of these services would include: Laboratory charges, pathology for special tests ordered, specimen evaluation, radiological services, etc.

Students/Short-term patients

If you would like we can send your statements and any correspondence to an alternate address (i.e., parents, permanent address etc.), however be advised that the mail will still be addressed to you if you are over eighteen and you will still be held financially responsible for any charges incurred. In addition, you will still be required to pay any co-pays at the time of service.

Collection Accounts, Administrative Fees and No-Show/Late Cancellation Fees

There will be a $25.00 fee for all no-show appointments and late cancellations cancelled less than 2 hours' notice. NSF checks will be charged $35.00. If your account is sent to collections due to non-payment, it will be referred to an outside collection agency. In addition, Pullman Regional Hospital Clinic Network LLC DBA Palouse Heart Center reserves the right to terminate the doctor-patient relationship if your account is sent to collections.

I read and understand the information above. If bills remain unpaid without previous payment arrangements, Pullman Regional Hospital Clinic Network, LLC DBA Palouse Heart Center may initiate collection procedures and/or legal actions, which will necessitate the release of confidential information for dates and types of services rendered. I agree to reimburse Pullman Regional Hospital Clinic Network, LLC the fees of any collection agency, which may be based on a percentage at the maximum of 40% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection effort. I hereby release Pullman Regional Hospital Clinic Network, LLC DBA Palouse Heart Center from all liability arising therefrom.

I understand that I am financially responsible for all charges whether or not paid by my insurance company. I, the undersigned, authorize treatment and request payment of authorized Medicare & Medicaid services and/or other insurance benefits be made payable on my behalf to Pullman Regional Hospital Clinic Network, LLC DBA Palouse Heart Center for any services furnished to me or my dependents by Palouse Heart Center or its affiliates. I authorize the holder of medical information about my dependents or me to release to the Centers for Medicare & Medicaid Services (CMS), its agents, and/or my current insurance company or any subsequent insurance companies from which I obtain coverage, any information needed to determine these benefits or the benefits payable for related services. If "other health insurance" is indicated, my signature authorizes release of the information to the insurer or agency shown.

Patient's Name: _____ **Date of Birth:** _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____
(Patient, Parent, Guardian, or legally authorized individual signature)

Printed name if signed on behalf of the patient: _____ (Revised: 09/20/17)