RICHARD PRAGER, M.D., FCCP, FCCM, ANDREW PASTEWSKI, M.D., FCCP

NATALIA LOUREIRO, MD ARKADY VAKNANSKY, MD ZAINAB SYED, MD

9299 Coral Reef Dr. Suite #203 Miami, FL 33157
Tel: 305-234-9180 Fax: 305-234-9182 Fax: 786-478-6439

NEW PATIENT REGISTRATION FORMS

DATE: ______________

PATIENT NAME: ________________________________ DATE OF BIRTH: __________________

SEX: (M / F) _____________ SOCIAL SEC. #: ________________________________

ADDRESS: ____

CITY: ____________________ STATE: ________________ ZIP CODE: _____________

HOME PHONE: ______________________ CELL PHONE: ________________________

E-mail ADDRESS: ____

MARITAL STATUS: Married / Single / Other
EMPLOYED: (Y / N) OCCUPATION: ____
EMPLOYER NAME or SCHOOL NAME: ____
EMPLOYER or SCHOOL ADDRESS: ____

REFERRING PHYSICIAN NAME: ____
REFERRING PHYSICIAN ADDRESS: ____
REFERRING PHYSICIAN PHONE NUMBER: ______________________________________

FAMILY PHYSICIAN NAME: ____
FAMILY PHYSICIAN ADDRESS: ____
FAMILY PHYSICIAN PHONE NUMBER: ____

PERSON TO NOTIFY IN CASE OF EMERGENCY: __________________________________
RELATIONSHIP TO PATIENT: ____
EMERGENCY PHONE: ____

INSURANCE INFORMATION

PRIMARY INSURANCE: __________________________
ID#: ____
GROUP #: ____________________________________
POLICY HOLDER: SELF SPOUSE PARENT CHILD
SUBSCRIBER NAME: ____
DOB: ______________________________ SSN: _______________________________
SECONDARY INSURANCE: ________________________
ID#: ____ GROUP #: ______________

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RECORDS RELEASE AUTHORIZATION

TO: ____

____

I, ______________________________ hereby request that you release

TO:

RICHARD PRAGER, M.D., FCCP, FCCM, ANDREW PASTEWSKI, M.D., FCCP
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A report of my diagnosis, treatment, prognosis and recommendations, as well as other data pertinent to your treatment of me from:

______________________________ to ______________________________

______________________________ ______________________________
(Date of Request) (Patients signature)

______________________________ ______________________________
(Witness) (Social Security)

______________________________ ______________________________
(Today's Date) (Date of Birth)

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MEDICATION RECORD

NAME: ______________________ M / F DOB: ____________________

WEIGHT: ____________ PHONE NUMBER: ____________________

PHARMACY: ________________ PHARMACY PHONE #: __________________

DRUG PLAN: Y / N

DRUG ALLERGIES

____

CONTINUING MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY	DATE	DATE	DATE	DATE	EXPLANATION FOR D/C OR △

Compliance/Notes: **Important Past Rx:**

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Dear patient: To better service you with your medical care, please list below your primary care physician, and all other specialists that you are currently seeing along with their information. *If you need more space, please feel free to use the back of the page*

Primary Physician

Name: ______________________________

Address: ______________________________

Phone Number: ______________ Fax Number: ______________

Specialist

Name: ______________________________

Address: ______________________________

Phone Number: ______________ Fax Number: ______________

Specialist

Name: ______________________________

Address: ______________________________

Phone Number: ______________ Fax Number: ______________

Specialist

Name: ______________________________

Address: ______________________________

Phone Number: ______________ Fax Number: ______________

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Name: ______________________________ Date: __________________

ASSIGNMENT OF BENEFITS

TO ALL PATIENTS: *(please initial and sign)*

- ______ I hereby authorize the above physicians to apply for benefits on my behalf for services rendered, and I authorize payment of all medical insurance benefits which are payable to me, under the terms of my insurance policy to be paid directly to PRAGER, SIMON & ASSOCIATES, LLP or it's physicians.

- _______ I certify that the information I have reported regarding insurance coverage is correct and authorize release of any necessary information and medical documentation for this or any future claim, to my insurance carrier (and for Medicare part B benefits to the Social Security Administration and Health Care Financing Administration).

- _______ I understand and agree that I am financially responsible for charges incurred. I further understand that if my account is turned over to an attorney or a collection agency for non-payment, that I will be responsible for any additional costs incurred, including collection fees of up to 33 1/3%, as well as attorney's fees and court costs.

- _______ I request that payment of authorized medicare benefits which are payable to me, be paid directly to PRAGER, SIMON & ASSOCIATES, LLP or it's physician or supplier. I authorize any holder of medical information about me, to release to the Health Care Financing Administration, and its agents, any information needed to determine these benefits or the benefits payable for related services.

______________________ ______________________

Signature Date

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PATIENT NAME: ______________________ DATE OF BIRTH: ________________

Telehealth Consent Form

TO ALL PATIENTS: *(please initial and sign)*

- ______ I hereby authorize Professional Health Care Associates to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition.
- ______ I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.
- ______ I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.
- ______ I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.
- ______ I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.

________________________ ________________________
Signature Date

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Pulmonary Function Test 24-hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, doctors Richard Prager and Andrew Pastewski reserve the right to charge a fee of ***$50.00**** for all missed PFT appointments ("no shows) and appointments which, absent a compelling reason, are not cancelled with a 24-hr advanced notice.

"No show" fees will be billed to the patient. *This fee is not covered by insurance and must be paid prior to your next appointment*. Multiple "no shows" in any 12-month period may result in termination from our practice.

Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients. ***Please be aware that more than (2) cancellations, will result in no rescheduling of pulmonary function test appointment.***

By signing below, you acknowledge that you have received this notice and understand this policy.

______________________ ______________

Printed name *Date*

____

Signature

**Office fees subject to change without notice. By signing this agreement, you agree to PROFESSIONAL HEALTHCARE ASSOCIATES office policies.*