St. Clair Health

St. Clair Medical Group

Thank you for scheduling with St. Clair Health Pulmonary and Critical Care.
Please read the information below thoroughly.

- Please be sure to bring your Photo I.D., Insurance Card, and any co-payment you might have with you to your appointment.
- Only the patient is allowed in the exam room. If someone accompanies you to your appointment, they will be initially asked to remain in the waiting room. If they wish to speak with the physician or come in for the appointment, office staff will notify the physician and they will make accommodations where possible.
- Please do not wear any perfumes or cologne to your appointment.
- Please complete all New Patient Registration forms in its entirety. This is extremely important for our Providers to be done prior to your appointment. Incompletion of these forms could result in a delay of your appointment or being asked to reschedule.
- Please be sure to have all of your pertinent records faxed to our office at 412.942.5639 prior to your appointment. If you had imaging completed outside of St. Clair Health, please bring a copy of the CD with you to your appointment.
- You will receive an automated call reminder prior to your appointment. Please follow the prompts to confirm or cancel.
- Please arrive 15 minutes prior to your appointment. Arriving late may result in being asked to reschedule your appointment.

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Name (Last, First, M.I.):	
❑ M ❑ F	Date of Birth: / /
Primary Care Physician:	

Local Pharmacy:

Local Pharmacy Phone: ( )

Mail Order Pharmacy:

Please explain reason for being seen today:

Past Medical History

Check if you currently have, or have had, any symptoms in the following areas.

Cardiovascular:

❑ Chest Pain	❑ Coronary Artery Disease	❑ Heart Attack
❑ Heart Stent	❑ Heart Valve Disease	❑ High Blood Pressure
❑ Irregular Heart Beat	❑ Murmur	❑ Pace Maker
❑ Palpitations	❑ Pulmonary Embolism	

Neurological:

❑ Fainting	❑ Seizures	❑ Stroke
❑ Tremors		

Pulmonary:

❑ Asthma	❑ COPD/Emphysema	❑ Lung Nodule(s)
❑ Obstructive Sleep Apnea ❑ Oxygen ❑ C-Pap ❑ Bi-Pap	❑ Shortness of Breath	

Other:

❑ Acid Reflux (GERD)	❑ COVID	❑ Diabetes
❑ Kidney Disease	❑ Peripheral Vascular Disease	❑ Stomach/Colon/Liver Disease
❑ Thyroid Disease		

Do you have medical equipment supplied through a Durable Medical Equipment (DME) Company or Supplier?

❑ Yes ❑ No

If the answer is yes, who is the supplier?

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Surgical History

	Date:
	Date:
	Date:
	Date:
	Date:
	Date:
	Date:

Family Medical History

Check if anyone in your family has a history of the following:				
Colon Cancer:	❑ Father	❑ Mother	❑ Sibling	
Emphysema/COPD:	❑ Father	❑ Mother	❑ Sibling	
Skin Cancer:	❑ Father	❑ Mother	❑ Sibling	
Breast Cancer:	❑ Father	❑ Mother	❑ Sibling	
Prostate Cancer:	❑ Father	❑ Grandfather	❑ Sibling	
Lung Cancer:	❑ Father	❑ Mother	❑ Sibling	
Diabetes:	❑ Father	❑ Mother	❑ Sibling	
Renal Disease:	❑ Father	❑ Mother	❑ Sibling	
Heart Disease:	❑ Father	❑ Mother	❑ Sibling	
Stroke:	❑ Father	❑ Mother	❑ Sibling	
Coronary Artery Disease:	❑ Father	❑ Mother	❑ Sibling	
High Blood Pressure:	❑ Father	❑ Mother	❑ Sibling	
High Cholesterol:	❑ Father	❑ Mother	❑ Sibling	
Sudden Cardiac Death:	❑ Father	❑ Mother	❑ Sibling	❑ Children

Social History

Occupation:		If retired, what was your previous occupation?	
Job Duration (yrs):			
Hobbies, interests:		Pets (dog, cat, bird, etc.)	
With whom do you live?		Where do you live?	❑ House ❑ Apartment ❑ Assisted Living ❑ Skilled Nursing
Height:		Weight:	

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Have you had exposure to:		
TB? ❑ Yes ❑ No	Chemicals? ❑ Asbestos ❑ Silica ❑ Heavy Metals ❑ Dust	Wood Dust? ❑ Yes ❑ No

Have you ever served in the military? ❑ Yes ❑ No	If yes, what branch?

Risk Factors

Tobacco Use:	❑ Current every day smoker ❑ Former Smoker	❑ Current occasional smoker ❑ Never smoker
	❑ Cigarettes ____ pks/day ❑ Cigars ____/day ❑ Smokeless/Chewing ____/day ❑ Vape/e-Cigarettes ____/day ❑ Medical Marijuana	Year Started: Year Quit:
Are you currently or have you recently been exposed to second hand smoke?	❑ Yes ❑ No	
Any other drug use?	❑ Yes ❑ No	
If yes, please explain:		
Do you use alcohol?	❑ Yes ❑ No	
How many drinks do you have per day? _____	Type:	

Medications

List your prescribed medications and over-the-counter medications, such as vitamins and inhalers.
If there is not enough room, please bring a separate medication list.

Name of Drug	Strength	Frequency Taken

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Allergies to Medications

Name of Medication	Reaction You Had

Cardiac Studies

❑ Echocardiogram	❑ Heart Catheterization	❑ EKG
❑ Stress Test	❑ Open Heart Surgery	❑ Cardioversion
❑ Other		
When & Where?		

Pulmonary Studies

❑ CT Scan	❑ Chest X-Ray	❑ PFT's
❑ Nocturnal Pulse Ox	❑ Six Minute Walk	❑ O2 ____ liters rest ____ liters on activity ____ liters sleep
When & Where?		

Sleep Studies

❑ Home Sleep Study	❑ In-Lab Sleep Study
C-PAP/BI-PAP	Settings O2 Bleed IN Auto Titrating
When & Where?	

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Today's Date:

New Patient Registration Form

Patient Demographic Information

Full Legal Name: _____
Last First Middle

Date of Birth: _____ Sex: ❑ Male ❑ Female ❑ Other _____

Marital Status: ❑ Married ❑ Single ❑ Divorced Salutation: ❑ Mr. ❑ Mrs. ❑ Miss ❑ Ms.
❑ Widowed ❑ Separated

Race/Ethnicity: ❑ American Indian/Alaskan ❑ Asian ❑ Black/African American ❑ Hawaiian/Pacific Islander
❑ Hispanic/Latino ❑ White ❑ Unknown ❑ Not Disclosed

Address: Street _____ APT # _____

City _____ State _____ Zip Code _____

Phone: _____
Please circle preferred Home Cell Work

Email Address: _____

Employment: ❑ Full-Time ❑ Part-Time ❑ Homemaker ❑ Retired ❑ Unemployed ❑ Student Full-Time ❑ Student Part-Time

Employer: _____ Occupation: _____

Emergency Contact: _____
Name Relation Phone

If Minor, Parent/Guardian: _____
Name Relation Phone

Primary Insurance	Secondary Insurance (if applicable)
Insurance Company: _____	Insurance Company: _____
Policy Holder Name: _____	Policy Holder Name: _____
ID# _____ Group # _____	ID# _____ Group # _____
Address _____	Address _____
Phone _____	Phone _____
DOB _____ SS# (optional) _____	DOB _____ SS# (optional) _____
Relationship to Patient _____	Relationship to Patient _____

Workers Compensation/Auto (if applicable)

Insurance Company _____ Phone _____ Fax _____
Claim # _____ Date of Injury _____ SS# (optional) _____
Billing Address _____
Adjuster Name _____ Phone _____
Employer Contact _____ Phone _____

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Today's Date:

Authorization for Use or Disclosure of Protected Health Information

Completion of this document authorizes the disclosure and/or use of your protected health information, as set forth below, consistent with Federal law concerning the privacy of such information. **Both sides must be completed and signature REQUIRED. Failure to provide *all* information requested may invalidate this Authorization.**

I hereby authorize the use or disclosure of my health information as follows:

Patient Name: _____ Date of Birth: _____
Last First M.I.

Address: Street _____ APT # _____

City _____ State _____ Zip Code _____

Phone: _____
Please circle preferred Home Cell Work

Use and Disclosure of Protected Health Information

St. Clair Medical Group Pulmonary & Critical Care ❑ SEND or ❑ RECEIVE
1050 Bower Hill Road, Suite 306, Pittsburgh, PA 15243
Phone: 412.942.5620 Fax: 412.942.5639

_____ is authorized to: ❑ SEND or ❑ RECEIVE
(PERSON/ORGANIZATION)

Practice Address: _____
Street Suite # City State Zip Code

Phone: _____ Fax: _____

My health information will be used for the following purpose(s): _____

This Authorization applies to the following information (select all applicable):

❑ **ALL** health information pertaining to any medical history, mental or physical condition and treatment received.

(Optional) Except: _____

OR

❑ **ONLY** the following records or types of health information:

❑ Inpatient	❑ Outpatient	❑ TCC	
❑ Discharge Summary	❑ Imaging Reports	❑ IRU	❑ PT/OT/Speech/Audiology
Treatment Dates: _____			
❑ History & Physical	❑ Laboratory Reports	❑ Operative Reports	❑ Emergency Department Record
❑ Consultations	❑ Transfer Abstract	❑ Pathology Reports	❑ Surgical Slides and/or Tissue

❑ Drug or alcohol abuse, Drug or alcohol dependence, Drug or alcohol related conditions

❑ HIV testing, HIV diagnosis, HIV related illness, AIDS diagnosis, AIDS related illness, and Sexual preference/contacts

❑ Mental health, Psychiatric condition/care, Psychological conditions/care, Behavioral health services

❑ Specific Exclusions: _____

St. Clair Health

St. Clair Medical Group

NOTE: If you want to authorize a use or disclosure of psychotherapy notes, a separate authorization form must be completed. This information has been disclosed to you from records protected by Pennsylvania Law.

NOTE: If this Authorization is for marketing purposes, please note the following: The organization authorized to use or disclose my protected health information ❑ **will** or ❑ **will not** receive direct or indirect compensation for the use or disclosure of my information.

Expiration of Use and Disclosure of Protected Health Information

This Authorization expires [insert date or event] if less than ninety days: _____

Patient Rights Regarding Protected Health Information

I understand that I may refuse to sign this Authorization.

I may revoke this authorization at any time. I understand that my revocation must be in writing, signed by me or on my behalf, and delivered to the following address: St. Clair Medical Group Pulmonary & Critical Care, 1050 Bower Hill Road, Suite 306, Pittsburgh, PA 15243

My revocation will be effective upon receipt, but will not be effective to the extent that St. Clair Health, its affiliates, and/or others have acted in reliance upon this Authorization.

I understand that I have the right to receive a copy of this Authorization.

I understand that a fee may be assessed to process this request.

I may inspect or obtain a copy of the health information that I am being asked to use or disclose.

I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected.

Neither treatment, payment, enrollment nor eligibility for benefits will be conditioned on me providing or refusing to provide this authorization.

Patient/Patient Representative Signature

Date: _____ Time: _____

Signature: _____
(Patient or Representative)

If signed by someone other than the patient, please state your legal relationship to the patient: _____

❑ ***Verbal response given (patient physically unable to give written consent)***

A verbal consent requires two(2) witness signatures. I witness that the patient (or responsible party) is definitely unable to provide a signature at this time but understands the nature of the release and freely gives his/her consent.

_____ _____
Witness Date

_____ _____
Witness Date

St. Clair Health

St. Clair Medical Group

St. Clair Medical Group Policies & HIPAA

Welcome to St. Clair Medical Group and thank you for choosing us as your healthcare provider. We would like to take this opportunity to advise you of our practice policies. These policies help us to provide quality care in an efficient manner. Please do not hesitate to contact our office manager if you have any questions about these policies.

NOTICE OF PRIVACY PRACTICES

We value our patients' rights to privacy in regard to their health information. Please take a moment to review our Notice of Privacy, which provides a complete description of permitted uses and disclosures of healthcare information.

DISCLOSURE OF HEALTH INFORMATION (HIPAA)

I wish to allow full disclosure to the following family members, friends, or individuals. I understand that I may change this list at any time:

NAME	RELATIONSHIP	PHONE NUMBER

Any exceptions to the disclosure, please note here: _____

_____

In the event that we need to contact you, are we permitted to leave a message on your answering machine? ❑ YES ❑ NO

In case of an emergency, may be contact an individual listed above? ❑ YES ❑ NO

ST. CLAIR MEDICAL GROUP POLICIES

- You are responsible for notifying us of any changes to your address, personal information, or insurance information.
- **St. Clair Medical Group** is pleased to process your insurance claim for reimbursement. However, please remember that:
  - ➢ You must present your insurance card and photo ID at each visit.
  - ➢ Your insurance is a contract between you, your employer, and the insurance company. **St. Clair Medical Group** is not a party to your health insurance contract.
  - ➢ Not all services are covered benefits on all insurance contracts. Some insurance companies have certain services that they will not cover.
- All co-payments are to be paid in full at the time of service.
- If you do not have health insurance coverage or do not bring proof of health insurance coverage to each visit, payment in full will be due at the time of your visit.
- We accept payments in the form of cash, personal check, and most major credit cards. However, we **do not accept Care Credit**. If you are in need of financial assistance, please review **St. Clair Medical Group** policy on https://www.stclair.org/billing-insurance/financial-assistance/
- **St. Clair Medical Group** and/or agencies working on St. Clair Medical Service's behalf may need to contact patient or guarantor via land phone line or cell phone regarding balance due for services.
- Out of consideration to our other patients, if you arrive more than 15 minutes late to your appointment, there may be a delay in your visit, or you may be asked to reschedule your appointment.
- Please understand that our appointment times are limited. If you are unable to keep your scheduled appointment, please notify us **at least 24 hours in advance** to reschedule.
- **St. Clair Medical Group** requests previous medical records so that we may have the best understanding of your medical history.

PATIENT ACKNOWLEDGMENT

I have read and understand my responsibilities as outlined above. I acknowledge the receipt of the Notice of Privacy Practices.

Patient Name (PRINTED)	Signature of Patient or Responsible Party, if a Minor	Date

FOR OFFICE USE ONLY		
A good faith effort was used to obtain written acknowledgment of the Notice of Privacy Practices on:		
Office Staff Name (PRINTED):	Office Staff Signature:	Date:

St. Clair Health

St. Clair Medical Group

ASSIGNMENT OF BENEFITS: I hereby assign all medical/surgical benefits to which I am entitled including major medical, Medicare, private insurance or other health plan benefits to the St. Clair Medical Group. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure payment.

MEDICARE: I request that Medicare benefits be made on by behalf to St. Clair Medical Group for healthcare services furnished. I authorize any holder of medical information about me to release HCFA and its agent any information needed to determine these benefits or the benefits payable for related services; I understand that my signature authorizes the release of medical information to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physicians agree to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and any non-covered services. Co-insurance and deductible amounts are based upon the charge determination of the Medicare carrier.

Signature of Patient or, if a minor, Responsible Party

Date

St. Clair Health

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