DR. LUIS J MESA MD
Pulmonary and Sleep Disorders

www.luismesamd.com

Luis J Mesa MD PA
Pulmonary & Sleep Disorders
Dr. Luis J Mesa, MD

1250 E Hallandale Beach Blvd #205A,
Hallandale Beach, FL 33009
Tel: 954-544-5979 Fax: 954-404-729

GENERAL CONSENT AND SERVICE TERMS

General Consent for Treatment: I agree to allow Pulmonary Practice Associates (Pulmonary Practice Associates) to provide all health care services to me that are routine or otherwise deemed necessary. I understand I have the right to refuse consent to any proposed procedure or treatment at any time prior to receiving it. I understand that any treatment involving material risks will be explained to me and that I will have the opportunity to ask questions about the associated risks, alternatives and prognosis before allowing the treatment to be performed. I agree that no guarantees have been given to me as to the outcome of any treatment. I agree my picture can be taken to identify me.

General Sharing Health Information: I agree to Pulmonary Practice Associates using and sharing all my health information, including but not limited to Highly Confidential Information (see definition below), for payment, my continued treatment, and healthcare operations. This includes sharing my information with the following:

- All physicians and other medical service providers associated with my treatment, as well as other physicians who are participating in integrated physician plan networks or Health Information Exchanges.
- Business partners of Pulmonary Practice Associates, its affiliates, and Physicians, who provide administrative, operational, financial, legal and technical support services.
- All insurance Payer(s) and healthcare plans responsible for paying or determining if I am eligible for payment for my treatment.

Substance, Drug, and Alcohol Abuse Authorization: I authorize and have initialed below for Pulmonary Practice Associates to release, should any exist, all my substance abuse and drug and alcohol abuse health information to any affiliate for my treatment, payment for my treatment, and the health care operations of Pulmonary Practice Associates. I understand this authorization may be cancelled at any time, unless Pulmonary Practice Associates have already acted and relied on it. If not previously revoked, I understand this authorization is effective until I am deceased.

Insurance Assignment and Payment: I permanently assign my third-party payer benefits payable directly to Pulmonary Practice Associates. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.
I authorize Pulmonary Practice Associates to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance or third-party payer will not direct payment to Pulmonary Practice Associates, I agree to forward Pulmonary Practice Associates all health insurance payments which I receive for the services rendered by Pulmonary Practice Associates.
Unless otherwise designated by the payer, I understand Pulmonary Practice Associates posts all payments received to the oldest balances first, except for copays, drugs and supplies. I give permission to apply and credit balances to offset amounts due to Pulmonary Practice Associates where I have received services for current accounts or accounts I have not paid yet.
I authorize the use of my signature below on all insurance submissions. I may at any time in the future cancel this authorization in writing.

BY SIGNING BELOW, I AM AGREEING TO THE PERMISSIONS, AGREEMENTS, AND AUTHORIZATIONS DESCRIBED IN THIS AGREEMENT. I HAVE READ THIS AGREEMENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

Name: _____ Signature: _____ Date: _____

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COVID-19 Screening Form

Patient's Name:_____

Please let us know if you have had any of the following:	YES	NO
Fever greater than 100F?	☐	☐
Fever greater than 100F?	☐	☐
Cough/ Shortness of Breath?	☐	☐
Pneumonia/ Flu- Recent?	☐	☐
Internationally or on a Cruise Ship?	☐	☐
Have you had contact with anyone who has a confirmed or currently Have you had contact with anyone who has a confirmed or currently	☐	☐

If you have any of the above symptoms or exposures, we ask that you do not visit at this time per CDC guidelines and to visit your local health department for further assistance.

In keeping in alignment with the CDC and AMA Guidelines, we thank you for your understanding and cooperation in helping us to keep you, our staff, and community safe.

Name: _____ Signature: _____ Date: _____

Staff Name: _____ Signature: _____ Date: _____

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PATIENT DEMOGRAPHICS

Last Name: _____ First Name: _____ Middle: _____

Home Phone: _____ Work Phone: _____Cell Phone: _____

Email: _____ Fax: _____ Preferred Language: _____

Date of Birth: _____ Age: _____ Gender: ☐ M ☐ F

Mailing Address: _____ _____ _____ _____ _____
Street Apt City State Zip

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Race/ Ethnicity: Black ☐ Caucasian ☐ Hispanic/Latino ☐ Asian ☐ Other ☐

Preferred Method of Contact: Phone ☐ Email ☐ Text ☐ Mail ☐

Referring Physician: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Pharmacy: _____ Phone: _____ Fax: _____

Patient's Employer:

Employer: _____ Phone: _____ Fax: _____

Occupation: _____ Email: _____

Address: _____ _____ _____ _____ _____
Street Apt City State Zip

Responsible Party (if other than Payer)

Last Name: _____ First Name: _____ Middle: _____

SSN: _____ Phone: _____ Email: _____

Mailing Address: _____ _____ _____ _____ _____
Street Apt City State Zip

Responsible Party (if other than Payer)

Name: _____ Relationship: _____

Address: _____ Phone: _____

Assignment of Benefits

I understand that I am financially responsible for all charges whether or not covered by insurance. I authorize the release of any medical or other information necessary to process any claim for medical care. I hereby authorize the Practice to bill my insurance company and/or Medicare/Medicaid for services provided to me and request that payments for such services to made to the Practice on my behalf.

Signature: _____ Date: _____

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Primary Insurance

Insurance Company Name: _____ Phone: _____ Effective Date:_____

Billing Address: _____

Group Number: _____ Policy or ID Number: _____

Secondary Insurance

Insurance Company Name: _____ Phone: _____ Effective Date:_____

Billing Address: _____

Group Number: _____ Policy or ID Number: _____

NOTICE OF PRIVACY PRACTICES CONSENT AND ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how LUIS J MESA MD PA, DR. LUIS J MESA, MD may use and disclose protected health information about you.

I consent to the use or disclosure of my protected health information by LUIS J MESA MD PA, DR. LUIS J MESA, MD for the purpose of diagnosing treatment to me, obtaining payment for my health care bill or to conduct health care operations of LUIS J MESA MD PA, DR. LUIS J MESA, MD.

I acknowledge that I have been provided with the Practice's Notice of Privacy Practices that provides a description of Protected Health In formation uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that the Practice reserves the right to change its Notice of Privacy Practices that will be effective for the health information the Practice already has about me, as well as any they receive in the future.

I understand that I may obtain a copy of the current Notice in effect upon request. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that the Practice is not required to agree to my requested restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

List of Names with whom we can share medical information:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Do you want any mail sent to you from our office marked as "Confidential"? ☐ YES ☐ NO

Can appointment reminders and other confidential messages be left on your voice mail? ☐ YES ☐ NO

Patient Signature: _____ Date: _____

****

OFFICE USE ONLY: I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below. (Please print)

Name: _____ Date:_____

Reason: _____

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Authorization for Disclosure of Health Information

Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ Phone: _____

Mailing Address: _____ _____ _____ _____ _____
Street Apt City State Zip

I authorize the use or disclosure of the above-named individual's health information as described below, by:

_____

The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____	Complete health records	_____	Lab results/X-ray reports
_____	Medical exam	_____	Consultation reports
_____	Immunization record	_____	Other (please specify)

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization:

LUIS J MESA MD PA, DR. LUIS J MESA, MD.

For the purpose of: _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____ . If I fail to specify an expiration date, event or condition, this authorization will expire in 365 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form to receive continued treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of participant or representative Date

_____ _____
Name of patient or representative Description of personal representative's authority

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Print Name of Patient / Guarantor / Legal Guardian: _____

DOB: _____ Signature of Patient / Guarantor / Legal Guardian: _____

CONSENT OF TREATMENT:

I authorize the staff at LUIS J MESAA MD PA to provide any diagnostic test and examination indicated for treatment.

Initial: _____

FINANCIAL RESPONSIBILITY AGREEMENT

I understand that charges not covered by my Insurance or by my secondary insurance if applicable are my responsibility if applicable as well as deductible, coinsurance, copayments are my responsibility. All professional services are charged to the patient at the time of service unless other arrangements are made unless other arrangements are made by the patient or his or health insurance carrier. If your insurance company has not paid the account in 90 days balance may be transferred to you (patient) for the payment.

If your insurance is HMO or other managed care, Luis J Mesa MD PA, will only bill them if you provide appropriate authorization form from them. You may still be responsible for deductibles, copayments and non-covered services. If you don't have an appropriate authorization for each visit/ treatment/ procedure you may be responsible for the entire payment.

For companies with whom our Physicians don't participate payment for the visit will be your responsibility, LUIS J MESA MD PA will bill your carrier after the second visit.

I understand that if I default on payments for services my account may be transferred to an independent collection agency designated as credit risk and payment for services will be requires at the time of registration for all future visits.

I have read the financial policy as above and I understand and agree to it. **Initial:** _____

MISSING APPOINTMENTS

Your appointment time is set aside especially for you. Resources are assigned to each individual patient. We ask that for the courtesy of the patient and the doctor, you show up to your scheduled appointment on time. If you do not show up to your scheduled appointment on time, there may be a charge of $50.

Initial: _____

MEDICATION POLICY CONSENT:

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I authorize the staff at LUIS J MESA MD PA to obtain a list of current medications/medication history from pharmacy for medical records.

Initial: _____

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I consent to the use or disclosure of my protected health information by LUIS J MESA MD PA, DR. LUIS J MESA, MD for the purpose of diagnosing treatment to me, obtaining payment for my health care bill or to conduct health care operations of LUIS J MESA MD PA, DR. LUIS J MESA, MD.

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List of Names with whom we can share medical information

Name: Relationship:

_ Phone:

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Name: Relationship:

Do you want any mail sent to you from our office marked as "Confidential"? _ Phone:

Yes

No _

Can appointment reminders and other confidential messages be left on your voice mail? Yes No

Patient Signature: Date:

****

********** OFFICE USE ONLY:

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Name: Date:

Reason:

Name: Date of Birth: Date Packet Completed:

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COMMUNICATION CONSENT FORM

I, _____ (name) _____(dob), hereby grant consent to LUIS J MESA MD PA, DR. LUIS J MESA, MD to communicate with me through following forms of communication for health care matters:

- PHONE
- SMS MESSAGE
- EMAIL
- POST MAIL

Patient's signature: _____ Date: _____

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Financial and Administrative Policies and Agreement Form

Insurance Information and Patient Financial Responsibility

Your health insurance is a contract between you and your insurer. Any charges not paid by your insurer for any reason, are your responsibility. It is your responsibility to understand your insurance benefits, including plan limitations, the difference between screening or preventive care benefits, diagnostic procedure benefits, and the need for referrals or pre-authorizations. We will bill your insurance for all services we provide; However, we require you pay any portion of your financial liability for care including but not limited to co-pays, deductibles, or co-insurance prior to any service. Certain services performed by our office for your benefit, may not be covered by your insurance plan(s); these will be your financial responsibility.

At the time of check-in, all co-payments and any outstanding balances must be paid unless previous arrangements have been made with our office. This includes both in-person and telemedicine visits. For your convenience, we accept cash, check or credit/debit cards. We run payments through a secure, HIPPA and PCI-compliant merchant services application. If you decide to use a credit/debit card, there will be a 3% service charge for any transaction.

Patients without insurance coverage or coverage by an insurance in which the office does not participate with your account will be set up as “Self-Pay.” You may be given an estimate of “Self-Pay” cost prior to your visit, but this cost may change depending on the level of care and any procedures required during your visit.

Outstanding balance Policy

All past due accounts are contacted via statements, letter, and/or phone calls within accordance with our internal policy by our billing office. If resolution is not made after these attempts, the account will be sent to our collection’s agency.

Insurance Information and Patient Financial Responsibility

I have read and understand the Luis J Mesa MD PA’s financial and administrative policies, and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

I authorize payment of medical and/or surgical insurance benefits to proceed directly to Luis J Mesa MD PA. I understand I am responsible for any copayments, non-covered services, and any balances my insurance plan does not cover. In the event I do not meet my obligations, I will be responsible for collections costs, if any, including legal fees and allowed interest. I authorize Luis J Mesa MD PA to release any information acquired during my treatment necessary to process insurance claims. I authorize the physician/practitioner to initiate a complaint to the insurance company for any reason on my behalf.

If my insurance has changed, it is my responsibility to notify the Luis J Mesa MD PA. If I do not notify the Luis J Mesa MD PA of changes in my insurance, then I am responsible for any costs that occur for medical care or procedures that are

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not covered, or that were not authorized by my new insurance plan, with the Luis J Mesa MD PA under my new insurance plan or lapsed insurance. This includes any fees for visits, procedures and labs.

I authorize Luis J Mesa MD PA, to use the payment information (debit/credit card) on file to charge for the applicable missed appointment fees and "patient-responsibility" balances under $300 as per the EOB from my insurance company. If there is no payment information on file, I understand that I will be billed for the applicable fee. Payments will not exceed my indebtedness to the practice. A photocopy of this assignment shall be considered as effective and valid as the original. I acknowledge that I have read, understand, and agree to the above policy statement regarding the fees for missed appointments.

Patient's signature: _____ Date: _____