V-PaCC
Virginia Pulmonology and Critical Care LLC

4604 Spotsylvania Parkway
Suite 340
Fredericksburg, VA 22408
(540) 200-8272
info@v-pacc.com
"...spiro,spero..."

Patient Information

Name: _____Date of Birth_____

Address: _____ City: _____ State: _____

Zip:_____

Phone (H): _____ Phone(C): _____

SSN#:_____ Email Address: _____

Please check one:

Sex: ◯ M ◯ F Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Employer: _____ Occupation: _____

Primary Care Physician: _____ Phone: _____

Pharmacy Name and Address: _____

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Authorization For Use of Disclosure of Protected Health Information

I authorize my physician and/or administrative and clinical staff of Virginia Pulmonology and Critical Care LLC to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices.

Name and relationship of person(s) who you wish to allow access: (e.g., your spouse, son, daughter, sibling, caretaker, and friend)

	Name of person or entity:	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

Consent to Treat, Insurance Assignments, Financial Agreement, Authorization to ReleaseInformation and Privacy Notice Acknowledgement

_____ (initials) I have been provided a copy of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Notice of Privacy Practices to read and understand, and I consent to use and disclosure of protected health information about myself for treatment, payment and health care operations.

_____ (initials) I have been provided a copy of the Financial Policy to read. I understand that I, the patient or the patient's representative, am responsible for payment of all charges for service rendered. I also acknowledge that non-payment of my account may result in collections proceedings and dismissal from the practice.

_____ (initials) I authorize the release of any medical information necessary to process all claims, and I authorize the release of payment for medical benefits to Virginia Pulmonology and Critical Care LLC.

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Patient General Consent to Treat

I, the undersigned, hereby consent to the following:

Administration and performance of general treatments

Use of prescribed medications

Performance of diagnostic procedures/tests and cultures

Performance of other medically accepted diagnostic/laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I, fully understand that this consent is given in advance of any specific diagnosis or treatment.

I, intend that this consent is continuing in nature even after specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

A digital copy or fax of this consent shall be considered as valid as the original.

I, the undersigned, authorize the practice to use and disclose my information for the purposes of:

Treatment, payment, and healthcare operations as described in the Notice of Privacy Practices.

I, certify that I have read and fully understand the above statement, and I consent fully and voluntarily to its content.

Date: _____

Patient (or responsible party) Signature: _____

If Responsible Party, Relation to Patient: _____