971 Lakeland Drive, Suite 1052
Jackson, MS 39216
Phone 601-981-9503

501 Marshall Street, Suite 200
Jackson, Mississippi 39202
Phone 601 914 9503

Jackson Pulmonary
ASSOCIATES, P. A.

Name_____

D.O.B._____ **SSN#**_____

Address: _____

_____

Email Address:_____

Phone#_____

Pharmacy_____

Preferred Method Communication ❑Phone❑ Mail❑ Email

Martial Status: ❑ Married ❑ Separated ❑ Divorced ❑Other

Race: ❑American Indian/Alaska Native ❑ Asian ❑ Black/ AfricanAmerican ❑ Nat Hawaiian / Pacific Islander ❑ White ❑ Other
Ethnicity: ❑ Declined ❑ Hispanic/Latino ❑ Not Hispanic/ Latino

Authorization for Medical Treatment: I authorize and consent to healthcare services including, but not limited to, diagnostic procedures and medical treatment at **Jackson Pulmonary Associates**. I acknowledge that no guarantees or promises have been made to me as to the result to be obtained from such services. ❑ **Authrorize PBM Consent (Pharmacy)** ❑ **Release Medical Records**

Assignment of Benefits: I hereby give lifetime authorization for payment of insurance benefits to be made directly to Jackson Pulmonary Associates, P.A., and any assisting providers, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fee. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that photocopy of this agreement shall be as valid as the original.

Statement to Permit Payment of Medicare Benefits to Provider, Physician and Patient: "I request that payment of authorized Medicare benefits be made either to me or on my behalf to **Jackson Pulmonary Associates** for any services furnished me by that physician/provider. 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."

Patient Self-Determination Act: I acknowledge that I have been asked whether I have an advance directive such as a living will or healthcare durable power of attorney. I also acknowledge that I have been provided with written information concerning (1) a patient's right to make decisions concerning medical care, Including the right to accept or refuse medical or surgical treatment and the right to make advance directives, and (2) **Jackson Pulmonary Associates** policy regarding implementation of those rights.
Living Will? ❑ Yes ❑ No Healthcare Durable Power of Attorney? ❑ Yes ❑ No

Acknowledgement of Receipt of Notice: Privacy Office: Brian Hudson (601)981-9503: I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

_____	_____	_____
Insurance Company (Primary)	**Policy Number**	**Group Number**
_____	_____	_____
Insured Date of Birth	**Relationship to Patient**	**Social Security #**
_____	_____	_____
Insurance Company (Secondary)	**Policy Number**	**Group Number**
_____	_____	_____
Insured Date of Birth	**Relationship to Patient**	**Social Security #**

Patient Signature_____

Co-Guarantor: I, _____, understand that by signing this document, I agree to accept financial responsibility for healthcare services provided by **Jackson Pulmonary Associates** to the patient identified below. If the patient is unable to sign at registration, I accept this "Conditions for Healthcare Services" on behalf of the patient.
I certify that I have reviewed this document in full, understand its terms, and have had the opportunity to ask questions regarding its contents. I understand that this document is valid and remains in effect unless revoked by **Jackson Pulmonary Associates.**

SSN# _____ Relationship to Patient _____

Spouse Name :_____ Date of Birth_____ Social Security # _____

Phone: ( )_____ ( )_____ ( )_____
Home Work Cell

Emergency Contact of different from Spouse: Name: _____

Phone: ( )_____ ( )_____ ( )_____
Home Work Cell

Designation of a Personal Representative

A personal representative may act on behalf of the patient for the purpose of:

- **Authorizing use and disclosure of protected health information**
- **Receiving information that otherwise would be sent to the patient**

A patient may designate a personal representative in writing. However, a person who is identified in the patient record as having a medical power of attorney or other legal authority to act on behalf of the patient will be recognized as a patient representative. A parent or legal guardian of an un-emancipated minor (generally a child under the age of 18) will be recognized as a personal representative of the child.

A personal representative may receive protected health information concerning the patient necessary to carry out the representative's legal duties to the patient (for example, providing an informed consent to treatment or, for enforcing an advanced directive concerning life support).

The following individual(s) are my personal representative(s) and is authorized to act on my behalf and/or receive information on my behalf.

Personal Representative(s) Name: ***(List any family member or other person we can disclose your health information to)***

Name	Phone	Relation
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature_____ **Date**_____

Unable to Sign at Registration: ❑ Reason
_____

Patient Received above Information: ❑ Yes ❑ No
Jackson Pulmonary Associates Representative _____ **Date** _____