PULMONARY ASSOCIATES of Fredericksburg

521 Park Hill Dr. Fredericksburg, VA 22401
540-899-1615

Welcome to our practice

We are located across the street from Mary Washington Hospital Emergency Room.

You have an appointment with:

_____ Jeffrey R. Rehm, MD
_____ Nicholas Kallay, MD
_____ Chelsea Snyder, CNP
_____ Elizabeth Gotsios, CNP
_____ PFT (testing)
_____ Rohit Goyal, MD
_____ Richard A. Fiero, MD
_____ Alissa Bledsoe, CNP
_____ Corinnia Wagner, CNP
_____Walk test

On _____ at _____ am pm

Please bring with you to the appointment:
[ ] The enclosed paperwork filled out
[ ] Your insurance card(s)
[ ] Photo ID
[ ] Copay
[ ] Referral if required
[ ] List of your current medications with dosages
[ ] List of allergies

!!!!CALL 540-899-1615 option 3 !!!! (BEFORE you leave for your appointment) if you have any of the following:

COVID related If you have a Fever, New Cough, New Shortness of Breath, Sore throat, Head or body aches or have traveled outside of VA or been in contact with a CoVid positive person in the last 14 days

YOU MAY BE CHANGED TO A TELEHEALTH VISIT.

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521 Park Hill Dr. Fredericksburg, VA 22401 phone 540-899-1615 fax 540-372-3525 www.pafred.com

Patient Information

First Name: _____ Last Name: _____ Middle Initial: ____

Date of Birth: _____ Gender: ☐Male ☐Female Or Identify As: ☐Male ☐Female

Social Security:_____ Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed

Ethnicity/Race: _____ Preferred Language: _____

Patient Phone Numbers and Address:

Address: _____
Street City Zip

Home:_____ Cell: _____ Work:_____

Email: _____ Primary Contact #: ☐Home ☐Cell ☐Work

Pharmacy: _____ Primary Care Provider:_____

Emergency Contact:

_____ _____ _____
Name Phone Number Relationship

If patient is a minor, please list responsible party information:

_____ _____
Name Relationship

Insurance Information	
Primary:	Secondary:
Policy Holder Name:	Policy Holder Name:
Policy Holder Date of Birth:	Policy Holder Date of Birth:

I hereby authorize Pulmonary Associates of Fredericksburg, Inc. to release such information as may be necessary to any of my physicians or insurance companies that may be pertinent to my case. I also authorize payment directly to Pulmonary Associates of Fredericksburg, Inc. for any benefits otherwise payable to me. I understand that I am financially responsible for charges not covered by this authorization. Patients not covered by insurance are responsible at the time of service for charges incurred or arrangement for payment may be made with the business office at the time of service. I also authorized Pulmonary Associates of Fredericksburg, Inc. to release or obtain such information as may be made necessary to assist in my medical treatment. If this account is to be turned over to an attorney / collection agency the undersigned agrees to pay all costs of collections including attorney fees, interest and court costs. This form will be placed in your chart and be applicable until such information is changed.

Signature: _____ Date:_____

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HIPAA Release Form

I authorize Pulmonary Associates to discuss the following items with the individuals listed below:

Name: _____ [ ] Phone Calls / Messages [ ] Pick Up Prescriptions [ ] Financial

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Name: _____ [ ] Phone Calls / Messages [ ] Pick Up Prescriptions [ ] Financial

Name: _____ [ ] Phone Calls / Messages [ ] Pick Up Prescriptions [ ] Financial

[ ] I do **not** authorize my medical information to be discussed with any party outside of continuity of care with another medical professional.

This authorization will be in effect for one year from the date signed.

Signature _____ Date _____

PULMONARY ASSOCIATES of Fredericksburg

Our Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. Present your current insurance card and photo ID at every visit. This is your verification of the correct insurance and consent to bill them on your behalf.
2. **All Copays and Balances** are due at the time of service unless other arrangements have been made prior.
3. All Balances over 90 days must be paid unless a Payment Plan with a Credit Card on file has been made.
4. If you have an HMO, you are required to obtain a referral from your PCP prior to your appointment. If you do not have a referral you will be asked to self-pay or reschedule your appointment. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
5. We do not submit to Secondary or Tertiary insurance plans. YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT. If you have a Federal Secondary Plan that is the ONLY time we will submit the claim for you.
6. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
7. If you have no insurance, payment in full is expect at the Time Of Service.
8. A $35 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
9. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
10. We reserve the right to cancel or reschedule your appointment if you are not in compliance with our Financial Policy.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

If this Policy is altered in any way, we will not see you as a Patient in our office.

Patient Name:	DOB:
Signature:	Date:

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Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: _____
_____
_____

I have either requested and received a copy of the Notice of Privacy Practices for the above-named practice or been made aware that if I do not take one today the office possesses one on file and I may ask for one at any time.

_____ _____
Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❑ An emergency existed & a signature was not possible at the time.
- ❑ The individual refused to sign.
- ❑ A copy was mailed with a request for a signature by return mail.
- ❑ Unable to communicate with the patient for the following reason:
  _____
- ❑ Other:_____
  _____

Prepared By _____

Signature _____

Date _____

www.pafred.com
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