MUIR PULMONARY CRITICAL CARE
AND SLEEP MEDICINE

Ramin Khashayar, M.D. • Vala Berjis, M.D. • Elvio Ardilles, M.D. • Ming-Tyh Maa, M.D. • George Juan, M.D.
Jigar Patel, M.D. • Nick Pakzad, M.D. • Jeffrey Scott, M.D. Mark Slootsky, M.D.
Matthew Lyons, M.D. • Anna Grzegorczyk, M.D.

1399 Ygnacio Valley Road, Suite 14
Walnut Creek, CA 94598

Phone (925) 939-3050
Fax (925) 939-3057

Primary Care Physician (PCP): _____ Referring Doctor: _____

Your Email Address: _____ Race / Ethnicity: _____

Preferred Lang: _____ DME or CPAP Company: _____

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MIDDLE NAME:	MARITAL STATUS: SING MAR DIV SEP
IS THIS YOUR LEGAL NAME? ☐ YES ☐ NO	IF NOT, WHAT IS YOUR LEGAL NAME?	BIRTH DATE:	SEX: ☐ MALE ☐ FEMALE
STREET ADDRESS:	CITY:	STATE:	ZIP CODE:
HOME PHONE:	CELL PHONE:	SOCIAL SECURITY NUMBER:	
CURRENT OCCUPATION:	EMPLOYER:	EMPLOYER TEL. NUMBER:	

In case of an emergency at our office, please list a person we can contact.

NAME:	RELATIONSHIP TO PATIENT:	TELEPHONE NUMBER:

Insurance Information

(Please provide your insurance cards to the front desk)

1. Primary Insurance: _____
2. Secondary Insurance: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physicians. I understand that I am financially responsible for any balance. I also authorize Muir Pulmonary Critical Care or my insurance company to release any information required to process my claims.

_____ _____

Patient / Guardian Signature Date

Revised 6/7/23
By:SBishop

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HIPAA ACKNOWLEDGEMENT AND CONSENT

I, _____ acknowledge Muir Pulmonary Critical Care's Notice of Privacy Practices, and a copy will be provided to me upon request.

RE: RECORDS RELEASE FEE FOR PATIENTS

Should the patient request copies of their medical records, a fee of $0.25 per page (**California law** -Health & Safety Code §123110) will be charged, and be paid by the patient at the time of the request.

_____
Patient Initials

RE: MISSED APPOINTMENT FEES

Any missed appointment is a loss for everyone. As a patient of Muir Pulmonary Critical Care, you will receive a courtesy reminder call prior to your scheduled appointment to our office. As a patient, it is your responsibility to cancel or reschedule your appointment with a minimum of 24 hours or 1 (one) business day notice.

The current charge for a missed follow up appointment is $50.00, pulmonary function test (PFT) is $100, and a sleep study is $150. This fee is not covered by your insurance.

_____
Patient Initials

RE: TELEMEDICINE CONSENT

In the event that I undergo a telemedicine appointment with my physician, I consent to the usage of video and audio functions required by this visit.

_____
Patient Initials

I have read, understand, and agree to the terms of this form.

_____ _____
Patient Signature Date

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MEDICATION REFILL POLICY

- It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.

- Medication refills will only be addressed during regular office hours (Monday-Friday 8am-5pm). The on-call physician will not return any phone calls regarding refills. Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or holidays.

- Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

- Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

- It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. <u>All prescriptions require a follow up appointment every 3 to 6 months.</u>

- If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed, please contact us immediately. New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

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