Bucks County
MEDICAL ASSOCIATES, P.C.

2003 Lower State Road, Building 100 Suite 110
Doylestown, PA 18901
(215) 348-1310 • Fax (215) 348-8615
https://www.bcmapa.com/

- Pulmonary Medicine
- Critical Care
- Sleep Disorders

Welcome to Bucks County Medical Associates!

Attached is our New Patient Paperwork. Please bring all completed forms, as well as photo ID, and insurance/pharmacy benefit cards. If your insurance requires a referral, please contact your primary doctor 1-2 weeks prior to your appointment.

Our NPI is 1952408015.

PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR APPOINTMENT

If you are seeing us for a sleep consultation, and are a current CPAP user, please bring your data chip along.

If you are not a current CPAP user but have had a sleep study in the past, please bring that report along with you to your visit. If no study is provided, a new test will be performed.

Please call us within 48 hours if you must cancel or reschedule your appointment. Due to an unprecedented number of no show/late cancellations, BCMA may charge a $50 (up to $100 if you are a new patient to our practice) fee.
We appreciate your cooperation in this matter and look forward to meeting you!

NOTICE

Please try to arrive 30 minutes prior to your appointment for check in. Be advised that we are also a FRAGRANCE FREE Office. Please refrain from wearing any perfumes, colognes, or body sprays when attending your appointments.

Thank you

Stanford D. Gittlen, M.D., F.A.C.P., F.C.C.P. Les A. Szekely, M.D., F.C.C.P., D.A.B.S.M., Pinak S. Acharya, M.D., F.A.C.P. Manuel Jimenez, M.D. Kathy A. Tran, D.O. Andrew Figueroa, M.D., Raminder S. Cheema M.D., Lora Crowley, M.S.N., C.R.N.P. Alice Thornhill, M.S.N., C.R.N.P. Taylor Maher, M.S.N., C.R.N.P.

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NOTICE OF PRIVACY PRACTICES

To our patients:

Doylestown Healthcare Partnership participates in various health information exchanges where we disclose your health information, as permitted by law, to other health careproviders for your treatment, or for payment or other heath care operations purposes. This notice describes how health information about you, as a patient of this practice, may be used and disclosed and how you may get access to your health Information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996.

Our commitment to your privacy:
Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidential of your health information.

Use and Disclosure of Health Information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in direct response to a court order.
3. Messages on answering machines about appointment and follow-ups.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
5. If you ii a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials if required for intelligence and national security.
7. For Workers Compensation and similar programs.

Research:

Under certain circumstances, we may use and disclose medical information about you for research purposes. We will not use or disclose Information about you until a special approval process, which evaluates the use of medical information, has approved the research project. We may disclose information about you to people preparing to conduct a research project so long as the information they review does not leave the practice.

Your Rights Regarding Health Information:

1. Communications. You may request that our practice communicate with you about your health and related Issues in a particular manner or location. For example, you may request that we only contact you at home or at work.
2. You may request a restriction in our use of disclosure of your health information beyond what is written here. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you. There will be small copying fee. You must submit your request in writing to ***Bucks County Medical Associate, P.C., Attn: Medical records, 2003 Lower State Rd, Unit 110, Doylestown, PA 18901.***
4. You may ask to amend your health information if you believe it to be incomplete or Incorrect. To request an amendment, your request must be made in writing and submitted to Bucks County Medical Associates, *Bucks County Medical Associate, P.C., Attn: Medical records, 2003 Lower State Rd, Unit 110, Doylestown, PA 18901*. You must provide us with a reason that supports your request.
5. Request a copy of this notice
6. Right to file a complaint. If you believe that your privacy right has been violated, you may file a complaint with our practice or the Secretary of the Department of Health and Human Services. Your complaint must be made In writing and submitted to ***Bucks County Medical Associate, P.C., Attn: Medical records, 2003 Lower State Rd, Unit 110, Doylestown, PA 18901.***

If you have any questions regarding this notice or our health Information privacy policies, please contact our office at 215-348-1310
I hereby acknowledge that I have been presented with a copy of Bucks County Medical As.soclates, P.C. Notice of Privacy Practice.

_____ _____

Signature of Patient **DATE**

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EFFECTIVE: JANUARY 1st, 2023

FINANCIAL RESPONSIBILITY POLICY

NAME:_____ DATE OF BIRTH:_____

In order to provide you with quality service we ask you to read and sign this form to acknowledge your understanding of your financial responsibility.

Bucks County Medical Associates ("BCMA") accepts Medicare, Most Medicare Advantage plans, and Most Commercial Insurance Plans. Services include office visits, diagnostic tests, labs, immunizations and any other billable services performed at or initiated by Bucks County Medical Associates.

Please be aware that some of the services may not be covered by your insurance plan. It is our policy not to perform services unless deemed medically necessary.

You are required to provide us with the your current and correct insurance information. If you have any changes in your insurance coverage, please notify us. You will be responsible for any charges incurred if the information provided is not correct or updated.

It is your responsibility to verify coverage of services, referrals and/or authorizations with your insurance plan. It is also your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as referral and authorization requirements. This information is furnished by your insurance plan. *Insurance contact information is listed on your insurance card(s).*

You are responsible for the payment of copays, coinsurance, deductibles, and services not covered by your insurance plan. Copays are due at the time of service. You may incur, and are responsible for payment of additional charges at the discretion of BCMA. These charges may include (but not limited to):

- Charge for cancellation or missed appointments without **48 hours** advance notice
  - Established Patient Visit - $50.00
  - Pulmonary Function Test Only Appointment - $75.00
  - Established Patient With Pulmonary Function Test - $100.00
  - New Patient Visit - $100.00
- Charge for returned checks - $25.00 Service Fee
- **Charges for completing forms can range from $10 - $20**
- Charges for the copying and distribution of your medical records. You will be informed of any potential charges and asked to sign a release of information ahead of time.

BCMA reserves the right to discontinue providing your medical care after canceled, no show or rescheduled appointments.

PATIENT SIGNATURE:_____ DATE:_____

BUCKS COUNTY MEDICAL ASSOCIATES
PATIENT HEALTH QUESTIONNAIRE

Name_____ DOB_____ Date_____

Local Pharmacy_____ Pharmacy Phone_____

Mail Order Pharmacy_____

Medication Allergies (list): _____

PERSONAL MEDICAL HISTORY. PLEASE CHECK ALL THAT APPLY.

Pneumonia		**Coronary Artery Dis**		**Frequent ear infections**	
Pleurisy		**Heart Attack**		**Colon Polyps**	
Asthma		**Irregular heartbeat**		**Colon Cancer**	
Emphysema/COPD		**Heart Murmur/Valve Disease**		**Kidney Stones**	
Chronic Bronchitis		**Deep Vein Thrombosis**		**Prostate Disease**	
Lung Cancer		**Pulmonary Embolism**		**Prostate Cancer**	
Lung Surgery		**Peripheral/Carotid Vascular Dis**		**Anemia**	
Hay fever		**Esophageal Disease**		**Diabetes**	
Hypertension		**Hiatal Hernia**		**Thyroid Disease**	
Insomnia		**Ulcers/Gastritis**		**Rheumatoid Arthritis**	
Sleep Apnea		**Liver Disease or Cirrhosis**		**Immune Disorder**	
Chronic sinusitis		**Allergic rhinitis**		**Nasal polyps**	
Eczema		**Osteoporosis**		**Osteoarthritis**	
Stroke		**Hyperlipidemia**		**Parkinson's**	
Seizures		**Depression or Anxiety**		**Migraines**	
Breast Cancer		**Tuberculosis**		**Other***	

***If other, please explain**_____

PREVIOUS SURGERIES

When	Procedure	When	Procedure

FAMILY HISTORY

		Which relative?
Asthma		
Chronic bronchitis		
Emphysema		
Tuberculosis		
Pulmonary embolism		
Deep vein thrombosis		
Lung Cancer		

		Which relative?
Hypertension		
Coronary disease		
Heart attack		
Diabetes		
Thyroid disease		
Other cancers (specify)		

If family member deceased, cause of death_____

TURN OVER ==>

Name_____ DOB_____ Date_____

SYSTEMS REVIEW. PLEASE CHECK ALL THAT CURRENTLY APPLY.

RESPIRATORY	
Wheezing	☐
Cough	☐
Coughing blood	☐
Breathlessness:	☐
At night	☐
Lying down	☐
With exertion	☐
Sputum	☐
Snoring	☐
Chest pain with respiration	☐
ALLERGY SYMPTOMS	
Hives	☐
Runny nose	☐
Eye irritation	☐
CARDIAC	
Chest pains	☐
Palpitations	☐
HEMATOLOGIC	
Easy bruising	☐
Enlarged glands	☐

GENERAL	
Fever	☐
Sweats	☐
Chills	☐
Weight Change	☐
Fatigue	☐
Musculoskeletal	☐
Joint pain	☐
Joint stiffness	☐
Joint swelling	☐
Back pain	☐
ENDOCRINE	
Heat intolerance	☐
Cold intolerance	☐
Excessive thirst	☐
Excessive urination	☐
Gland swelling	☐
PSYCHIATRIC	
Mood swings	☐
Depression	☐

GI	
Nausea	☐
Vomiting	☐
Diarrhea	☐
Constipation	☐
Heartburn	☐
Change in bowels	☐
Rectal bleeding	☐
GU	
Difficulty urinating	☐
Blood in urine	☐
Voiding at night	☐
Frequent voiding	☐
Testicular pain	☐
Abnormal menses	☐
Post-menopausal	☐
SKIN	
Rashes	☐
Ulcers	☐
Jaundice	☐
Change hair,skin,nails	☐

EARS	
Hearing Loss	☐
Discharge	☐
EYES	
Blurred Vision	☐
Double Vision	☐
Inflammation	☐
NOSE	
Postnasal drip	☐
Nosebleeds	☐
Obstruction	☐
Discharge	☐
Sinus pain	☐
MOUTH/THROAT	
Gum soreness	☐
Swallow dysfunction	☐
Hoarseness	☐

MEDICATIONS STARTING WITH RESPIRATORY MEDICATIONS (ATTACH ADDITIONAL SHEETS OR MEDICATION LIST IF AVAILABLE)

Medication	Strength	Frequency

Medication	Strength	Frequency

Do you have pets (cats, dogs, birds, other)? If so, _____
Recent travel _____

Any occupational exposure? Asbestos☐ Silica☐ Chemicals☐ Exhaust☐ Concrete☐ Wood☐ Dust☐
Occupation (or if retired, by history) _____
Have you ever worked...Metal worker☐ Foundry☐ Welder☐ Mine☐ Quarry☐ Farm☐

Do you smoke?☐ For how long?_____ How much daily?_____
If not currently smoking, when did you quit? _____ How long smoking?_____ How much?_____
Do you drink alcohol?☐ How many drinks _____

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AUTHORIZATION FOR DISCLOSURE

In the event we need to contact you regarding test results, medications or verbal physician orders may we:

Leave a message on your answering machine? Yes ☐ No ☐

Leave a message with a family member? Yes ☐ No ☐

Are there any exceptions or special instructions you would like to list?

_____

_____

_____

Is there a designated person(s) that you authorize us to discuss your medical condition with if necessary?

Name:_____DOB:_____Relationship:_____

Phone Number:_____

Name:_____DOB:_____Relationship:_____

Phone Number:_____

I hereby authorize Bucks County Medical Associates, P.C. to handle the disclosure of my health information as stated above.

Name of Patient (please print)_____

Signature of Patient:_____ Date:_____