Gregory R. Brevetti MD, PC
631-353-0909
Port Jefferson | West Islip | Amityville

Payment Policy Statement

The following is a statement of our financial policy.

Participating Providers: This means that the physician you will see accepts your insurance.

- Please present insurance card
- Co-payments are DUE AT TIME OF SERVICE
- The patient or guarantor will be held responsible for any deductibles, co-insurance, or any other financial obligations dictated by your insurance contract. It is the patient's responsibility to know the terms of their insurance contract.
- The patient acknowledges that any charge not covered by their insurance is their financial responsibility
- Patients without insurance card(s) and valid referrals may be asked for payment in full at time of service if their insurance cannot be verified.

Non-Participating Providers: This means that the physician you will see does NOT accept your insurance.

Payment for all services related to the visit is DUE AT TIME OF SERVICE. You will be provided with a receipt for you to submit to your insurance. Please be aware of what your contract is with your insurance. If you do not have out of network benefits you will not be eligible for reimbursement from your insurance company.

The following methods of payment are provided for your convenience:

- Cash
- Checks
- All major credit cards (Visa, Mastercard, American Express, Discover)

I have read the payment policy; I fully understand and agree to it.

_____ _____

Patient Name (Please Print) Patient Signature

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Patient Demographics

Name: _____ Date of Birth: _____

Social Security #: _____

Gender identity: Male _____ Female_____ Prefer not to specify_____

Race / Ethnicity: _____

Home Phone#: _____ Mobile #: _____

Address: _____City:_____Zip:_____

Email: _____

Pharmacy: _____Phone#: _____

Pharmacy address: _____City:_____Zip:_____

Primary Insurance: ***Please present to front desk upon arrival***

Next of Kin: _____Relationship to patient: _____

Contact #: _____

Emergency Contact: _____Phone#:_____

Relationship to patient: _____

How were you referred to us? _____

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Pulmonologist: _____

Primary Care: _____

Cardiologist: _____

Oncologist: _____

Other Specialty: _____

Social History

Smoker: _____Non-Smoker: _____ Quit year: _____

Alcohol use: _____ drink(s) per day_____ No alcohol use: _____

Recreational Drug use: _____ Type: _____ Never: _____

Family Health History

Relative: _____ Condition: _____

_____

_____

_____

_____

Allergies (List type and reaction)

Medication / Environmental: _____ Reaction: _____

_____

_____

_____

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Surgeries (List Type and Date)

Type of Surgery: _____ Date of Surgery: _____

_____
_____
_____
_____

Ongoing Medical Problems (i.e., COPD, CHF etc.)

_____
_____
_____
_____

Medications

Name of Medication: _____ Dose: _____ Frequency: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____

Implantable Devices

Device Identifier: _____

Implant Date: _____

Active: _____Inactive: _____

Asbestos Exposure Questionnaire

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What is your occupation? If retired, what was your occupation?

Do you have any known exposure to asbestos?

What did your parents do for a living?

Have you ever worked in construction?

Did you ever have any summer or part-time jobs in construction, that may have exposed you to asbestos.

Has your spouse ever been exposed to asbestos?

Did you or your spouse ever work in a shipyard?

Did you or your spouse ever work in a powerhouse?

Did you or your spouse ever work around asbestos brakes?

Did you ever work on or around boilers that would have exposed you to asbestos?

Did you or your spouse ever work around pumps, valves, precipitators, heating, and ventilation? Equipment, turbines, or any equipment that may have had asbestos in it?

In your trade, did you work around others using asbestos?

Have you ever worked in, or around any of the following trades? (check all that apply)

Pipe coverer	Pipefitter	Steamfitter
Plumber	Metal Lather	Shipyard Worker
Powerhouse Worker	Electrician	Carpenter
Auto Mechanic	Welder	Painter
Transit Authority	Engineer	Navy
Sheet Metal Worker	Glazier	Machinist
Mason Tender	Roofer	Other

Patient Name (Please Print)

Date of Birth

DISCLOSURE OF HEALTH INFORMATION

Gregory R. Brevetti MD, PC

631-353-0909

Port Jefferson | West Islip | Amityville

Patient: _____ Date of Birth:_____

I authorize the following using or disclosing party: **Gregory R. Brevetti MD, PC** to use or disclose the following health information.

☐ - All of my health information

☐ - My health information relating to the following treatment or condition:

_____

☐ - My health information covering the period from _____ (date) to _____ (date)

Other: _____

This authorization ends: On (date)_____

A copy of this authorization is as valid as the original.

_____

Patient Name (Print)

_____ _____

Patient or Legally Authorized Representative Signature Date

_____ _____

Legally Authorized representative (Print) Relationship to Patient

HIPPA Compliance

I have received Notice of Privacy Practices and PHI policy either electronically or in paper form.

_____

Patient Name (Print)

_____ _____

Patient or Legally Authorized Representative Signature Date

_____ _____

Legally Authorized representative (Print) Relationship to Patient