PULMONARY PRACTICE ASSOCIATES

Consent, Release, and Notification for treatment, payment, and other health care operations.

Instructions: Please read form in its entirety, initial where necessary, and sign at the bottom.

Consent and Release

I, _____, hereby authorize Pulmonary Practice Associates, its practitioners, and its staff to use and/or disclose my health information, which specifically identifies me or can reasonably be used to identify me to carry out my treatment, payment, and health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, Pulmonary Practice Associates can refuse to treat me.

I have received and/or reviewed a copy of the Notice of Privacy Practices (the "Notice"), which more fully describes the uses and disclosures that can be made of my individually identifiable health information for treatment, payment and health care operations.

I understand I may revoke the consent at any time by notifying Pulmonary Practice Associates in writing. However if I revoke my consent, such revocation will not affect any actions that Pulmonary Practice Associates took before receiving my revocation.

I understand Pulmonary Practice Associates reserves its right to change its privacy practices and that I can obtain such change notification upon request.

I understand I have the right to request that Pulmonary Practice Associates restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment or health care operations. I further understand Pulmonary Practice Associates does not have to agree to such restrictions, but once such restrictions are agreed to, Pulmonary Practice Associates must adhere to such restrictions.

_____ ◄
Initial

Appointment Reminder

Pulmonary Practice Associates…

…may leave a message at my **home** using doctor's/practice name: ☐ Yes ☐ No

…may leave a message at my **work** using doctor's/practice name: ☐ Yes ☐ No

Pulmonary Practice Associates has permission to discuss my medical care with myself and the following person(s):

_____ _____ ◄
Initial

Patient Responsibility and Notification Responsibility

I understand it is my responsibility to contact the office within 7–10 days after the study/test/procedure has been completed to verify results are negative/normal/stable and no other testing/office visit is necessary if my follow-up appointment is cancelled or rescheduled by myself or by Pulmonary Practice Associates after completing a radiological imaging study (X-ray, CAT Scan, MRI), or any other test/procedure. _____ ◄
Initial

I understand that my scheduled appointment time does not necessarily guarantee I will be seen by a clinician at that time, but instead it places me in an order to be seen. Also, I understand that if I am more than 10 minutes late for my scheduled appointment, I may be asked to reschedule my appointment. I further understand if I do not show for my scheduled appointment, I may be charged a minimum fee of $25 per occurrence. _____ ◄
Initial

Attestation: *By my signature below, I agree to all information stated herein and understand my rights and responsibilities as a patient of Pulmonary Practice Associates.*

_____ _____
Signature of Patient or Patient Representative Date

_____ _____
Printed Name of Patient or Patient Representative Relationship to patient

PULMONARY PRACTICE ASSOCIATES

Release, Authorizations, and Assignments

Instructions: Please read form in its entirety, initial where necessary, and sign at the bottom.

Release of Information

I authorize Pulmonary Practice Associates, MD, PA, to release to any insurance company or government agency any medical information contained in my records, when such material is required in connection with determining a claim for payment.

I authorize Pulmonary Practice Associates, MD, PA, to release any medical information accumulated in the course of my examination or treatment to any other doctor, hospital, or nursing home.

I authorize the release of any medical information contained in any other doctors' or hospitals' records to Pulmonary Practice Associates, MD, PA.

_____ ◄
Initial

Insurance Assignment

I authorize payment from any insurance company or any governmental agency to Pulmonary Practice Associates, MD, PA, for any medical or surgical benefits otherwise payable to me for the services provided by Pulmonary Practice Associates, MD, PA, but not to exceed the reasonable and customary charge for these services.

_____ ◄
Initial

Authorization of Care and Acknowledgment of Responsibility for Payment

I authorize Pulmonary Practice Associates, MD, PA, to examine me and order/perform such tests and/or procedures as are reasonable and necessary in the diagnosis and treatment of my case.

I understand that it is my responsibility to understand what professional services are covered/not covered by my insurance.

I understand that it is my responsibility to contact my insurance company to determine what is my out-of-pocket expense responsibility for services provided or will be provided to me for medical care.

I agree to pay Pulmonary Practice Associates, MD, PA, the professional fees in return for the above rendered services.

I agree that, should the amount of any insurance benefits be insufficient to cover the professional fees of services rendered to me for medical care, I will be responsible for the payment of the difference.

I agree to pay the entire amount of my professional fees if my professional fees are not covered by my insurance benefits.

_____ ◄
Initial

Original Assignments, Authorizations, and Releases on File

I permit a copy of the above assignments, authorizations, and releases to be used in place of the original, which has been filed in the office of Pulmonary Practice Associates, MD, PA.

_____ _____
Signature of Patient or Patient Representative | Date

_____ _____
Printed Name of Patient or Patient Representative | Relationship to patient

PULMONARY PRACTICE ASSOCIATES: Registration Form

*Directions: All sections must be completed. Write **"N/A"** if not applicable*

1. PATIENT INFORMATION

Patient's Last Name	First	MI	Date of Birth	Age

Former Last Name (if any)	Gender ☐ M ☐F	Social Security #

Race	Ethnicity
☐Asian ☐Black ☐White ☐Other ☐Refuse To Respond	☐Hispanic/Latino ☐Non-Hispanic/Latino ☐Refuse To Respond

Mailing Address	City	State	ZIP Code

Home Address (if different from Mailing Address)	City	State	ZIP Code

Home Phone #	Cell Phone #	Email

Chose Clinic Because/Referred to Clinic by	Other Family Members Seen Here

2. INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD(S) AND A PHOTO ID TO THE RECEPTIONIST)

Is This Patient Covered By Insurance? ☐ **Yes** ☐ **No (If Not Covered by Insurance, Payment Is Due On The Date Of Service)**

Name of Primary Insurance _____ ☐ PPO ☐ HMO

Patient's Relationship to Subscriber of Primary Insurance ☐ Self ☐Spouse ☐ Child ☐ Other

If Not Primary Subscriber,
Subscriber's Full Name:_____ Social Sec#:_____ DOB:_____

Name of Secondary Insurance (if applicable) _____

Patient's Relationship to Subscriber of Secondary Insurance ☐ Self ☐Spouse ☐ Child ☐ Other

If Not Primary Subscriber,
Subscriber's Full Name:_____ Social Sec#:_____ DOB:_____

3. MEDICAL INFORMATION

Pharmacy Name	Phone #

Are you allergic to any medications? ☐ Yes ☐ No Are you allergic to Penicillin? ☐ Yes ☐ No

Please list all medicine allergies: 1. _____ 2._____ 3. _____

List ALL medications you take including dosage (include any over the counter medications/vitamins):

1. _____ 2._____ 3. _____ 4._____

5. _____ 6._____ 7. _____ 8._____

4. EMERGENCY CONTACT

Name of Local Friend or Relative	Relationship to Patient	Home Phone #	Alternate Phone #

5. ADVANCED CARE PLANNING – Patients age 65 years and older only

☐ I have an advanced care plan / living will and my Surrogate Decision Maker's Name is stated below.
☐ I have an advanced care plan / living will but I do not wish or I am unable to name my Surrogate Decision Maker.
☐ I do not have an advanced care plan / living will, but I would like information.

My Surrogate Decision Maker's Name	Phone #

MEDICARE PATIENTS ONLY: I request payment of my MEDIGAP benefits be made to Pulmonary Practice Associates ("PPA") for services provided to me. I authorize PPA to release to my MEDIGAP company any information needed to determine benefits.

_____ _____
Signature of Patient or Patient Representative Date

_____ _____
Printed Name of Patient or Patient Representative Relationship to patient

PULMONARY PRACTICE ASSOCIATES: Intake Form (*Page 1*)

*Directions: All sections must be completed. Write **"N/A"** if not applicable*

PATIENT INFORMATION	
Name	DOB

FAMILY HISTORY

☐ Unobtainable/Unknown (Adopted) ☐ No Significant History ☐ Early Deaths

(Use the following: "M" = Mother, "F" = Father, "S" = Sister(s); "B" = Brother(s): *Who in your family has had…*

Allergies		CAD		Gout		Renal (Kidney) Disease	
Anxiety Disorder		Cancer		Heart Attack		Sarcoidosis	
Arthritis		*Cancer Type*		Heart Disease		Seizure Disorder	
Arthritis Type		Colon Cancer		High Cholesterol		Sleep Disorder	
Asbestosis		COPD		High Blood Pressure		Stroke Syndrome	
Asthma		Depression		Lung Cancer		Thyroid Disorders	
Breast Cancer		Diabetes		Mental Disorder		Tuberculosis	
Bronchitis		Emphysema		Prostate Cancer		Ulcers	

Father's Side	Age	State of Health (If Living)	Cause of Death (If Applicable)	Age at Death
My Grandfather				
My Grandmother				
Mother's Side				
My Grandfather				
My Grandmother				
My Father				
My Mother				
My Brother(s)				
My Sister(s)				
My Child(ren)	M/F			
	M/F			
	M/F			

PULMONARY PRACTICE ASSOCIATES: Intake Form (*Page 2*)

*Directions: All sections must be completed. Write **"N/A"** if not applicable*

PATIENT INFORMATION

Name	DOB	Today's Date

SOCIAL HISTORY

List **ALL OCCUPATIONS** including MILITARY HISTORY, from current occupation to previous.

Marital Status (Check One) ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Engaged

Employment Status (Check One) ☐ Full Time ☐ Part Time ☐ Unemployed ☐ Retired ☐ Student

Occupation (If retired, write "Retired")	Employer	Employer Phone #

Smoking History / Exposure: Do you smoke ☐ Cigarettes? ☐ Cigars? ☐ Pipe?

If you do not currently smoke, have you ever smoked? ☐ Yes ☐ No, If yes, when did you quit? _____

How much per day? _____ For how long? _____

Check all that apply: ☐ Wish to stop smoking. ☐ Recently stopped smoking. ☐ Unsuccessful attempt(s) to stop smoking.

Exposure to second-hand smoke? ☐ Yes ☐ No.

Do you use the following (check all that apply): ☐ Alcohol, ____drinks per week. ☐ Caffeine, ____ cups per day.
☐ Drug Use, Type: _____

Do you have the following (check all that apply): ☐ Poor exercise habits ☐ Physical Disability ☐ Stress ☐ Exposure to TB
☐ Difficulty understanding the Native Language ☐ School/Work Absenteeism

Pet Exposure: Exposure to animals triggers a reaction? ☐ Yes ☐ No.

I have… ☐ had recent contact with pets or other animals. ☐ animals living in my home.
☐ Birds: How many? _____. ☐ Cats: How many? ____. ☐ Dogs: How many? _____

PAST MEDICAL HISTORY

Have you ever been diagnosed as having any of the following illnesses (check all that apply):

☐ Allergic Rhinitis	☐ CHF	☐ HIV Infection	☐ Mumps	☐ Sarcoidosis
☐ Alpha 1 Antitrypsin Deficiency	☐ CVA (Stroke)	☐ High Cholesterol	☐ Narcolepsy	☐ Seizure Disorder
☐ Anemia	☐ Depression	☐ Hyperthyroidism	☐ Pancreatitis	☐ Sinusitis
☐ Anxiety Disorder	☐ Diabetes	☐ Hypothyroidism	☐ Pneumonia	☐ Sleep Apnea
☐ Arthritis: Type_____	☐ Emphysema	☐ Jaundice	☐ Polio	☐ Syncope
☐ Asthma	☐ Gout	☐ Kidney Stones	☐ PVD	☐ Tuberculosis
☐ Blood Clots	☐ Hay Fever	☐ Liver Disease	☐ Kidney Disorder/Failure	☐ Stomach Ulcer
☐ Bronchitis	☐ Heart Attack	☐ Lung Cancer	☐ Kidney Disease End Stage	☐ Upper Resp. Infection
☐ CAD	☐ Heart Disease	☐ Lung Mass/Nodule	☐ Restless Legs	☐ Varicose Veins
☐ Cancer: Type_____	☐ High Blood Pressure	☐ Measles	☐ Restrictive Lung Disease	☐ Whooping Cough
☐ COPD	☐ Low Blood Pressure	☐ Mental Illness	☐ Rheumatic Fever	☐ Other:_____

☐ Previous Hospitalizations: Reason & Date_____

_____

Your major problem at this time: _____

PULMONARY PRACTICE ASSOCIATES: Intake Form (*Page 3*)

*Directions: All sections must be completed. Write **"N/A"** if not applicable*

PATIENT INFORMATION

Name	DOB	Today's Date

SURGICAL HISTORY

Please check any surgeries you have had and provide details (check all that apply):

Date and Details

General Surgery

- ☐ Amputation(s)_____
- ☐ Aneurysm _____
- ☐ Arm _____
- ☐ Back _____
- ☐ Breast _____
- ☐ Cataract _____
- ☐ Facial _____
- ☐ Foot _____
- ☐ Hand _____
- ☐ Hip _____

Gynecological Surgery:

- ☐ C-Section _____
- ☐ Hysterectomy _____

Cardiovascular Surgery:

- ☐ AAA _____
- ☐ CABG _____
- ☐ Carotid Endarterectomy _____
- ☐ Stent _____

Gastro:

- ☐ Appendectomy _____
- ☐ Cholecystectomy _____
- ☐ Colonoscopy _____
- ☐ Gastrointestinal _____

Hernia:

- ☐ Hernia Repair _____
- ☐ Inguinal Repair _____

Lung Surgery:

- ☐ Bronchoscopy _____
- ☐ Lung Biopsy_____
- ☐ Thoracentesis _____

Date and Details

- ☐ Kidney _____
- ☐ Knee _____
- ☐ Neck _____
- ☐ Shoulder _____
- ☐ Sinus _____
- ☐ Thyroid _____
- ☐ Tonsillectomy _____
- ☐ Uvuloplasty _____
- ☐ Wrist _____
- ☐ Other _____

- ☐ Mastectomy _____
- ☐ Oophorectomy _____

- ☐ Heart Valve Replacement _____
- ☐ Angioplasty _____
- ☐ Pacemaker _____
- ☐ Total # Performed _____

- ☐ Hemorrhoidectomy _____
- ☐ Prostatectomy _____
- ☐ Splenectomy _____
- ☐ Vasectomy _____

- ☐ Umbilical Repair _____
- ☐ Ventral Repair _____

- ☐ Lobectomy _____
- ☐ Lung Surgery _____
- ☐ Pneumonectomy _____

- ☐ Excision of Lesion of Mediastinum _____
- ☐ Excision Lesion of Chest Wall _____
- ☐ Wedge Resection of Lung _____

PULMONARY PRACTICE ASSOCIATES: ROS

*Directions: All sections must be completed. Write **"N/A"** if not applicable*

PATIENT INFORMATION		
Name	DOB	Today's Date

Height _____ Usual Weight _____ Present Weight _____

SYMPTOMS: Are you having any of these symptoms (check all that apply):

- ☐ Fever
- ☐ Night Sweats
- ☐ Chills
- ☐ Rashes
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ Sputum: *Color* _____
- ☐ Blood in Sputum
- ☐ Headache
- ☐ Sinus Congestion
- ☐ Nasal Discharge
  - ☐ *Discharge drips down throat, causing cough*
- ☐ Excessive Thirst
- ☐ Swollen Glands (neck)
- ☐ Sore Throat
- ☐ Difficulty Swallowing
- ☐ Hoarseness
- ☐ Chest Pain / Discomfort
- ☐ Pleuritic Chest Pain
- ☐ Chest Trauma
- ☐ Feelings of Weakness
- ☐ Fainting
- ☐ Paralysis
- ☐ Seizure(s)
- ☐ Weight Change
- ☐ Abdominal Pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Heartburn
  - ☐ *Causes Awakening*
  - ☐ *with Regurgitation*
- ☐ Calf Tenderness
- ☐ Leg Swelling
- ☐ Limb Swelling
- ☐ Legs feel Restless
- ☐ Snoring
- ☐ Sleepiness
- ☐ Fatigue
- ☐ Sleep too much
- ☐ Insomnia
- ☐ Sleep Disturbances
- ☐ Muscle Aches
- ☐ Joint Pain / Arthritis
- ☐ Hearing Loss
- ☐ Fast Heart Rate
- ☐ Palpitations

Exposure to…

- ☐ *Asbestos*
- ☐ *Fumes*
- ☐ *Sandblasting*

- ☐ Anxiety
- ☐ Depression

Are you here for or do you have a history of Asthma? ☐ Yes ☐ No

Are you here for Sleep Apnea / Sleep Problems? ☐ Yes ☐ No

VACCINATION INFORMATION

Have you received your FLU vaccine this year? ☐ Yes ☐ No ☐ Refused If yes, date _____

When was your last Pneumonia Shot? Date/Year _____

ADVANCED SLEEP DISORDER CENTER
at
PULMONARY PRACTICE ASSOCIATES
"Better Sleep, Better Health"
CPAP CLINIC FOLLOW-UP REPORT

Name _____

DOB _____ BMI _____ Neck Circumference _____ (inches)

Rate each description according to your normal way of life in recent times. Even if you have not been in some of these situations recently, try to determine how sleepy you would have been. Use the following scale to choose the best number for each situation:

0 = would never doze.
1 = would have a SLIGHT CHANCE of dozing.
2 = would have a MODERATE CHANCE of dozing.
3 = would have a HIGH CHANCE of dozing.

SITUATION: Likelihood of falling asleep:	CHANCE OF DOZING
1. During the day, after lunch, without alcohol..……..	_____
2. Sitting and reading……....	_____
3. Watching TV……....	_____
4. Sitting inactive in a public place (e.g. theater, or in a meeting)…….……..	_____
5. Sitting as a passenger in a car for an hour without a break……..…….	_____
6. Lying down to rest in the afternoon……..……..….	_____
7. Sitting and talking to someone……..……..….	_____
8. In a car while stopped in traffic……..……..…...	_____
TOTAL SCORE	_____

Answer the questions below ONLY IF you have had CPAP or BiPAP ordered.

1. If you have CPAP, BiPAP, or Oxygen equipment, what company set up your equipment?
   _____
2. What is the approximate date you began using your equipment? _____
3. Was the use, cleaning, and care of your equipment explained completely to you be the company? ___YES ___NO
4. Have you had any problems with the company? ___YES ___NO. If YES, explain:
   _____
5. If you had CPAP or BiPAP ordered, how many hours a night are you using your equipment?
   _____ Hours per night _____ Days per week
6. If you are not using your equipment as ordered, why not? Explain in detail:_____
   _____
7. Do you feel your treatment has improved your quality or life and health? ___YES ___NO
   If yes, how? (check all that apply) ___I have lost weight. ___I have more energy.
   ___I socialize more. ___My overall health is better/feel better.

   Comments: _____

Pulmonary Practice Associates - **Asthma Assessment Tool**
(Only complete if you were previously diagnosed with Asthma)

Pt. Name _____ Date: _____

1. In the past 4 weeks, how much of the time did your asthma keep you from getting as much done as usual at work, school, or at home?

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
All of the time	Most of the time	Some of the time	A little of the time	None of the time

2. During the past 4 weeks, how often have you had shortness of breath?

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
More than once a day	Once a day	3-6 times a week	Once or twice a week	Not at all

3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning?

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
4 or more nights a week	2-3 nights a week	Once or twice a week	Once a week	Not at all

4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication?

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
3 or more times per day	1 or 2 times per day	2 or 3 times per week	Once a week or less	Not at all

5. How would you rate your asthma control during the past 4 weeks?

☐ **1**	☐ **2**	☐ **3**	☐ **4**	☐ **5**
Not controlled at all	Poorly controlled	Somewhat controlled	Well controlled	Completely controlled

TOTAL SCORE: _____

Daytime asthma symptoms occur…

☐ Most days ☐ 1 - 2 time a week ☐ 1 - 2 times a month ☐ Never

Nighttime asthma symptoms…

☐ disturb sleep ☐ cause night waking ☐ disturb sleep weekly

☐ disturb sleep frequently ☐ 1 - 2 times a month ☐ never disturb sleep