PULMONARY PRACTICE ASSOCIATES

General Consent and Service Terms

General Consent for Treatment

I agree to allow Pulmonary Practice Associates (Pulmonary Practice Associates) to provide all health care services to me that are routine or otherwise deemed necessary. I understand I have the right to refuse consent to any proposed procedure or treatment at any time prior to receiving it. I understand that any treatment involving material risks will be explained to me and that I will have the opportunity to ask questions about the associated risks, alternatives and prognosis before allowing the treatment to be performed. I agree that no guarantees have been given to me as to the outcome of any treatment. I agree my picture can be taken to identify me.

General Sharing Health Information

I agree to Pulmonary Practice Associates using and sharing all my health information, including but not limited to Highly Confidential Information (see definition below), for payment, my continued treatment, and healthcare operations. This includes sharing my information with the following:

All physicians and other medical service providers associated with my treatment, as well as other physicians who are participating in integrated physician plan networks or Health Information Exchanges.

Business partners of Pulmonary Practice Associates, its affiliates, and Physicians, who provide administrative, operational, financial, legal and technical support services.

All insurance Payer(s) and healthcare plans responsible for paying or determining if I am eligible for payment for my treatment.

Substance, Drug, and Alcohol Abuse Authorization

I authorize and have initialed below for Pulmonary Practice Associates to release, should any exist, all my substance abuse and drug and alcohol abuse health information to any affiliate for my treatment, payment for my treatment, and the health care operations of Pulmonary Practice Associates. I understand this authorization may be cancelled at any time, unless Pulmonary Practice Associates have already acted and relied on it. If not previously revoked, I understand this authorization is effective until I am deceased.

Initial here: _____

Insurance Assignment and Payment

I permanently assign my third-party payer benefits payable directly to Pulmonary Practice Associates. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered.

I understand and agree that payment of my out-of-pocket portion for all elective services must be paid 10 days prior to receiving the service or the service will be cancelled and then rescheduled when such payment is received. If I do not pay for all my services and an attorney or collection agency asks me to pay, I agree to pay the reasonable attorney's fees and/or collection expenses in addition to paying for the cost of all my services.

I authorize Pulmonary Practice Associates to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance or third-party payer will not direct payment to Pulmonary Practice Associates, I agree to forward Pulmonary Practice Associates all health insurance payments which I receive for the services rendered by Pulmonary Practice Associates.

Unless otherwise designated by the payer, I understand Pulmonary Practice Associates posts all payments received to the oldest balances first, except for copays, drugs and supplies. I give permission to apply and credit balances to offset amounts due to Pulmonary Practice Associates where I have received services for current accounts or accounts I have not paid yet.

I authorize the use of my signature below on all insurance submissions. I may at any time in the future cancel this authorization in writing.

Medicare Assignment of Benefits

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carries any information needed for this or a relate Medicare Claim. I permit a copy of this authorization to be used in place of the original. I request that payment of the authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me.

Self-Pay Request

If I do not want my insurance company(ies) to receive health care information about this treatment I understand I will need to inform the staff and complete the Request to Restrict Use and Disclosure of Protected Health Information form.

Communication

Messages and Mail:
I understand you may communicate with me through US Mail, electronic mail, telephone or voice mail messages, to remind me about my appointments, treatment follow-up or to tell me about new services that are available. I understand that I must tell you if I do not want you to communicate with me like this.

Sharing PHI with family and friends:
I understand you will share my PHI with the family members, friends, or other individuals who are present with me unless I tell you otherwise.

Wireless Calls and Texting:
I agree and have initialed below for Pulmonary Practice Associates to use an automated telephone dialing system, and texting, to contact the cellular telephone number(s) that I provided for appointment, treatment, and payment purposes.

Initial here: _____

Signatures

BY SIGNING BELOW, I AM AGREEING TO THE PERMISSIONS, AGREEMENTS, AND AUTHORIZATIONS DESCRIBED IN THIS AGREEMENT. I HAVE READ THIS AGREEMENT AND HAVE BEEN ABLE TO ASK QUESTIONS. I UNDERSTAN THIS AGREEMENT IS VALID FOR ONE YEAR FROM THE DATE I SIGN IT.

Printed Name of Patient or Legal Representative: _____ Date: _____

Date of Birth: _____

Patient or Legal Representative Signature: _____ Date: _____

Relationship of Person signing if not Patient: _____ Date: _____

Please review the highly confidential information as defined by your state:

Florida: Mental health, HIV/AIDS, genetic testing, venereal disease, and tuberculosis information

PULMONARY PRACTICE ASSOCIATES

Registration Form

1. PATIENT INFORMATION

Patient´s Last Name	First	MI	Date of Birth	Age

Email	Preferred Language	Gender ☐M ☐F	Social Security #

Race
☐ Asian ☐ Black ☐ White ☐ American Indian / Alaskan Native ☐ Other

Marital Status
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Ethnicity
☐ Hispanic / Latino ☐ Non Hispanic / Latino ☐ Refuse To Respond

Address	City	State	ZIP Code

Home Phone #	Cell Phone #	Work Phone #

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

Primary Care Doctor	Address	Phone #

Pharmacy Name	Address	Phone #

Lab Name	Address	Phone #

Imaging Center	Address	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 #

_____ _____

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	_____	Heart Disease	_____
Alpha 1 Antitrypsin Deficiency	_____	High Blood Pressure	_____
Arthritis	_____	Pulmonary Embolism	_____
Arthritis type	_____	Renal (Kidney) Disease	_____
Asbestosis	_____	Sarcoidosis	_____
Asthma	_____	Sleep Disorder	_____
Cancer	_____	Stroke Syndrome	_____
Cancer type	_____	Thyroid Disorders	_____
COPD	_____	Tuberculosis	_____
Deep Venous Thrombosis	_____		

SURGICAL HISTORY

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

General Surgery

	Date & Details		Date & Details
☐ Amputation (s)	_____	☐ Tonsillectomy	_____
☐ Aneurysm	_____	☐ Uvuloplasty	_____
☐ Sinus	_____	☐ Wrist	_____
☐ Thyroid	_____	☐ Other	_____

Cardiovascular Surgery

☐ AAA	_____	☐ Heart Valve Replacement	_____
☐ CABG	_____	☐ Angioplasty	_____
☐ Carotid Endarterectomy	_____	☐ Pacemaker	_____
☐ Stent	_____	☐ Total # Performed	_____

Lung Surgery

☐ Bronchoscopy	_____	☐ Lobectomy	_____
☐ Lung Biopsy	_____	☐ Lung Surgery	_____
☐ Thoracentesis	_____	☐ Pneumonectomy	_____
☐ Excision of Lesion of Mediastinum	_____		
☐ Excision Lesion of Chest Wall	_____		
☐ Wedge Resection of Lung	_____		

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? ☐ E-Cigs / Vaping?

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? (years) _____

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 week

☐ Drug Use, Type: _____

For how long? (years) _____

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 ☐ Cats ☐ Dogs How many? _____

PAST MEDICAL HISTORY

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

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

☐ Previous Hospitalizations: _____

_____

Your major problem at this time: _____

PULMONARY PRACTICE ASSOCIATES

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 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 SLIGHTLY 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 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 question below ONLY IF you have had CPAP or BiPAP ordered:

Do you feel your treatment has improved your quality of 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

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
  - ☐ *Dischage 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)
- ☐ Anxiety
- ☐ Depression
- ☐ 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 Disturbance
- ☐ Muscle Aches
- ☐ Joint Pain / Arthritis
- ☐ Hearing Loss
- ☐ Fast Heart Rate
- ☐ Palpitation

Exposure to...

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

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

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

Current Smoker? ☐ Yes ☐ No ☐ Never smoked.If No Longer a smoker, when did you quit? Date/Year _____

Any Changes in your Family, Social, Medical, or Surgical History since you last appointment? ☐ Yes ☐ No If Yes, please list changes on back of this page.

VACCINATION INFORMATION

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

When was your last Pneumonia Shot? Date/Year _____ Prevnar 13 Shot? Date/Year _____

PULMONARY PRACTICE ASSOCIATES

Asthma Assesment Tool

(Only Complete if you were previously diagnosed with Asthma)

Patient 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, shortnes 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 times a week ☐ 1-2 times a month ☐ Never

Nighttime asthma symptoms…

☐ disturb sleep ☐ cause night walking ☐ disturb sleep weekly

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