MEADOWS HEALTH

PULMONOLOGY AND SLEEP MEDICINE

(Please Print)

Today's date	

PATIENT DEMOGRAPHIC INFORMATION			
Last Name		Employer Name	
First Name		Employer Address	
Middle Name		Employer City	
Birthdate _____/_____/_____ MM / DD / YYYY		Employer State	ZIP Code
Sex ☐ Male ☐ Female ☐ Other		Employer Phone	
Social Security Number		Occupation	Employment Status ☐ FT ☐ PT ☐ Unemployed
Address		Language	
City	ZIP Code	Marital Status	
State		Race	
Email Address or NA ☐		Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Unknown	
Home Phone		Cell Phone	
Work Phone		Primary Care Provider	

PATIENT DEMOGRAPHIC INFORMATION (FOR MINORS ONLY)			
MOTHER'S INFORMATION		**FATHER'S INFORMATION**	
Name		Name	
DOB	Social Security Number	DOB	Social Security Number
Address		Address	
City, State, ZIP		City, State, ZIP	
Home Phone Number		Home Phone Number	
Cell Phone Number		Cell Phone Number	
Employer Name		Employer Name	
Work Phone Number		Work Phone Number	

INSURANCE INFORMATION		
Primary Insurance		
Name of Insurance Holder (Last, First, Middle)		
Relation to Patient		
Birthdate	Sex □ Male □ Female □ Other	
Address		
City	State	ZIP
Insurance Holder Phone Number	Phone Type □ Home □ Cell □ Work	
Policy Number	Group Name	
Group Number		

EMERGENCY CONTACT INFORMATION		
Name (Last, First, Middle)		
Relation to Patient	Phone	Type □ Home □ Cell □ Work
Address		
City	State	ZIP

GUARANTOR INFORMATION *SKIP IF SAME AS PATIENT*		
Name (Last, First, Middle)		
Relation to Patient	Social Security Number	
Address		
City	State	ZIP
Home Phone	Cell Phone	
Employer Name	Employer Address	
Employer City	Employer State	Employer ZIP
Employer Phone	Employer fax	
Employment Status □ FT □ PT □ Unemployed		

COMMUNICATION PREFERENCES REGARDING:						
	Appointment		Clinical		Financial	
Method **(Check for All: ☐)**	May Call	May Leave Messages	May Call	May Leave Messages	May Call	May Leave Messages
Cell Phone	☐	☐	☐	☐	☐	☐
Home Phone	☐	☐	☐	☐	☐	☐
Work Phone	☐	☐	☐	☐	☐	☐

ACKNOWLEDGMENT OF RECEIPT OF HIPAA NOTIFICATION FORM

Signature below is acknowledgment that have been given and had the opportunity to read our **Notice of Privacy Practices**. Should you wish to read the Notice at any other tine, please request upon the arrival of your office visit. Any questions concerning our policy should be directed to our staff for clarification. It is our policy to provide this Notice at your first visit, and you may obtain another copy at any subsequent visit. This acknowledgment and authorization remains in effect until we are notified, in writing, by you of any changes.

Please list all additional authorized persons with whom we may discuss any of your medical information (including sheduled appointments):

Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number
Name	Relationship to Patient	Phone Number

Patient Name	Patient's DOB
Signature	Today's Date

NEW PATIENT REGISTRATION – ACKNOWLEDGEMENT AND DISCLOSURES
STANDARD FORM FOR ALL ENTITIES ASSOCIATED WITH MEADOWS HEALTH AND/OR MEADOWS REGIONAL MEDICAL CENTER, INC. OF WHICH THIS CENTER IS ASSOCIATED

PHYSICIAN PRACTICES POLICY AND RELEASE OF INFORMATION
The following is a statement of our Financial Policy for services provided within our office and does not apply to any testing of diagnostic procedure performed outside of the physician practice. We require you to read and sign this document prior to treatment by this facility.

PATIENT RESPONSIBILITY
All professional services rendered are charged to the patient and are due at the time of service. As a courtesy, this practice will file your claim with your insurance carrier; however, the patient or responsible party is ultimately responsible for the charges not covered by your contract with the carrier. **Any co-payments or deductible amounts not satisfied with your carrier are due at the time of service.**

Initial: _____

Insurance carriers typically do not cover all medical costs. Some pay fixed allowances for each procedure and office visit while others pay only a percentage of the costs. Surgical procedures, labs and other outpatient procedures may have a higher co-payment or fall under the deductible. It is the patient's responsibility to understand their insurance coverage.

Initial: _____

When you receive a statement, you are required to pay the balance upon receipt of the statement. If for some reason you do not agree with the balance due amount, you must contact a billing representative at the phone number noted on the statement. Do not ignore the bill, as it may result in turning the balance to an outside collection agency for recovery.

Initial: _____

AUTHORIZATION FOR TREATMENT AND TO RELEASE INFORMATION
The signature below serves as authorization for medical treatment by the physician, physician's assistant, nurse practitioner, or nurse for the named patient. It also provides authorization for our office to furnish and/or release any information necessary to insurance carriers, third party administrators, self-insured plan administrator and/or other health benefit payor or representative in order to process health care claims incurred at this office or for utilization review or quality assurance. This authorization serves as permission to obtain a copy of your complete medical record for or from other physician practices or medical facilities. A copy of this authorization may be used in place of the original in obtaining the medical records. I understand that I may withdraw this authorization to release medical information at any time, by communicating to the practice either in writing or verbally, followed by a written withdrawal.

Initial: _____

I understand that I m functionally responsible for any balance not covered by the insurance carrier.

ASSIGNMENT OF BENEFITS
I hereby assign and authorize my insurance benefits or claims be paid directly to this office.

_____
PATIENT NAME (PLEASE PRINT)

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY **DATE**

MEADOWS HEALTH
PULMONOLOGY AND SLEEP MEDICINE

Name _____
Date of Birth _____

Briefly describe your present symptoms: _____

PAST MEDICAL HISTORY: (PLEASE ATTACH ADDITIONAL SHEETS IF NEEDED)
Operations: _____

Medical Problems or Hospitalizations: _____

Allergies: _____
Current Pharmacy (Name and Location): _____
Current Medications and Doses: _____

Circle any equipment that you are currently using
Oxygen Nebulizer CPAP/BiPAP
Supplier of equipment: _____

SOCIAL HISTORY
Marital Status: (please circle) Single Married Divorced Widowed
Number of Children: _____ Occupation: _____

Any toxin exposure? Please circle all that apply:
Asbestos Beryllium Lead Coal dust Silica
Please list any other exposure: _____
Any pets _____ what type and how many, indoor or outdoor _____
Hobbies _____

Personal Habits: (please circle)
Do you smoke? YES NO If yes, how many years? _____
How many packs per day? _____
Have you ever smoked? YES NO If yes, how many packs per day? _____
How many years did you smoke? _____ When did you quit? _____
Do you drink alcohol? YES NO If yes, how many drinks/day? _____
Do you snore? YES NO
Do you experience daytime drowsiness? YES NO
Do you feel rested in the morning? YES NO

IF YOU ARE OVER 65 PLEASE ANSWER THE FOLLOWING:
Do you have an Advanced Care Plan in the event you become unable to make medical decisions? _____

Have you named a surrogate decision maker in the event you are unable to make medical decisions? _____

FAMILY HISTORY: Has any blood relative had any of the following? (please circle)

Heart Attack	YES	NO	Diabetes	YES	NO
Stroke	YES	NO	Kidney Disease	YES	NO
High Blood Pressure	YES	NO	Cancer	YES	NO

Are there any other medical problems that run in your family? _____

REVIEW OF SYSTEMS: Have you had any of the following? (please circle)

Constitutional			**Gastrointestinal**		
Weight change in the past year	YES	NO	Abdominal pain	YES	NO
Recent Fever/Chills	YES	NO	Indigestion	YES	NO
Fatigue	YES	NO	Neasuea	YES	NO
Eyes			Gallstones	YES	NO
Cataracts	YES	NO	Change in bowel habits	YES	NO
Loss of Vision	YES	NO	Dark black stools/blood in stools	YES	NO
Ear, Nose, Throat			**Genital Urinary**		
Hearing Loss	YES	NO	Kidney Stones	YES	NO
Ringing in ears	YES	NO	Blood in Urine	YES	NO
Nosebleeds	YES	NO	Waking at night to urinate	YES	NO
Hoarseness	YES	NO	**Skin/Breast**		
Cardiovascular			Rashes	YES	NO
Chest Pain	YES	NO	Breast Lump	YES	NO
High Blood Pressure	YES	NO	**Neurologic**		
Morning Headaches	YES	NO	Stroke	YES	NO
Palpitations	YES	NO	Seizures	YES	NO
Loss of consciousness (passed out)	YES	NO	Numbness/inability to move/speak	YES	NO
Murmur	YES	NO	Vertigo (dissiness)	YES	NO
Swelling in ankles	YES	NO	**Psychiatric**		
Leg cramps when walking	YES	NO	Depression	YES	NO
History of rheumatic fever	YES	NO	Psychiatric Disorder	YES	NO
Scarlet fever, diptheria, syphilis	YES	NO		YES	NO
Respiratory			**Heme/Lymph**		
Shortness of breath at rest	YES	NO	Anemia	YES	NO
Shortness of breath on exertion	YES	NO	Bleeding tendency	YES	NO
Do you have to sleep prooped up?	YES	NO	**Endocrine/Metabolic**		
Emphysema	YES	NO	Diabetes	YES	NO
Asthma	YES	NO	Thyroid disease	YES	NO
Chronic cough/sputum productior	YES	NO	High Cholesterol	YES	NO
Musculoskeletal			**Immunologic**		
Arthritis	YES	NO	Immune system problems	YES	NO

LAB PROCEDURES

This clinic may utilize an outside lab to process lab-related services that cannot be performed in our office. In that case you and/or your insurance company will receive a bill from the outside lab for your lab work.

To avoid out-of-network charges, **which will result in additional cost to you**, please let your doctor of the nurse know **immediately** if your health insurance policy requires us to send your lab work to another lab. Patients or guardians are responsible for communicating this insurance requirement to our staff at each appointment.

I have read and understand the above two Notices. I also understand that I will be responsible for all charges incurred related to out-of-network lab services.

_____	_____	_____
Patient Name (please print)	Date	Patient/Guardian Signature

MEADOWS HEALTH

GENERAL CONSENT FORM

MEADOWS HEALTH AND/OR ITS AFFILLIATED ENTENTIES OF WHICH THIS CLINIC IS ONE

Patient:_____ DOB:_____ Today's Date:_____

I, the undersigned, agree to the following:

(1) CONSENT FOR MEDICAL TREATMENT

I hereby voluntarily consent for care encompassing diagnostic, laboratory, imaging, examinations and surgical procedures and treatment by my physician/nurse practitioner, his/her assistants, designees or consultants, as may be necessary in the judgement of my physician/nurse practitioner. I also understand that I will be billed directly for those services provided. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made as to the results of the treatments of examination in this clinic. I understand that my medical record may be maintained and authorize access to persons involved in my care.

(2) RELEASE FROM RESPONSIBILITY FOR LOSS OF VALUABLES

Meadows Health and this Clinic (all-encompassing and hereinafter referred to as the "Clinic") are not responsible for valuables, including money, jewelry, glasses, dentures, documents and other personal items.

(3) RELEASE FROM RESPONSIBILITY

If I should leave the Clinic against medical advice or prior to treatment being completed, I hereby relieve said physician and the Clinic of all liability for my action.

(4) AUTHORIZATION FOR RELEASE AND USE OF MEDICAL INFORMATION FOR TREATMENT

I authorize the Clinic or the Clinic's designee to disclose to payors including, but not limited to, insurers, workers compensation carriers, Centers for Medicare and Medicaid Service, or any other parties that may be liable for all or part of the Clinic's charges. ("Third Party Payers"), all or part of my medical records as may be necessary to process payments for health care services provided. I authorize these payors to pay directly to the Clinic. I also authorize the Clinic to utilize my medical information, or to release all or part of my medical information to other health care providers consulted by my physician or the Clinic and utilization review nurse or case manager who may not be an employee of the Clinic, as my be necessary. I understand that the Clinic will take actions in reliance on this authorization to release medical information and that this information will be released only as necessary to carry out treatment, payment or Clinic and/or Meadows Health system of entities operations.

(5) NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given a copy of the Clinic's **Notice of Privacy Practices**. My signature below acknowledges receipt of a copy. I understand that the Clinic reserves the right to change the terms of its notice provisions and that I can obtain from the Clinic any revisions to this privacy policy.

(6) **ASSIGNMENT OF BENEFITS**

I hereby assign to the Clinic, or its duly authorized agents and/or assigns, all rights, benefits and interests in all proceeds from all Third Party Payers for the payment of all charges associated with my treatment. I further authorize the Clinic to take all necessary actions to ensure that any insurance benefits otherwise payable to me, or my estate, are paid directly to the Clinic. This authorization includes, but is not limited to billing insurance, filing petitions, filing suit in name or on behalf of the Clinic or Meadows Health or its assignees, filing proofs or claim, filing probate claims and filing grievances and all other similar procedures. I agree to provide and sign any other documents that may be reasonably necessary to accomplish any of the above purposes. I understand that any amount paid in excess of regular charges will be refunded as appropriate to the Third Party Payer, the patient or guarantor.

(7) **FINANCIAL RESPONSIBILITY AGREEMENT**

I understand that I am financially responsible to the Clinic and its lawful assignees for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, self-insured health plans or other Third Party Payer are due and payable upon services based on the best estimates available as determined by the Clinic. Charges remaining on this account are payable upon demand. Unless payment is made in full at the time of service, then patient authorizes the Clinic or its agents to obtain a credit report. Should the account be referred for collection to a collection agency, the undersigned agrees to pay all court costs of collection may include reasonable attorney fees of up to and including 15% of the debt involved. The undersigned patient and insured also agree that the Clinic or Meadows Health or its assignees may apply any payments received from the patient against any other amounts due at the time from or for the undersigned patient. All amounts not paid when due may accrue interest at the rate of 1½% per month on the unpaid principal balance. If applicable, I certify that the information provided to the Clinic in requesting payment under Title XVIII and Title XIX of the Social Security Act is correct.

(8) **NON-CERTIFICATION OF SERVICES**

I hereby agree that as the policyholder or patient, I share the responsibility of assuring certification is obtained from the insurance company on the above party for any services indicated. If certification is not obtained, I further agree that in the event the insurance denies either all or part of their payment on the Clinic account, I will par the account in full upon demand.

(9) **CONSENT TO PHOTOGRAPH, VIDEOTAPE OR OTHER IMAGING**

I authorize the Clinic to photograph, videotape or digitally image me as appropriate for medical record identification purposes and/or to document my medical condition. I release the Clinic, its physicians, employees and agents from any liability in the making and use of these requested photographs, videos, or digital images.

(10) **MEDICAL EXCHANGE OF INFORMATION**

I hereby authorize the Clinic to store my information electronically and to exchange this information within the medical community (e.g. pharmacy, lab, hospital, referring provider) to continue my medical care.

(11) **ACKNOWLEDGEMENT**

My signature below constitutes my acknowledgement and agreement that I read and understand the above, was given the opportunity to discuss this form and ask questions, that all questions were answered to my satisfaction, and I am satisfied I understand the form's contents and significance. I understand that this consent form will be valid and remain in effect as long as I am a patient of the Clinic.

I certify that I have read the foregoing, and I am either the patient or am duly authorized by the patient's general agent to execute the above and accept the terms.

_____ _____

Signature of Patient or Authorized Individual Date

Relationship of Signer to the Patient:

_____

(self, mother, father, son, daughter or explain other)

_____

Guarantor of Payment (If patient not signing)

If patient is unable to sign, state reason: _____

_____

_____ _____

Witness Date

MEADOWS HEALTH

PULMONOLOGY AND SLEEP MEDICINE

Name _____ **Date of Birth** _____

Please answer each of the following:

Yes No I have been told I snore.

Yes No I wake up from sleep gasping for air.

Yes No I have been told I stop breathing while I sleep.

Yes No My limbs feel irritable before I fall asleep.

Yes No I have been told I kick/jerk during sleep.

Yes No I have a history of sleepwalking or other unusual activity during sleep.

Yes No I wake up frequently during the night to use the restroom.

Yes No I wake up after a normal amount of sleep and still feel tired.

Yes No I am excessively sleepy during the day.

Yes No I am/was a shift worker.

Yes No Have you ever had a sleep study?
If yes, where: _____ when: _____
Please try to obtain copies of your previous study prior to your office visit.

Yes No Do you currently use a CPAP/BiPAP?
If yes, what is your current pressure setting? _____

Yes No Do you have any other characteristics of your sleep that we should be aware of?
If yes, please explain:

_____

_____

_____

MEADOWS HEALTH

PULMONOLOGY AND SLEEP MEDICINE

Sleepiness Scale

Name:_____ DOB: _____

Today's Date: _____ Male/Female

How likely are you to doze off or fall asleep in the following situations in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	_____
Watching television	_____
Sitting inactive in a public place (e.g. a theatre or a meeting)	_____
As a passenger in a car for an hour with a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting quietly after a lunch without alcohol	_____
Sitting and talking to someone	_____
In a car, while stopped for a few minutes in traffic	_____
TOTAL	_____