Suburban Pulmonary and Sleep Associates

Date: _____

Patient's Name_____ DOB: _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Social Security Number _ _ _ _ - _ _ - _ _ _

Mailing Address: _____ City _____

Zip Code: _____ State: _____ Email: _____

Home Phone: _____ Other/Cell: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Pharmacy Name: _____ City: _____ Phone: _____

EMPLOYER INFORMATION

Employer: _____ Phone: _____

Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID #: _____ Secondary

Insurance: _____ ID #: _____

ARE YOU THE POLICY HOLDER: Yes_____ No _____ (if no, please complete section below)

POLICY HOLDER INFORMATION

Name: _____ DOB _____

Address: _____

Social Security Number: _____ Phone Number: _____ Relationship: _____

Employer Name: _____

Employer Address: _____

In case of Emergency, Contact: _____ Phone: _____

To Whom Can Medical Records be released: _____

I hereby authorize Suburban Pulmonary and Sleep Associates as a holder of Medical Information, to release to my insurance carrier or its intermediaries any information needed for this or future related claim(s). I further request payment be made to Suburban Pulmonary and Sleep Associates and authorize Suburban Pulmonary and Sleep Associates to submit claims on my behalf for any bills or services furnished to me during the next 12-month period (year). I hereby acknowledge and understand that I am financially responsible for any portion of my bill not covered by my insurance carrier. If this account is placed in the hands of a collector or an attorney for collection, reasonable cost of collection including attorney fees will be paid by the undersigned.

Signature _____ Date _____

Suburban Pulmonary and Sleep Associates

AUTHORIZATION FOR TREATMENT

I agree to any examination, treatment and procedures that may be performed during office visits, including emergency treatment considered necessary by the Physician and/or his Healthcare providers.

CONSENT TO OBTAIN MEDICATION HISTORY

I authorize Suburban Pulmonary & Sleep Associates to obtain my medication history from my pharmacy. This consent includes any prescription medications used to treat AIDS/HIV, mental health or psychiatric conditions. This information will become part of your medical record.

RELEASE OF INFORMATION

I authorize the facility to release to my insurance carrier or its designated agents any information concerning medical care (physical or psychological), advice, treatment or supplies provided to me for purposes of administration, review, investigation or evaluation of valid as the original. I will notify the facility in writing of any information I do not want released.

ASSIGNMENT OF INSURANCE BENEFITS

I authorized the assignment of benefits payable to Suburban Pulmonary and Sleep Associates, LTD, and/or its designees for Physician services and supplies by government and or any other private third-party payer. I understand I will be held responsible for payment of all co-payments, co-insurance, deductibles and non-covered services.

FINANCIAL POLICY

- **Co-payments are required by your insurance to be paid at the time of check in for your appointment. Co-pays, coinsurance, deductibles and non-covered services cannot be waived by our office as it is an insurance requirement. We accept cash, checks or credit cards. Our office does not bill for co-pays. If you are unable to pay at the time, your appointment will be rescheduled.**
- **Self-Pay accounts are required to be paid at the time of check-out after your office visit has been completed. All services that were provided at the time of service must be paid in full.**
- **Workman's Compensation and Motor Vehicle Accidents: It is the responsibility of the patient to advise this office if their injury is work related. You must provide this office with your employer's name, address, phone number. Additionally, you will provide this office with the worker's compensation insurance carrier's name, phone number, and claim number. Patients involved in a motor vehicle accident are responsible for presenting their individual group health insurance information; the patient will be responsible for submitting all claims to the responsible parties' insurance. This office does not submit third party insurance claims.**
- **Insurance: o It is the patient's responsibility to confirm with our office and the insurance company that the physician is currently under contract with your plan.**
    - **Insurance cards are required at each visit. If there are any changes to your insurance including, but not limited to, new insurance identification number and/or group number, it is the responsibility of the patient to inform this office immediately.**
    - **If your plan requires a referral prior to seeing a specialist, please contact your primary care physician and bring the referral with you to your appointment. Failure to bring the necessary referral will cause your appointment to be rescheduled.**
    - **Our office will bill all insurance companies for the services provided. Upon response of insurance, you will be sent a statement stating your payment responsibility. Our office requires balances to be paid within 30 days of receiving the billing statement.**

I agree to pay any outstanding balances within 30 days after receiving a statement from Suburban Pulmonary and Sleep Associates, LTD, notifying me of such balance.

ADDITIONAL FEES

If any lawsuit or action is brought to collect this account or any portion thereof, the patient/guarantor will be responsible for all costs not limited to attorney's fees, court costs, collection fees, interest and any additional costs that this action may occur.

Suburban Pulmonary and Sleep Associates

No Show Appointment: an appointment is considered a "no show" when there is neither a phone call or appearance at the scheduled appointment time. There is no charge for the first occurrence. Second or subsequent occurrences of a no-show appointment are subject to a $50.00 charge per occurrence which is not covered by insurance

Form completion: There will be a fee of $40 per packet for completion of FMLA (Family and Medical Leave Act) and/ or other forms. This is to be paid prior to form completion and is not billed to the insurance company. However, patients requesting a Disability Form be completed by a physician will require an extended office visit with their physician for completion. Disability forms will not be completed without an office visit. There is no form completion charge for disability forms as it is specifically covered in the office visit.

UNCOOPERATIVE PATIENTS

Physicians are not required to continue treatment of a patient who is uncooperative, refuse to follow treatment advice and/or presents difficulties in the doctor-patient relations. Our goal is to try to accommodate all our patients' needs. Demanding and abusive language toward our physicians or staff does not help us meet that goal. Patients may be dismissed from our practice for non-compliance.

RECEIPT OF NOTICE OF PRIVACY PRACTICES FROM

I HEREBY ACKNOWLEDGE receipt of the Physician's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how the Practice may use and disclose my confidential information. I understand that the Physician has reserved a right to change his or her privacy Practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available for any review at all Suburban Pulmonary and Sleep Associates, LTD, locations.

_____ _____

Signature of Patient/Guarantor **Print Name of Patient/Guarantor**

Date Signed _____

Suburban Pulmonary and Sleep Associates

Patient Name: _____ DOB _____

ALLERGIES

☐ **NO KNOWN ALLERGIES**

LIST ANY MEDICATION ALLERGIES OR ADVERSE REACTIONS:

DRUG	REACTION

MEDICATIONS

Please list all medicines that you are CURRENTLY taking:

MEDICATION	DOSE	FREQUENCY		MEDICATION	DOSE	FREQUENCY

IMMUNIZATIONS

IMMUNIZATION	DATE of MOST RECENT
Influenza/Flu	
Pneumovax	
Prevnar 13	
COVID-19	

Patient Name _____DOB __/__/____

Primary Reason for Visit _____

Work Status: Full time/ Part time/ Self-Employed/ Retired/ Other_____

Social History (Check all items that apply)

	No	Yes	If yes, fill out below
Do you currently smoke?			**Type_____** **Average packs per day_____** **Total number of years smoked _____**
Did you smoke in the past?			**Year quit_____** **Type_____** **Average packs per day_____** **Total number of years smoked _____**
Do you use recreational drugs?			**Type of drug_____** **Date last used_____**
Do you drink alcoholic beverages? **Have you ever been treated for dependency?**			**Type of alcohol_____** **Average per day _____**
Do you use caffeine? (Coffee, soda, Tea, Pills)			**Type of caffeine_____** **Average per day_____**
	No	**Yes**	
When was your last TB skin test?			**N/A _____** **Date ___/___/____** **Results: Positive or Negative (circle)**

Patient Name_____DOB_____

PAST MEDICAL/SURGICAL HISTORY:

	YES		YES
No significant Medical History		Heartburn	
Arthritis		Kidney Disease	
Asthma		Narcolepsy	
Atrial Fibrillation		Parkinson's Disease	
Heart Defibrillator or Pacemaker		Pulmonary Fibrosis	
Blood Clots (legs, lungs, other)		Pulmonary Hypertension	
☐ DVT		Sarcoidosis	
☐ Pulmonary Embolism		Seizures	
Cancer (type_____)		Sinusitis	
Congestive Heart Failure		Sleep Apnea	
COPD		Stroke	
Coronary Artery Disease		Thyroid Disease -Overactive (Hyper)	
Bypass Surgery Date_____		Thyroid Disease -Underactive (Hypo)	
Heart Attack Date _____		Artificial Joint Type _____	
Heart Stent Date _____		Dentures (upper/lower)	
Valve Surgery Date _____		Cane/Walker/Wheelchair	
Diabetes (Type I or II)		**Other**:	
Emphysema			
Fibromyalgia			
High Blood Pressure			

FAMILY MEDICAL HISTORY (CHECK ALL ITEMS THAT APPLY)

	YES		YES
No significant Family History		High Blood Pressure	
Asthma		Narcolepsy	
Blood Clots (legs, lungs, other)		Pulmonary Hypertension	
☐ DVT		Sleep Apnea	
☐ Pulmonary Embolism		Thyroid Disease -Overactive (Hyper)	
Cancer (type_____)		Thyroid Disease -Overactive (Hypo)	
COPD			
Coronary Artery Disease		Other:	
Diabetes (Type I or II)			
Emphysema			

Patient Name_____DOB_____

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Patient Name: _____ DOB: _____ Date: _____

THE EPWORTH SLEEPINESS SCALE: 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 have not 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.

SCALE: 0=NEVER 1=SLIGHT 2=MODERATE 3=HIGH

SITUATION	CHANCE OF DOZING?
Sitting and reading	□0 □1 □2 □3
Watching TV	□0 □1 □2 □3
Sitting, inactive in a public place (e.g., theater or a meeting)	□0 □1 □2 □3
As a passenger in a car for an hour without a break	□0 □1 □2 □3
Lying down to rest in the afternoon when circumstances permit	□0 □1 □2 □3
Sitting and talking to someone	□0 □1 □2 □3
Sitting quietly after lunch without alcohol	□0 □1 □2 □3
In a car, while stopped for a few minutes in traffic	□0 □1 □2 □3
TOTAL: add up your answers	

BRIEF SLEEP HISTORY	YES	NO
1. Have you already been diagnosed with sleep apnea through a sleep study? a. **If yes**, i. Where was your last sleep study performed, and what Year? Place _____ Year _____ ii. How is it treated? (check below) □ Oral Appliance □ CPAP type of device - Pressure Setting if known _____ □ No device being used		
2. If you have never had a sleep study,	YES	NO
Do you snore?		
Do you have periods of snorting/gasping/stopping breathing while asleep?		
Do you deal with daytime sleeping or fatigue?		
3. Typical time you go to bed:		PM/AM
4. Typical time you arise or wake up:		PM/AM