PULMONARY ASSOCIATES OF BRANDON

The Florida Sleep Disorder Center

NEW PATIENT INFORMATION

Hello,

We are delighted that you have scheduled an appointment with Pulmonary Associates of Brandon/Florida Sleep Disorder Center. We are honored to participate in your health care.

Pulmonary Associates of Brandon providers care for some of the most complicated and critically ill patients in the Greater Tampa Bay area, both in area hospitals and in the outpatient office environment in three locations. Our providers are Board Certified specialists in pulmonary diseases, critical care medicine, and sleep medicine.

Our goal is to provide you with exceptional medical care and superior service. To help ensure you have the best possible visit, we offer a few tips:

1. Please completely fill out the required paperwork prior to your arrival for your first appointment. If you have completed all the requested paperwork prior to your appointment, you should plan to arrive at least 15 minutes prior to your scheduled appointment time. If you are unable to complete the required paperwork prior to your appointment, you must arrive at least 30 minutes prior to your scheduled time. We know that sounds like a long time, but your providers want to have as much information about you as needed to provide you with exceptional medical care.
2. Please bring a list of all current medications or complete list of all prescription and over-the-counter medications you are taking, along with the dose and frequency.
3. Please bring your insurance card(s) and photo identification. We are required to verify the identity and insurance eligibility of all our patients. We are also required to collect any co-payments and/or deductibles at the time services are provided.
4. Bring cash, check or credit card for you co-payment or deductible.

If you are unable to keep your appointment for any reason, please notify us at least 24 hours in advance to avoid a missed appointment fee.

Should any questions or concerns arise before your next visit with us, please feel free to contact our office at (813) 681-4413. We are available Monday through Friday from 8:00am-5:00pm in the office and through our answering service after hours.

Please complete the following paperwork prior to your appointment.

All patients must complete Pages 2-5. Complete Page 6 if you are a pulmonary patient. Complete Pages 7-8 if you are a sleep patient. If you are a combined pulmonary/sleep patient, complete all pages in the packet.

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Patient Demographics

Last Name: _____ First Name: _____ Middle: _____

Home Phone: _____Work Phone: _____Cell Phone: _____

Email Address: _____

Date of Birth: _____ Social Security Number: _____ Sex: M ❑ F ❑

Mailing Address: _____
Street Apt City State Zip

Marital Status: Single ❑ Married ❑ Divorced ❑ Widowed ❑

Race/Ethnicity: Black ❑ Caucasian ❑ Hispanic/Latino ❑ Asian ❑ Other ❑

Preferred Language: _____

Preferred Method of Contact: Phone ❑ Email ❑ Text ❑ Mail ❑

Referring Physician: _____ Phone: _____ Fax: _____

Primary Care Physician: _____ Phone: _____ Fax: _____

Pharmacy: _____ Phone: _____ Fax: _____

Patient's Employer

Employer: _____ Phone: _____

Occupation: _____

Address: _____
Street Suite # City State Zip

Responsible Party (if other than the patient)

Last Name: _____ First Name: _____ Middle: _____

Address: _____
Street Apt City State Zip

Social Security Number: _____ Phone: _____

Emergency Contact (not living with you)

Name: _____ Relationship: _____

Address: _____Phone: _____

Assignment of Benefits

I understand that I am financially responsible for all charges whether or not covered by insurance. I authorize the release of any medical or other information necessary to process any claim for medical care. I hereby authorize the Practice to bill my insurance company and/or Medicare for services provided to me and request that payments for such services to made to the Practice on my behalf.

Signature: _____ Date: _____

Chart #: _____

Primary Insurance

Insurance Company Name: _____ Phone: _____ Effective Date: _____

Billing Address: _____

Group Number: _____ Policy or ID Number: _____

Secondary Insurance

Insurance Company Name: _____ Phone: _____ Effective Date: _____

Billing Address: _____

Group Number: _____ Policy or ID Number: _____

Notice of Privacy Practices Consent and Acknowledgement

Our Notice of Privacy Practices provides information about how Pulmonary Associates of Brandon, P.A./Florida Sleep Disorder Center may use and disclose protected health information about you.

I consent to the use or disclosure of my protected health information by Pulmonary Associates of Brandon, P.A./Florida Sleep Disorder Center for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Pulmonary Associates of Brandon, P.A.

I acknowledge that I have been provided with the Practice's Notice of Privacy Practices that provides a description of Protected Health Information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this statement. I understand that the Practice reserves the right to change its Notice of Privacy Practices that will be effective for the health information the Practice already has about me, as well as any they receive in the future.

I understand that I may obtain a copy of the current Notice in effect upon request. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that the Practice is not required to agree to my requested restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

List of Names with whom we can share medical information

Name: _____ Relationship: _____Phone: _____

Name: _____ Relationship: _____ Phone: _____

Do you want any mail sent to you from our office marked as "Confidential"? Yes ❑ No ❑

Can appointment reminders and other confidential messages be left on your voice mail? Yes ❑ No ❑

Patient Signature: _____ Date: _____

****

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below. (Please print)

Name: _____ Date: _____

Reason: _____

Chart #: _____

PERSONAL MEDICAL HISTORY

Reason for Visit: _____

Review of Symptoms (Please check any that have been active in the past 2 weeks):

General

- Fever ❑
- Fatigue ❑
- Drenching Night Sweats ❑
- Weight Gain ❑
- Weight Loss ❑

Skin

- Severe Bruising ❑
- Hives ❑

HEENT

- Glaucoma ❑
- Nasal Congestion ❑
- Sleep Apnea ❑
- Seasonal Allergies ❑
- Sinus Pain ❑
- Snoring ❑

Neck

- Neck Mass ❑
- Neck Swelling ❑

Respiratory

- Bloody Sputum ❑
- Acute Cough ❑
- Difficulty breathing with Exertion ❑
- Wheezing ❑
- Sputum/phlegm ❑

Cardiovascular

- Chest Pain ❑
- Edema ❑
- Heart Stint ❑
- Irregular Heart Beat ❑
- Palpitations ❑

Gastrointestinal

- Change in Bowel Habits ❑
- Difficulty Swallowing ❑
- Heartburn ❑
- Black or Bloody Stools ❑

Musculoskeletal

- Backache ❑
- Leg Cramps ❑
- Leg pain when walking ❑

Neurological

- Attention Deficit ❑
- Decreased Memory ❑
- Difficulty Speaking ❑

Psychiatric

- Anxiety ❑
- Depression ❑
- Hypersomnia/ sleepiness ❑
- Insomnia ❑

Allergies (include any environmental allergies such as grass or pollen and any medication and/or food allergies): _____

_____

Immunizations: PPD ❑ Date: _____ Flu ❑ Date: _____ Pneumonia ❑ Date: _____

Immediate Family History:

Please check if any immediate blood relatives have had any of the following

- COPD ❑
- Asthma ❑
- Emphysema ❑
- Tuberculosis ❑
- Lung Cancer ❑
- High Blood Pressure ❑
- Heart Disease ❑
- Stroke ❑
- Diabetes ❑
- Sleep Disorder ❑

Is your mother Living ❑ Deceased ❑ Cause of Death? _____

Is your father Living ❑ Deceased ❑ Cause of Death? _____

Social History:

Do you have any pets? Yes ❑ No ❑ If yes, type of pet(s): _____

History of Tobacco Use:

Do you smoke? Yes ❑ No ❑ Have you ever smoked? Yes ❑ No ❑

Type of Tobacco: _____ # of Packs Per Day: _____

Year Starting Smoking: _____ Year Quit Smoking: _____ Exposure to Second Hand Smoke? Yes ❑ No ❑

Medications (please list all medications that you are currently taking, including over-the-counter medications and vitamins):

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Recent Diagnostic Studies:

Chest X-Ray Date: _____ CT/PET: Date _____ Sleep Study: Date: _____

A**sbestos History/Occupational History:**

Have you ever been exposed to asbestos? Yes No If yes, when and for how long? _____

Please list your current and past occupations: _____

_____

Past Medical History (Please check any that apply):

COPD	❑	Sleep Apnea	❑
Asthma	❑	Restless Legs	❑
Emphysema	❑	Lung Cancer	❑
Tuberculosis	❑	Coronary Disease	❑
Pneumonia	❑	Atrial Fibrillation	❑
Respiratory Failure	❑	Cardiomyopathy	❑
Pulmonary Embolism	❑	Stroke or Paralysis	❑
DVT	❑	High Blood Pressure	❑
Pleural Effusion	❑	Diabetes	❑
Bronchitis – Recurrent	❑	Other Cancer	❑

Surgical History

Please check if you have been hospitalized or had surgery for:

Lung Surgery	Yes	❑	No	❑	If yes, when: _____
Heart Surgery	Yes	❑	No	❑	If yes, when: _____
Abdominal Surgery	Yes	❑	No	❑	If yes, when: _____
Tonsillectomy	Yes	❑	No	❑	If yes, when: _____
Sleep Apnea Surgery	Yes	❑	No	❑	If yes, when: _____

Other Major Hospitalizations or Surgeries: _____

_____

Chart #: _____

PULMONARY QUESTIONNAIRE

Cough:

Do you usually cough first thing in the morning?	Yes ❑	No ❑
Do you usually cough after going to bed at night	Yes ❑	No ❑
Do you cough every day for at least three months of the year?	Yes ❑	No ❑
How long have you had this cough? ____ # of Days	____ # of Weeks	____# of Months
Do you bring up phlegm or sputum when you cough?	Yes ❑	No ❑
Have you ever coughed up blood?	Yes ❑	No ❑
Did you see a doctor about this?	Yes ❑	No ❑
Do you wake at night with an acid sour taste in your mouth?	Yes ❑	No ❑
Do you wake up with a sore throat in the morning?	Yes ❑	No ❑
Do you experience burning chest pain, especially when lying down?	Yes ❑	No ❑

Wheezing/Asthma:

Have you ever noticed whistling or wheezing in your chest? Yes No

If yes, how frequently? Daily ❑ Weekly ❑ Monthly ❑ After Colds Only ❑

Is your wheezing more common during a particular season? Yes ❑ No ❑ Which Season? _____

Is your wheezing related to any of the following? (Check all that apply)

House Dust ❑ Animals ❑ Deep Breaths ❑ Cough ❑ Meals ❑

Have you ever gone to the Emergency Room for Asthma? Yes ❑ No ❑

How often do you have an attack? _____

Sinus

Do you have postnasal drip?	Yes ❑	No ❑
Do you frequently have tenderness in your cheekbones?	Yes ❑	No ❑

Chart #: _____

SLEEP QUESTIONNAIRE

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can. This information will be held in the strictest confidence:

Describe you main problem(s) in your own words, including when and how this began and what treatment you have received for this in the past:

_____

_____

_____

SLEEP HISTORY

Do you experience any of the following?

Snoring ❑ Insomnia ❑ Leg Cramps ❑ Stopping Breathing ❑ Excessive Daytime Sleepiness ❑

What time do you go to sleep _____

How long does it take you to fall asleep? _____

What time do you wake up on the weekdays? _____ On the weekends? _____

How many times do you wake up during the night? _____

Do you have feelings of depression/anxiety?	Yes	❑	No	❑
Do you have drop attacks during the day?	Yes	❑	No	❑
Do you have hallucinations upon falling asleep or upon waking?	Yes	❑	No	❑
Do you have crawling sensations in your legs?	Yes	❑	No	❑
Do you work split shifts or variable shifts?	Yes	❑	No	❑
Do you usually drink caffeine within two hours of going to bed?	Yes	❑	No	❑
Awaken from sleep short of breath or gasping for air	Yes	❑	No	❑
Awaken at night with heartburn, belching or cough	Yes	❑	No	❑
Snore	Yes	❑	No	❑
Sweat excessively at night	Yes	❑	No	❑
Notice your heart pounding or beating irregularly during the night	Yes	❑	No	❑
Fall asleep during the day	Yes	❑	No	❑
Fall asleep involuntarily or while driving	Yes	❑	No	❑
Fall asleep or lose muscle tone when laughing or crying	Yes	❑	No	❑
Feel unable to move (paralyzed) when waking or falling asleep	Yes	❑	No	❑
Experience vivid dreamlike scenes upon awakening or falling asleep	Yes	❑	No	❑
Remember your dreams	Yes	❑	No	❑
Kick or have body jerks during the night	Yes	❑	No	❑
Experience crawling and aching feelings in your legs	Yes	❑	No	❑

Chart #: _____

Epworth Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired. This refers to your usual way of life in recent times. Even if you have not done some of these activities recently, try to work out how they would affect 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	0❑	1❑	2❑	3❑
Watching TV	0❑	1❑	2❑	3❑
Sitting, inactive in a public place (theatre, meeting, etc)	0❑	1❑	2❑	3❑
As a passenger in a car for an hour without 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 a lunch without alcohol	0❑	1❑	2❑	3❑
In a car, while stopped for a few minutes in traffic	0❑	1❑	2❑	3❑

Total _____

Chart #: _____

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The Florida Sleep Disorder Center

Financial Policy

Thank you for choosing Pulmonary Associates of Brandon/Florida Sleep Disorder Center to participate in your medical care. We are committed to providing the best possible medical care to our patients while also minimizing administrative costs. This financial policy has been established with these objectives in mind, and to prevent any misunderstanding or disagreement concerning payment for professional services.

All Patients are financially responsible for services provided by Pulmonary Associates of Brandon/Florida Sleep Disorder Center

- Pulmonary Associates of Brandon/Florida Sleep Disorder Center requires that you provide a copy of your current insurance card and photo ID at every visit.

- Pulmonary Associates of Brandon/Florida Sleep Disorder Center participates with numerous insurance plans. For patients who are covered by one of these insurance plans, our billing office will submit a claim for our services on your behalf, directly to your insurance company.

- Co-Payments are due at the time of the service. If you are coming in for a sleep study at night and you have a co-payment due, we will bill this to your account. Payment for the sleep study is due within 30 days of your study or your next appointment, whichever comes first.

- Payment of Co-Insurance or any charges not covered by your plan is required at the time of service.

- Payment is required in full at the time of services from uninsured patients, unless arrangements have been made with the Business Office in advance.

- Payment for services can be made with cash, check, or credit card.

- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice prior to the visit. Visits may be rescheduled due to lack of referral or authorization.

- Our providers may order tests, including radiology exams, labs, sleep studies, and other procedures to assist them with their medical decision making about your health. These tests may or may not be covered by your insurance. It is imperative that you check with your insurance prior to having these tests to ensure that the cost of the test is covered. You are responsible for the cost of these tests and this cost is determined through your insurance provider. If our provider orders a test and/or procedure and your insurance does not cover it or requires a prior authorization, please call our office at (813) 681-4413 before you complete the test.

- You will be charged for the administrative costs of copying medical records as per State guidelines. This includes all requests for medical records, including the patient's personal request. There is no charge for requests from another Doctor's Office.

- There is a usually a charge for the provider to complete forms such as FMLA, Disability, etc. Please allow the office at least 10 business days in which to review your records for the information requested to be completed, copied, and/or mailed or faxed.

- Missed appointment fee is $50. After three missed appointments, you may be discharged from the practice at the physician's discretion.

- Patients with outstanding balances (90 days or more) are required to pay the bill in full prior to Pulmonary Associates of Brandon/Florida Sleep Disorder Center providing additional services.

- Our staff members are happy to answer insurance questions relating to how a claim was filed, or regarding any additional information the payer might need to process the claim. However, specific coverage issues can only be addressed by the insurance company member services department. You can find this phone number on your insurance card.

Pulmonary Associates of Brandon/Florida Sleep Disorder Center firmly believes that a good physician-patient relationship is based upon mutual understanding and good communication. All questions and communication about financial arrangement should be directed to the Business Office at 813-681-4413. We are happy to help you.

Our Office Policies

Same Day/Next Day Appointments

We will do our best to work with you when we schedule your appointments. If you have an urgent need to see one of our physicians, please ask to speak with the nurse or the office manager. Based on the severity of your need, you may be scheduled for any of our physicians who are working in the office. This physician will have access to your medical records via our electronic health record.

Medication Refills

To request prescription medication refills, please contact your pharmacist.

We are happy to order appropriate medication refills for patients who have been seen by our providers within the past twelve (12) months upon receiving a refill request from your pharmacist. Only refill requests for medications originally ordered by our provider will be refilled by our office.

Pulmonary Associates of Brandon/Florida Sleep Disorder Center orders the vast majority of medications for our patients electronically. This state-of-the-art system will expedite your requests and ensure that you have the medications you need, when you need them. There are some prescriptions that cannot be processed electronically. For these medications, we will receive a refill request from your pharmacist, and you will need to come to the office to pick up a handwritten prescription.

We encourage you to anticipate your medication needs and call your pharmacy BEFORE you run out of your medications.

Current Medications

For your safety, we are required to reconcile your medications at each visit. You will be asked to verify a list of your medications based on what we have in our electronic health record. If the information is not correct, please inform the medical assistant who takes your vitals and he/she will enter the correct information in your electronic health record.

Release of Information

If you would like for us to provide a copy of your medical record to another person or organization, we will ask you to complete an Authorization to Release Medical Records.

Cancellation and Rescheduling

Please be courteous to other patients in need of care: if you must cancel an appointment, please do so as far in advance as possible. At least 24 hours notice is expected. We will make appointment reminder calls two days prior to your appointment. This is an automated call and you will have the option to confirm or cancel your appointment.