Patient Information

PulmoCrit Associates • (844) 428-5864 • pulmocrit.com

Last Name: **First Name:**

Date of Birth: **Gender:** **Preferred Language:**

Marital Status: **SSN (optional):**

Address:

City: **State:** **Zip Code:**

Home Phone: **Cell Phone:**

Email:

Responsible Person:

Primary Physician: **Phone #:**

Referred by: **Phone #:**

Emergency Contact

Contact Name: **Relationship:**

Home Phone: **Cell Phone:**

Pharmacy Information

Pharmacy Name: **Phone #:**

Address:

City: **State:** **Zip Code:**

PulmoCrit Associates | 17075 Devonshire St. Ste 205, Northridge CA 91325 | 16260 Ventura Blvd. Ste 600, Encino CA 91436 | 555 Marin St. Ste 110, Thousand Oaks CA 91360 Phone: (844) 428-5864 | Fax: (818) 709-3833

Consent to Treat

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Patient Name: **Date of Birth:**

Consent to Treatment:

The undersigned consents to health care encompassing routine diagnostic procedures, medical treatment and other health services, rendered to the patient.

No Guarantees:

It is understood that the practice of medicine, surgery and the rendering of health care is not an exact science and that no guarantees have been made as to the end results of treatment, examination, or other health services rendered by the healthcare providers and staff at PulmoCrit Associates Inc.

Release of Information:

The undersigned agrees that, to the extent necessary to determine liability of payment and to obtain reimbursement, PulmoCrit Associates Inc. may disclose portions of the patient's records, including medical records, to any person or entity which is or may be liable for all or part of the payment to PulmoCrit Associates Inc. charges.

Assignment of Insurance Benefits:

The undersigned authorizes direct payment to PulmoCrit Associates, Inc. of benefits otherwise payable to or on behalf of the undersigned for treatment and health services rendered, at a rate not to exceed PulmoCrit Associates, Inc. regular charges. Payment to PulmoCrit Associates, Inc. pursuant to this authorization, by an insurance company shall discharge said insurance company of all obligations under the policy to the extent of such payment.

Certification:

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or a duly authorized agent of the patient to execute this agreement and accept its terms.

Patient Signature / Legal Representative: **Date:**

Sleep Assessment Questionnaire

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Name: _____ **Age:** _____ **Date:** _____

Height: _____ **Weight:** _____ **BMI:** _____ **Blood Pressure:** _____ **Neck (in):** _____

PATIENT MUST COMPLETE THIS PART

Question	Yes	No
Do you snore?	■	■
Are you unable to stay awake in the daytime?	■	■
Do you wake up with a headache in the morning?	■	■
Do you wake up in the middle of the night unable to breathe or gasping for air?	■	■
Do you have sudden episodes of loss of muscle control, especially during emotional situations?	■	■
Do your legs jerk at night or feel restless?	■	■
Do you ever feel unable to move when falling asleep or waking up?	■	■
Have you gained a lot of weight in a short time?	■	■
Do you have problems falling asleep?	■	■
Do you have a hard time staying asleep?	■	■
Has someone seen you stop breathing while sleeping? If yes, for how long? _____	■	■

Do you frequently wake up with (circle all that apply): **Dry Mouth • Stuffy Nose • Headache • Heartburn • Chest Pain • Choking & Gasping**

Epworth Sleepiness Scale — How likely are you to doze off or fall asleep (not just feel tired) in the following situations? 0 = Never 1 = Slight 2 = Moderate 3 = High chance

Situation	0	1	2	3
Sitting and reading	■	■	■	■
Watching TV	■	■	■	■
Sitting, inactive, in a public place (theater, meeting)	■	■	■	■
As a passenger in a car for an hour without a break	■	■	■	■
Lying down to rest in the afternoon when possible	■	■	■	■
Sitting and talking to someone	■	■	■	■
Sitting quietly after lunch without alcohol	■	■	■	■
In a car, while stopped for a few minutes in traffic	■	■	■	■

PHYSICIAN MUST COMPLETE THIS PART — Check ONE and sign/date

■ If patient meets health plan criteria for sleep study, proceed with home diagnostic sleep study (CPT 95806) with the group's preferred vendor. If home study is positive (AHI/RDI > 15, or 5–15 with co-morbidities), proceed with auto-titrate CPAP (5–20 cmH■O). If the patient is high-risk, proceed with a split-night in-lab sleep study with CPAP titration (CPT 95811).

■ Proceed directly to a split-night in-lab sleep study with CPAP titration (CPT 95811) with the group's preferred vendor. (NOTE: This option cannot be approved if criteria are not met for an in-lab study.)

Physician Signature: **Date:**

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Smoking History & Employer Information

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Smoking Questions

Smoking Status — circle which applies:

Current Former Never

Frequency: _____

How many per day: _____

Start Date: _____

End Date: _____

Employer Information

Name of Employer:

_____

Phone Number: _____

Address: _____

PulmoCrit Associates Fees

Service	Fee
Disability Forms	$50.00
MD Excuse Note	$25.00
Medical Records	$50.00

Notice: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at openpaymentsdata.cms.gov.

Patient Signature: _____ **Date:** _____

Medical Records Release Form

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I, _____, request that my medical records include only the last two office visits, skin test results, sleep studies, spirometry, recent X-Rays / CT scans, and vaccine sheet, and that they be sent to:

PulmoCrit Associates

Babak Eshaghian, MD | Sasan Sani, MD

Kasra Sedarati, MD | Keren Fogelfeld, MD

16260 Ventura Blvd., Suite 600, Encino, CA 91436

Fax: (818) 360-3533

Patient Date of Birth:

Patient Signature: **Date:**

Consent to Release Patient Medical Records

PulmoCrit Associates • (844) 428-5864 • pulmocrit.com

I hereby authorize PulmoCrit Associates to release my medical records to be faxed or forwarded to all of my treating physicians involved with my healthcare.

Patient Name (Last, First):

Date of Birth:

Patient Signature: **Date:**

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Audio and Video Recording Policy

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By signing this form, you agree to refrain from taking any photography, video, and audio recordings during your visit at PulmoCrit Associates. Our office does not consent to any form of recording. Any in-office recording will be a violation of the California Penal Code — PEN § 632.

Patient Name:

Patient Signature: **Date:**

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HIPAA Notice of Privacy Practices

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Effective Date: April 14, 2003

How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

Treatment

We use medical information about you to provide your medical care. We may share your medical information with other physicians, health care providers, pharmacists, or labs involved in your care. We may also disclose medical information to family members who can help you when you are sick or injured.

Payment

We use and disclose medical information about you to obtain payment for the services we provide, including providing your health plan with required information before it will pay us.

Health Care Operations

We may use and disclose medical information to review and improve the quality of care we provide, for legal services, audits, fraud detection, and business planning. We may share your information with business associates (such as our billing service) who are contractually required to protect your information.

Appointment Reminders

We may use and disclose medical information to contact and remind you about appointments, including leaving messages on your answering machine.

Notification and Communication with Family

We may disclose your health information to notify a family member, personal representative, or other person responsible for your care about your location or general condition. You will be given the opportunity to object prior to such disclosures when possible.

Required by Law / Public Health / Law Enforcement

We will disclose your health information as required by law, including for public health purposes, reporting abuse or neglect, responding to judicial or administrative proceedings, and law enforcement purposes, subject to applicable limitations.

Fundraising

We may contact you for fundraising activities using basic demographic and treatment information. You may opt out at any time by contacting our Privacy Officer.

When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice, this medical practice will not use or disclose health information which identifies you without your written authorization. You may revoke your authorization in writing at any time.

Your Health Information Rights

Right to Request Special Privacy Protections: You may request restrictions on certain uses and disclosures of your health information.

Right to Request Confidential Communications: You may request that we communicate health information to you at a specific location or in a specific way.

Right to Inspect and Copy: You have the right to inspect and copy your health information, with limited exceptions. A reasonable fee may apply.

Right to Amend or Supplement: You may request that we amend health information you believe is incorrect or incomplete.

Right to an Accounting of Disclosures: You may receive an accounting of disclosures of your health information made by this practice,

subject to certain exceptions.

Right to a Paper or Electronic Copy of this Notice: You have the right to a paper copy of this Notice upon request.

Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice at any time. The revised Notice will apply to all protected health information we maintain. A copy will be available at each appointment.

Complaints

Complaints about this Notice or how we handle your health information should be directed to our Privacy Officer. If you are not satisfied, you may submit a formal complaint to: OCRMail@hhs.gov

Patient Signature: **Date:**