

Patient Information

Patient Name

— Last: _____ First: _____ Middle Initial: _____

Date of Birth: _____ Gender: _____ SSN #: _____

Marital Status: _____ Preferred Language: _____

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: _____

Employer Information

Employer Name: _____

Phone Number: _____ Address: _____

Insurance Information

Primary Insurance: _____ ID #: _____ Group #: _____

Secondary Insurance: _____ ID #: _____ Group #: _____

Consent to Treat

Patient Name: _____

DOB: _____

Consent to Treatment

The undersigned consents to health care encompassing routine diagnostic procedures, medical treatment, and the rendering of such professional services by or under the supervision of licensed physicians and practitioners employed by or on the medical staff of PulmoCrit Associates as are necessary or advisable for my diagnosis and treatment.

No Guarantees

It is understood that the practice of medicine, surgery and the rendering of health care is not an exact science and no guarantees have been made to the patient concerning the results of examination or treatment.

Release of Information

The undersigned agrees that, to the extent necessary to determine liability of payment and to obtain reimbursement, PulmoCrit Associates may disclose portions of the patient's medical record to appropriate persons or organizations.

Assignment of Insurance Benefits

The undersigned authorizes direct payment to PulmoCrit Associates of the insurance benefits otherwise payable to or on behalf of the patient for services rendered, and authorizes the use of this signature on all insurance submissions.

Certification

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

Patient Signature / Legal Representative

Date

Printed Name

Relationship to Patient (if not patient)

Sleep Assessment Questionnaire

Name: _____ Age: _____ Date: _____
 Height: _____ Weight: _____ BMI: _____ Blood Pressure: _____ Neck (in): _____

PATIENT MUST COMPLETE THIS PART

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

Do you frequently wake up with: (please circle as many as apply)

- Dry mouth
 Sore throat
 Headache
 Heartburn
 None

EPWORTH SLEEPINESS SCALE

HOW LIKELY ARE YOU TO DOZE OFF OR FALL ASLEEP IN THE FOLLOWING SITUATIONS?
 0 = Would Never Doze • 1 = Slight Chance • 2 = Moderate Chance • 3 = High Chance

Situation	0	1	2	3
Sitting and reading	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Watching TV	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting, inactive, in a public place (e.g., theater or meeting)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
As a passenger in a car for an hour without a break	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down to rest in the afternoon when circumstances permit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting and talking to someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sitting quietly after a lunch without alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In a car, while stopped for a few minutes in traffic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PHYSICIAN MUST COMPLETE THIS PART (check ONE and sign/date):

- If patient meets health plan criteria for sleep study, proceed with home sleep test (HST) if no contraindications.
 Proceed directly to a split-night in-lab study (PSG) — criteria must be met; request cannot be approved otherwise.

Physician Signature

Printed Name

Date

Smoking History

Smoking Status (circle one):

Current Smoker

Former Smoker

Never Smoked

Frequency /
Amount:

Start Date:

End Date (if applicable):

Employer Information

Employer Name:

Phone Number:

Address:

PulmoCrit Associates — Administrative Fees

Disability / FMLA Forms:

\$50.00

MD Excuse Note:

\$25.00

Medical Records Request:

\$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

I, _____, request that my medical records including the last two office visits, lab results, radiology reports, and all relevant records (if applicable) 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

I, _____ (Last Name, First Name), hereby authorize the release of my medical records from PulmoCrit Associates to be faxed or forwarded to all of my treating physicians involved with my healthcare.

Date of Birth: _____

Patient's Full Name:

Patient's Signature:

Date:

Audio and Video Recording Policy

PulmoCrit Associates uses audio and video recording in our clinical areas for the purpose of patient safety, quality assurance, and staff training. Recordings may be made during your visit to our office or sleep center.

All recordings are stored securely and are accessible only to authorized personnel. Recordings may be used for internal quality improvement purposes, compliance review, and as part of the medical record when clinically appropriate.

You have the right to ask questions about our recording practices at any time. By signing below, you acknowledge that you have been informed of and consent to the use of audio and video recording as described above.

If you have any concerns or wish to revoke your consent at any time, please notify our staff in writing.

Patient Signature / Legal Representative

Date

Printed Name

Relationship to Patient (if not patient)

HIPAA Notice of Privacy Practices

Effective Date: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

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 disclose medical information to our employees and others who are involved in providing the care you need.

Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us.

Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff.

Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

Notification and Communication with Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition, or in the event of your death.

Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to what is relevant to satisfy the requirement.

Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for reasons related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the FDA problems with products and reactions to medications; and reporting disease or infection exposure.

Research. We may disclose your health information to researchers conducting research with respect to which an Institutional Review Board has waived the requirement for your authorization.

Your Rights. You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information below.

Changes to This Notice. We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of our current notice in the office. The notice will contain on the first page, in the top right-hand corner, the effective date.

Complaints. If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our office. You also may send a written complaint to the U.S. Department of Health and Human Services. The person in charge of privacy matters is our Privacy Officer. You will not be penalized for filing a complaint.

By signing below, I acknowledge that I have received and reviewed the HIPAA Notice of Privacy Practices.

Patient Signature

Date