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PULMONARY & SLEEP ASSOCIATES OF HUNTSVILLE, P.C.

Board Certified in Critical Care, Sleep and Pulmonary Medicine

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PATIENT HISTORY FORM

Welcome to Pulmonary and Sleep Associates of Huntsville. In order to ensure your best care, it is important that you take the time to complete both sides of this medical questionnaire. Thanks.

Name _____ Date of Birth _____

Referring Doctor _____ Primary Doctor _____

Cardiologists _____ Other Physicians _____

Pharmacy Name _____ Pharmacy Phone Number _____

The reason for your visit: _____

Do you have a handicap designation? Y / N

Do you use a wheelchair? Y / N

Past Medical History:

Past Medical History: (Please Circle All That Apply) None

- | | | | |
|--|---|--|--|
| Heart:
Angina
Atrial Fibrillation
Atrial Flutter
Blood Clots
Cerebrovascular Disease
Congestive Heart Failure
Coronary Disease
Endocarditis
Fast Heart Rate
Heart Attack
Heart Valve Disease
High Cholesterol
Hypertension
Peripheral Vascular Disease
Slow Heart Rate
Stroke
Varicose Veins | Lungs:
Asthma
COPD
Sleep Apnea
Use CPAP
Tuberculosis

Mental:
Anxiety
Depression

Gastrointestinal:
Acid Reflux
Cirrhosis
Crohn's Disease
Diverticulitis
GI Bleed
Hepatitis
Liver Disease
Stomach Ulcers
Any Additional Illnesses? _____ | Urinary:
Dialysis
Erectile Dysfunction
Kidney Disease
Kidney Stones

Skeletal:
Arthritis
Osteoporosis

Neurological:
Fainting
Parkinson's Disease
Seizures | Hematology/Oncology:
Anemia
Autoimmune Disease
Blood Transfusion
Brain Tumor
Cancer
Chemotherapy
Radiation Therapy
Hemochromatosis
HIV

Other:
Diabetes
Hypothyroidism
Hyperthyroidism
Lupus
Fibromyalgia
Rheumatic Fever (Childhood) |
|--|---|--|--|

Past Surgical History:

None

- | | | |
|---|---|--|
| <input type="checkbox"/> Abdominal Surgery
<input type="checkbox"/> Amputation
<input type="checkbox"/> Angioplasty
<input type="checkbox"/> AV Fistula Creation
<input type="checkbox"/> Aortic Valve Repaired
<input type="checkbox"/> Aortic Valve Replaced
<input type="checkbox"/> Appendix Removed
<input type="checkbox"/> Back Surgery
<input type="checkbox"/> Bladder Surgery
<input type="checkbox"/> Brain Surgery
<input type="checkbox"/> Bronchoscopy
<input type="checkbox"/> Carotid Artery
<input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Cataract Removal
<input type="checkbox"/> Colon Surgery
<input type="checkbox"/> Defibrillator Implanted
<input type="checkbox"/> Dialysis Catheter
<input type="checkbox"/> Gallbladder
<input type="checkbox"/> Gastric Bypass
<input type="checkbox"/> Heart Bypass
<input type="checkbox"/> Hemorrhoid Surgery
<input type="checkbox"/> Hip Replacement
<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Kidney removed
<input type="checkbox"/> Kidney Transplant
<input type="checkbox"/> Knee Arthroscopy | <input type="checkbox"/> Knee Replacement
<input type="checkbox"/> Kyphoplasty
<input type="checkbox"/> Lung Removed
<input type="checkbox"/> Mitral Valve Repair
<input type="checkbox"/> Mitral Valve Replaced
<input type="checkbox"/> Pacemaker Implanted
<input type="checkbox"/> Pain Epidural Injections
<input type="checkbox"/> Prostate Surgery
<input type="checkbox"/> Shoulder Surgery
<input type="checkbox"/> Sleep Apnea Surgery
<input type="checkbox"/> Thyroid Surgery
<input type="checkbox"/> Tonsils Removed
<input type="checkbox"/> Vascular Surgery |
|---|---|--|

Anesthesia Problems

No Yes

Surgical Complications

No Yes

Post Operative Complications

No Yes

Vaccinations / Skin Test

Vaccine	Month/Year
Influenza	
Pneumonia	
PPD/TB skin test	

Medications	Dose	Times per day

Medications	Dose	Times per day

Any allergies to medications, etc.? _____

Reaction: _____

Please continue on other side

Social History:

History of tobacco use:

Do you smoke cigarettes / cigars? Y / N
If so, how many per day? _____
How many years have you smoked? _____
If you used to smoke, how long ago did you quit? _____

History of Alcohol Use:

Do you consume alcohol? Y / N
If so, how many drinks per week? _____

Environmental History:

Have you ever been exposed to any harmful substances?

Name of Harmful Substance	# of years

Illicit Drug Use:

Do you use illegal drugs? Y / N
If so, what type and how often? _____

Marital Status:(circle one)

Single / Married / Divorced / Widowed

Children:

Number of children: _____

Occupational Information:

List all occupations and how long you worked at each:

Occupation	# of years

Family History:

Family Member	Living	Deceased	Age/Age at death	Health Condition or Cause of Death
Father				
Mother				
Spouse				
Siblings				

System Review: (Please check all that apply.)

General: Fevers Chills Night sweats Weight loss Weight gain Headaches

Pulmonary: Shortness of breath Cough Wheezing Phlegm Cough up blood

Sleep: Difficulty in sleeping Snoring Morning headaches Daytime sleepiness

Stop breathing during sleep

Eyes: Bluriness of vision Dry eyes Light sensitivity

ENT: Decreased hearing Loss of smell Runny or stuffy nose Sinus pain/drainage Sore throat

Thrush Hoarseness of voice

Cardiac: Chest pains Palpitations Heart murmur Leg Swelling

Gastrointestinal: Nausea Vomiting Heartburn Difficulty to swallow Abdominal pain

Blood in stool

Genitourinary: Pain with urination Blood in urine Frequent Urinary tract infections

Musculoskeletal: Joint pain Joint swelling Muscle pain Back pain

Hematology: Bruise easily Bleeding disorder History of blood transfusion Anemia

Skin: Rashes Tattoos Itching Skin discoloration

Psychiatric: Depression Anxiety Suicide attempts

Neurological: Seizures Paralysis Dizziness Numbness/tingling Memory loss

Please bring a list of all medications to appointment.

Signature: _____ **Date:** _____

Pulmonary and Sleep Associates of Huntsville

725 Madison Street • Huntsville, AL 35801
1041 Balch Road, Suite 175 • Madison, AL 35758

Date: _____

INITIALS	OFFICE USE ONLY
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PATIENT'S NAME IN FULL (NO NICKNAMES) Last Name First					MARITAL		DATE OF BIRTH	AGE	SEX	
					S	M	W	D	SEP	
RACE: <input type="checkbox"/> AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> CAUCASIAN / WHITE <input type="checkbox"/> NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN / ALASKA NATIVE <input type="checkbox"/> DECLINED <input type="checkbox"/> UNKNOWN										
PRIMARY LANGUAGE:					ETHNICITY:					
<input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER _____					<input type="checkbox"/> HISPANIC <input type="checkbox"/> NON-HISPANIC <input type="checkbox"/> DECLINED <input type="checkbox"/> UNKNOWN					
ADDRESS					CITY, STATE & ZIP					
SOCIAL SECURITY NO.	MAIN PHONE NO.		SECONDARY PHONE NO.		EMAIL					
		()		()						
OCCUPATION (INDICATE IF STUDENT)			EMPLOYER			HOW LONG EMPLOYED?		RELIGION (OPTIONAL)		
EMPLOYERS ADDRESS				CITY, STATE & ZIP						
HUSBAND, WIFE, PARENT OR GUARDIAN NAME				DATE OF BIRTH			SSN			
EMPLOYER OF ABOVE NAME			CITY & STATE		ZIP CODE		BUSINESS PHONE NO.			
							()			
PERSON TO NOTIFY IN CASE OF EMERGENCY OTHER THAN SPOUSE			RELATIONSHIP		HOME TELEPHONE NO.		BUSINESS PHONE NO.			
					()		()			
ADDRESS					CITY, STATE & ZIP					

REFERRING PHYSICIAN				
ADDRESS		CITY & STATE	ZIP CODE	PHONE
				()
FAMILY PHYSICIAN				
ADDRESS		CITY & STATE	ZIP CODE	PHONE
				()

PERSON RESPONSIBLE FOR BILL: _____
IF OTHER THAN PARENT, S.S.# _____
ADDRESS OF RESPONSIBLE PARTY _____

PRIMARY INSURANCE CO.		NAME OF POLICY HOLDER		POLICY HOLDER DOB	COPAY
CONTRACT NUMBER		GROUP NUMBER		EMPLOYED BY:	
SECONDARY INSURANCE CO.		NAME OF POLICY HOLDER		POLICY HOLDER DOB	COPAY
CONTRACT NUMBER		GROUP NUMBER		EMPLOYED BY:	
OTHER INSURANCE		NAME OF POLICY HOLDER		POLICY HOLDER DOB	COPAY
CONTRACT NUMBER		GROUP NUMBER		EMPLOYED BY:	

AUTHORIZATION FOR SERVICES

The signature below serves as authorization for services rendered by Pulmonary and Sleep Associates of Huntsville for the above named patient, and release of information necessary to file insurance; and assign benefits otherwise payable to policy holder to the doctor or group indicated on the claim. I understand I am financially responsible for any balance not covered by the insurance carrier - a copy of the signature is as valid as the original. Authorization is continuing while patient is under care of Pulmonary and Sleep Associates of Huntsville or until patient revokes authorization.

AUTHORIZATION FOR RELEASE OF INFORMATION

The signature below serves as authorization for Pulmonary and Sleep Associates of Huntsville to release or receive medical information for the purpose of patient referral. A copy of this signature is as valid as the original. Authorization is continuing while patient is under care of Pulmonary and Sleep Associates of Huntsville or until patient revokes authorization.

Signature: _____ Date: _____

SERVICES CAN BE CHARGED TO YOU THROUGH MASTERCARD, VISA OR DISCOVER



DISCLOSURES & PRIVACY PRACTICES

Patient Name: _____

DOB: _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner:

	Phone Number	OK to leave message with detailed information	Leave message with call-back number only
Home Phone			
Work Phone			
Cell Phone			

I acknowledge that I have received a copy of the Notice of Privacy Practices and that Pulmonary and Sleep Associates of Huntsville may, at its discretion change the terms and conditions of this notice.

(Please Initial) _____

Release of Medication History Authorization:

I give Pulmonary and Sleep Associates of Huntsville permission to obtain/retrieve and view my medication history. I understand that this information will be disclosed as part of my medical records release.

(Please Initial) _____

Pulmonary and Sleep Associates of Huntsville and its staff has my permission to discuss my account or medical conditions which may include symptoms, treatments, tests, medicine or other protected health information with the following persons to facilitate my treatment and payment of my account.

Name	Relationship	Phone Number

Printed Name: _____

Signature: _____

Date: _____



Pulmonary & Sleep Associates
o f H u n t s v i l l e

FINANCIAL POLICY

PSA believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. **PAYMENT** is expected at the time of visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance payment in full is expected at the time of your visit. We do ask for a copy of a picture ID due to the many cases of identity theft in the news lately. (Please do not be offended!)
2. **INSURANCE.** We are participating providers with several insurance plans. We will file all insurance claims as a courtesy to you. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay PSA within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayments to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff can not guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Not all insurance plans cover all services. In the event you're insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed by PSA are considered covered unless limited by your specific insurance policy.

3. **RETURNED CHECKS** will incur a \$50.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the \$50 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the \$50 service fee and collections action. All returned checks written to PSA are subject to collections and will be prosecuted by Madison County District Attorney.
4. **BILLING OFFICE:** If you have questions in regard to any of your billing statements, our insurance staff at PSA is available to assist you. CALL 256-883-2110.
5. **CANCELLATIONS OR MISSED APPOINTMENTS:** If you do not cancel your appointment at least 24 hours before, or if you-no-show, we may assess you a \$25.00 missed appointment fee that must be paid prior to scheduling another appointment. This charge will not be filed with your insurance.
6. **RESPONSIBILITY FOR PAYMENT:** I understand that I, personally, am financially responsible to PSA for charges not covered by the assignment of insurance benefits. **SELF PAY PATIENTS.** All monies owed are expected on date of service. Charges for supplies, tests, immunizations, medications, or procedures are never discounted. PSA will be happy to assist you with a patient financial arrangement however, the first visit will need to be paid in full prior to any arrangements being made.
7. **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby, assign, transfer, and set over directly to PSA sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said office. I authorize PSA to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to PSA. I authorize PSA to release all medical information (including, but not limited to, information on psychiatric conditions, Sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.
8. **COLLECTION FEES:** I understand that in the event my account is placed in collections status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

I have read and understand the PSA financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

Signature of Patient

Date:_____

ADVANCED CARE PLANNING

Patient Name - _____ **DOB** - _____

This form is intended for you to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy.

Place your initials by only ONE answer:

_____ I do not want to name a health care proxy at this time.

_____ I would like to discuss advanced care planning with my family and will discuss this further with my doctor at a later date.

_____ I do want the person listed below to be my health care proxy. I have talked with this person about my wishes.

FIRST Choice Health Care Proxy Name: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Day-time phone: _____ Night-time phone: _____

SECOND Choice Health Care Proxy Name: _____

Relationship to me: _____

Address: _____

City: _____ State: _____ Zip: _____

Day-time phone: _____ Night-time phone: _____

Patient's Signature: _____ **Date:** _____