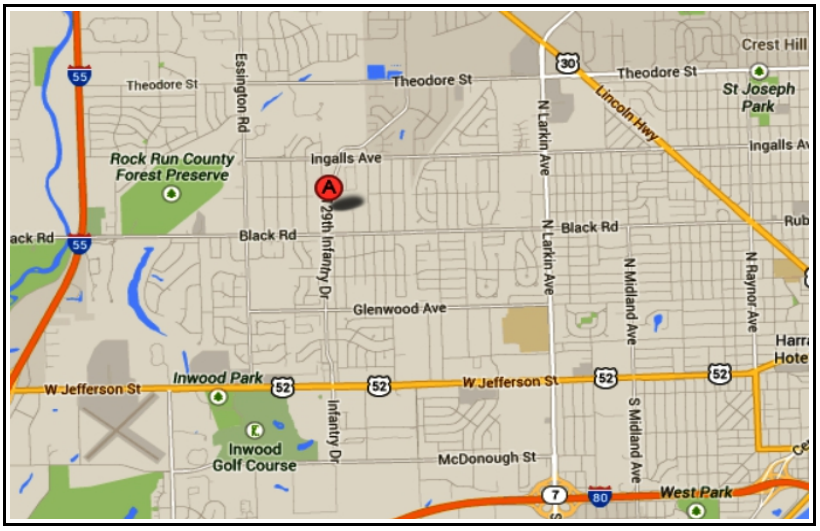
Midwest Respiratory, Ltd.

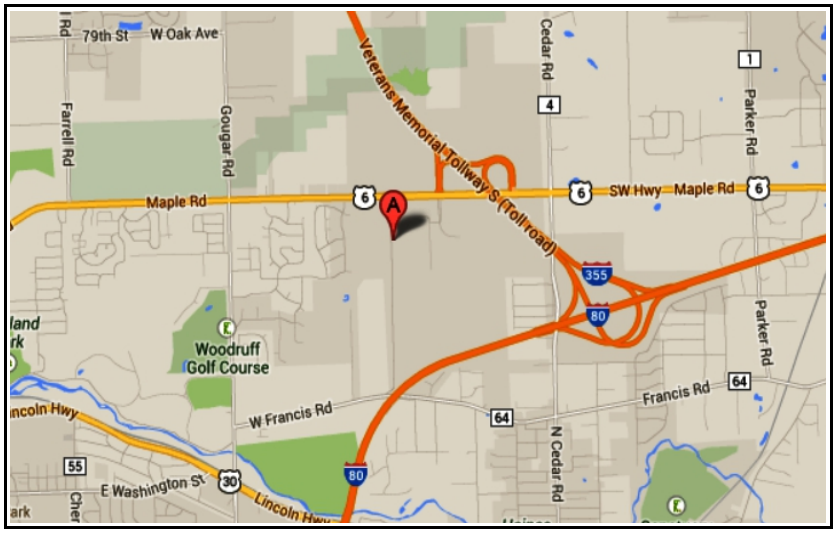
Your first appointment is: _____

- ❑ Alexander Z. Sosenko, M.D.
- ❑ Amar B. Garapati, M.D.
- ❑ Mazen Abdel-Hadi, M.D.
- ❑ Kristopher M. McDonough, M.D.
- ❑ Diana C. Doeing, M.D.
- ❑ John M. Walsh, M.D.
- ❑ Philip S. Leung, M.D.
- ❑ Salah Lababidy, M.D.
- ❑ Visvanatha V. Giri, M.D.

❑ 903 129th Infantry Dr., Suite 400
Joliet, Illinois 60435
Phone: 815-725-2653 Fax: 815-744-3232



❑ 1890 Silver Cross Blvd., Ste. 535
New Lenox, Illinois 60451
Phone: 815-740-1301 Fax: 815-723-6778



Name: _____ **DOB**: _____	**Midwest Respiratory, Ltd.**

Midwest Respiratory, Ltd. Practice Policy

Thank you for choosing us as your health care provider. Our staff and physicians are committed to providing you the best service we can. The following is a statement of our office policies, which we ask that you *read* and *sign*.

We accept assignment of insurance benefits as a courtesy to our patients; however the balance is your responsibility. Deductibles applied by your insurance, not covered by another insurance, will also be your responsibility. Patients are responsible for verifying insurance coverage, for the office visits and/or any tests ordered by the physician. You will be responsible for payment of all services not covered by your insurance.

Unless valid insurance is presented, you will be responsible for payment in full at the time of visit.

Co-pays are due at the time services are rendered. If your insurance is an HMO or requires a referral, it is the patient's responsibility to have referral sent or brought in at time of visit. If no referral is present, your appointment will need to be rescheduled.

Patients are responsible for bringing any recent x-rays/films/discs, labs, or previous breathing tests to the appointment.

We request a 24-hour cancellation notice with our office during regular office hours; our answering service does not take cancellation notices. Failure to call, no shows, will be charged a "No Show Fee." The fees are as follows: New Patients: $60, Follow Up Appointments: $30, Pulmonary Function Tests: $60. These fees are not billable to your insurance and therefore your responsibility.

We attempt to make courtesy phone calls to remind you of an appointment, but are unable to provide this service at all times. Lack of a reminder phone call does not cancel the above no show policy.

Please call your pharmacy for refill requests and do not wait until you run out to call. Prescription refills may take 24-48 hours to be processed, mail away prescriptions may take longer.

There is a fee for copied Medical Records. We will notify you of the records fee and it should be paid prior to the release of the records. We require at least 5 business days to receive copies of medical records.

Patients are not always called in order of arrival due to the fact that we have many physicians. We make every effort for you to be seen at your scheduled times, however there are times when physicians may have an unforeseen emergency causing us to run behind.

Should you arrive late for an appointment, you may be asked to reschedule or you may have to wait to be seen between or after the other patients who have arrived on time.

I have read, understand, & agree to the office policies of Midwest Respiratory, Ltd. listed above.

_____ _____

Signature of Responsible Party **Date**

Midwest Respiratory, Ltd.

Pulmonary Diseases, Critical Care Medicine, Internal Medicine, and Sleep Medicine

Medical Questionnaire

Name: _____ **Date of Birth:** _____

Reason for pulmonary consultation: _____

I. RESPIRATORY CONCERNS

	Yes	No	Notes		Yes	No	Notes
Cough				Exposure to TB			
Sputum Production				Hoarseness			
Chest Tightness				Recent Weight Loss			
Shortness of Breath				Recent Weight Gain			
Wheezing				Loud Snoring			

II. MEDICAL HISTORY

	Yes	No	Notes		Yes	No	Notes
Allergies				Heart Problems			
Anemia				High Blood Pressure			
Asthma				Kidney Disease			
Blood Clot				Liver Disease			
Bronchitis				Mental Disease			
Cancer				Sarcoidosis			
COPD				Stroke			
Diabetes				Sleep Apnea			
Emphysema				Tuberculosis			

	Yes	No	Notes
Chest X-Ray/Chest CT Scan in last 5 years			
Pulmonary Function Test in last 5 years			

Any other chronic illnesses:

III. SURGICAL HISTORY

Surgical Procedure(s)	Date of Surgery	Notes

VI. FAMILY HISTORY

Relation	Health Problem(s)	Deceased at Age	Notes
Father			
Mother			
Brother(s)			
Sister(s)			

V. SOCIAL HISTORY

Smoking History: ☐ Never Smoked ☐ Current Everyday Smoker; Pack(s) per day: _____ Number of Years Smoking: _____ ☐ Former Smoker; Pack(s) per day: _____ Number of Years Smoked: _____ Year Quit: _____
Have you been exposed to secondhand smoke?
Are you single, married, divorced or other?
What is/was your occupation?
How many caffeinated beverages do you consume in a day?
How many alcoholic beverages do you consume in a week?
Do you keep animals in your home?
Do you exercise regularly and what kind of exercise?
Do you use illegal drugs?

VI. MEDICATION ALLERGIES

Please list all medications you are **allergic** too: ☐ **I do NOT have any known allergies to medications.**

_____

_____

_____

VI. MEDICATIONS

Please list all **current** medications you are taking (including over the counter): ☐ **I am NOT currently taking any medications.**

_____

_____

_____

_____

_____

Midwest Respiratory, Ltd.

Pulmonary Diseases, Critical Care Medicine, Internal Medicine and Sleep Medicine

Patient Registration Form

Name: _____ *DOB*: _____

Age: _____ *Gender*: M / F *Social Security Number*: _____-_____-_____

Address: _____

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

Home Phone: ( ) _____ *Cell Phone*: ( ) _____

Preferred Method of Contact: ❒ Home ❒ Cell

*E-Mail:*_____

Employer: _____

Race: _____ *Preferred Language*: _____ *(now required by most insurances)*

Spouse's Name: _____ *DOB*: _____ *SSN (if guarantor)*: _____-_____-_____

Primary/Referring Physician: _____

Emergency Contacts:

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Pharmacy Name & Location:

_____

_____

I hereby give my consent for medical treatment rendered to me by the physicians and associates at Midwest Respiratory, Ltd. I hereby authorize the release of medical information to parties involved in my treatment, payment, or healthcare operations. I am aware of the new "HIPAA" guidelines and have read, "The notice of privacy practices" given to me by Midwest Respiratory, Ltd., and associates. I may have a copy if I so request. I hereby assign Midwest Respiratory, Ltd., and associates all payments for medical services rendered unless paid for at the time of service. I am responsible for all charges not covered by my insurance company. I am responsible for all co-pays due at time of service rendered.

☒ **PLEASE SIGN: _____ Date: _____**

NOTICE OF PRIVACY PRACTICES

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

The *effective date* of this Privacy Notice is January 2010.

This Notice of Privacy Practices is being provided to you as a requirement of the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how **Midwest Respiratory, Ltd.** may use and disclose medical information about you to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control protected health information about you. Your personal health information (i.e. "protected health information" or "PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition. We are required by law to maintain the privacy of your PHI, and we must abide by the terms of this notice.

ACKNOWLEDGMENT OF RECEIPT OF THIS PRIVACY NOTICE

You are receiving our current Privacy Notice and are asked to sign an acknowledgment that you have received it. You may provide the signed acknowledgment by initialing the attached "Acknowledgment of Receipt".

HOW WE MAY USE AND DISCLOSE PHI ABOUT YOU

The following categories describe different ways that we use and disclose PHI. All of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use and disclose your PHI as reasonably necessary to provide for your treatment. We do not need to obtain your permission for us to do this. We may disclose PHI about you to doctors, nurses, technicians or other healthcare personnel who are involved in taking care of you. For example, a specialist who is providing care to you may need your medical history to better evaluate your medical condition.

For Payment. We may use and disclose your PHI about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about a procedure performed in our office so your health plan will pay us or reimburse you for the procedure. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Healthcare Operations. We may use and disclose PHI about you for healthcare operations. These uses and disclosures are necessary to run our office and make sure that all individuals receive quality care. Some examples of how we may use your PHI performing day to day tasks include calling you by name from the waiting room. As another part of healthcare operations, we may use and disclose PHI about you to our business associates. Our business associates, such as transcription services, collection agencies, and answering services perform services on behalf of our practice. Out business associates who have access to PHI agree to protect the privacy of your personal health information.

Appointment Reminders. Test Results. As a part of our healthcare operations, we may use and disclose PHI to contact you as a reminder that you have an appointment for treatment or medical care at our office. We may leave a message on an answering machine or voicemail system including system including your name, the name of the physician in which you have an appointment, the practice name and a reminder to bring your co-payment, insurance referral and/or medical records or x-rays to your appointment. We may contact you to discuss treatment and/or test results. If you are not available, we may leave a message using your name, the name of the physician and the practice name so you may return our call.

As Required By Law. We will disclose PHI about you when required to do so by federal, state, or local law.

Workers' Compensation. We may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

Public Health Risks. We may disclose PHI about you for public health activities. These activities generally include the following:

-to prevent or control disease, injury, or disability;
-to report reactions to medications or problems with products;
-to notify people of recalls of products they may be using;
-to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Coroners, Medical Examiners, and Funeral Directors. We may release PHI to a coroner or medical examiner. We may also release PHI about an individual to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Pursuant to an Authorization. We will require a signed authorization form before we disclose your PHI to a third party for reasons other than those listed above. We will retain a copy of any signed authorization you give us that is attached to a request to us for your PHI. We will also keep a record of when, to whom and what we provided in response to the request for disclosure.

YOUR RIGHTS REGARDING PHI ABOUT YOU. You have the following rights regarding PHI we maintain about you:

Right to inspect and Copy. You have the right to inspect and copy Phi that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contract you at work or on your cell phone.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. You may obtain a copy of this notice at our website, www.midwestresp.com.

Name: _____ DOB: _____	**Midwest Respiratory, Ltd.**

Acknowledgment of Privacy Practices and Privacy Options

■ I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. ☐

(Please Initial)

❑ **I want no one to receive my Personal Health Information except myself.**

❑ **I request the following person(s) be allowed to access my Personal Health Information:**

_____

_____

_____

❑ **I SPECIFICALLY request the following person(s) <u>do NOT receive</u> any of my Personal Health Information:**

_____

_____

_____

_____ _____

Signature of Responsible Party **Date**