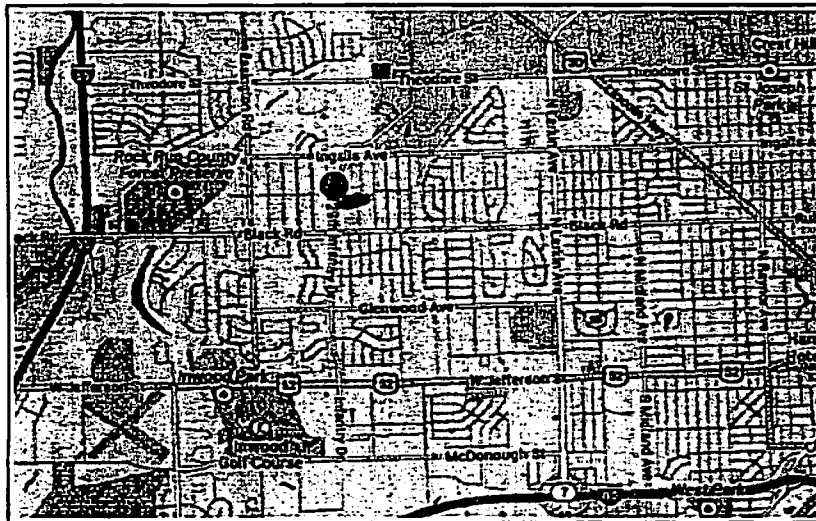


Midwest Respiratory, Ltd.

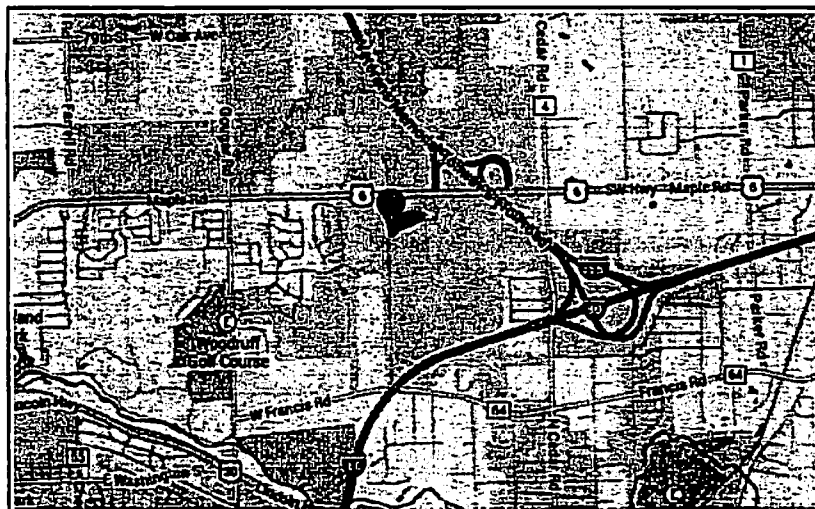
Your first appointment is: _____

- | | |
|--|---|
| <input type="checkbox"/> Alexander Z. Sosenko, M.D. | <input type="checkbox"/> John M. Walsh, M.D. |
| <input type="checkbox"/> Amar B. Garapati, M.D. | <input type="checkbox"/> Philip S. Leung, M.D. |
| <input type="checkbox"/> Mazen Abdel-Hadi, M.D. | <input type="checkbox"/> Salah Lababidy, M.D. |
| <input type="checkbox"/> Kristopher M. McDonough, M.D. | <input type="checkbox"/> Visvanatha V. Giri, M.D. |
| <input type="checkbox"/> Diana C. Doeing, 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



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. Our 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 contact 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.

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: _____

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

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

Acknowledgment of Privacy Practices and Privacy Options

<input checked="" type="checkbox"/> I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.	<div style="border: 1px solid black; width: 50px; height: 30px; display: inline-block;"></div> (Please Initial)
<input type="checkbox"/> I want no one to receive my Personal Health Information except myself.	
<input type="checkbox"/> I request the following person(s) be allowed to access my Personal Health Information:	

<input type="checkbox"/> I SPECIFICALLY request the following person(s) <u>do NOT receive</u> any of my Personal Health Information:	

Signature of Responsible Party

Date

Name:

Date of birth:

Date:

Sex/Age:

Weight:

Height:

Please help us find out about you by filling out this form. You can write additional information on the "Comment" section.

If you don't know the answer to one of the questions, ask your bed partner if he/she can answer them.

PATIENT	COMMENT	
Why are you coming for a sleep consultation or sleep study? _____	CC	
How long has this been bothering you? _____	HPI	
Daytime sleepiness? _____		
Cannot sleep? _____		
What affects your sleep? _____		
Who sleeps in bed with you? _____		
What do you do before bed time? _____		
Sleep Schedule:		
Retires to bed at around: _____ am/pm		_____ am/pm
Fall asleep at around: _____ am/pm		_____ am/pm
Get out of bed at: _____ am/pm		_____ am/pm
Easy/difficult to fall asleep? I wake up _____ times. I go to the bath room _____ times on average. It takes me _____ minutes to fall back asleep.		
How do you feel when you wake up?		
	No sometimes Yes <i>Tell us more</i>	
Exhausted/tired?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Any heahaches?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Any nasal congestion?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Any dry or sore throat?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Any heart burn?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Do you snore frequently?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Stop breathing?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Wake up gasping/choking?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Night sweat?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Leg discomfort/restlessness?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Leg kicking?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Difficulty falling asleep?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Mind is busy at night?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Sleep better outside bed room?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Waken too early?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
A lot of worries?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	
Using sleep aid?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> _____	

PATIENT	COMMENT																																				
Please list all your illnesses: _____ _____ _____ _____	PMH																																				
Please list all your previous surgery / injury: _____ _____ _____																																					
Please list all drug allergy: _____ _____	ALL																																				
List all your medications (prescription/over the counter/health/natural products): _____ _____ _____	MED																																				
Please circle all of the followings that applies to you: <table border="0" style="width: 100%;"> <tr> <td>Headaches</td> <td>Migraine</td> <td>Numbness</td> <td>Weakness</td> </tr> <tr> <td>Seizure</td> <td>paralysis</td> <td>Loss of balance</td> <td>Loss of Memory</td> </tr> <tr> <td>Chest pain</td> <td>Dizziness</td> <td>Black out</td> <td>Heart palpitation</td> </tr> <tr> <td>Cough</td> <td>wheezing</td> <td>Sputum</td> <td>Short of breath</td> </tr> <tr> <td>Belly pain</td> <td>Nausea</td> <td>Vomitting</td> <td>Blood in stool</td> </tr> <tr> <td>Diarrhoea</td> <td>Constipation</td> <td>Thirsty</td> <td>Frequent urination</td> </tr> <tr> <td>Weight loss</td> <td>Cancer</td> <td>Bleeding</td> <td>Sexual problems</td> </tr> <tr> <td>Back pain</td> <td>Joint pain</td> <td>muscle pain</td> <td>Hard of hearing</td> </tr> <tr> <td>Hard to see</td> <td>Cannot drive</td> <td>Itchy skin</td> <td></td> </tr> </table> Weight gain _____ pounds in the past 10 years	Headaches	Migraine	Numbness	Weakness	Seizure	paralysis	Loss of balance	Loss of Memory	Chest pain	Dizziness	Black out	Heart palpitation	Cough	wheezing	Sputum	Short of breath	Belly pain	Nausea	Vomitting	Blood in stool	Diarrhoea	Constipation	Thirsty	Frequent urination	Weight loss	Cancer	Bleeding	Sexual problems	Back pain	Joint pain	muscle pain	Hard of hearing	Hard to see	Cannot drive	Itchy skin		ROS
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Hard to see	Cannot drive	Itchy skin																																			

Feeling Inventory

This questionnaire consists of 21 groups of statements. Read each group of statements carefully, and then pick out the one statement in each group that best describes the way you have been feeling during the past two weeks, including today. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, check the highest number for that group. Be sure you do not choose more than one statement for any group.

Q.1 Sadness

- 0 = I do not feel sad.
- 1 = I feel sad much of the time.
- 2 = I am sad all the time.
- 3 = I am so sad or unhappy that I can't stand it.

Q.2 Pessimism

- 0 = I am not discouraged about my future.
- 1 = I feel more discouraged about my future than I used to be.
- 2 = I do not expect things to work out for me.
- 3 = I feel my future is hopeless and will only get worse.

Q.3 Past Failure

- 0 = I do not feel like a failure.
- 1 = I have failed more than I should have.
- 2 = As I look back, I see a lot of failures.
- 3 = I feel I am a total failure as a person.

Q.4 Loss of Pleasure

- 0 = I get as much pleasure as I ever did from the things I enjoy.
- 1 = I don't enjoy things as much as I used to.
- 2 = I get very little pleasure from the things I used to enjoy.
- 3 = I can't get any pleasure from the things I used to enjoy.

Q.5 Guilty Feelings

- 0 = I don't feel particularly guilty.
- 1 = I feel guilty over many things I have done or should have done.
- 2 = I feel quite guilty most of the time.
- 3 = I feel guilty all of the time.

Q.6 Punishment Feelings

- 0 = I don't feel I am being punished.
- 1 = I feel I may be punished.
- 2 = I expect to be punished.
- 3 = I feel I am being punished.

Q.7 Self-Dislike

- 0 = I feel the same about myself as ever.
- 1 = I have lost confidence in myself.
- 2 = I am disappointed in myself.
- 3 = I dislike myself.

Q.8 Self-Criticalness

- 0 = I don't criticize or blame myself more than usual.
- 1 = I am more critical of myself than I used to be.
- 2 = I criticize myself for all of my faults.
- 3 = I blame myself for everything bad that happens.

Q.9 Suicidal Thoughts or Wishes

- 0 = I don't have any thoughts of killing myself.
- 1 = I have thoughts of killing myself, but I would not carry them out.
- 2 = I would like to kill myself.
- 3 = I would kill myself if I had the chance.

Q.10 Crying

- 0 = I don't cry any more than I used to.
- 1 = I cry more than I used to.
- 2 = I cry over every little thing.
- 3 = I feel like crying, but I can't.

Q.11 Agitation

- 0 = I am no more restless or wound up than usual.
- 1 = I feel more restless or wound up than usual.
- 2 = I am so restless or agitated that it's hard to stay still.
- 3 = I am so restless or agitated that I have to keep moving or doing something.

Q.12 Loss of Interest

- 0 = I have not lost interest in other people or activities.
- 1 = I am less interested in other people or things than before.
- 2 = I have lost most of my interest in other people or things.
- 3 = It's hard to get interested in anything.

Q.13 Indecisiveness

- 0 = I make decisions about as well as ever.
 1 = I find it more difficult to make decisions than usual.
 2 = I have much greater difficulty in making decisions than I used to.
 3 = I have trouble making any decisions.

Q.14 Worthlessness

- 0 = I do not feel I am worthless.
 1 = I don't consider myself as worthwhile and useful as I used to.
 2 = I feel more worthless as compared to other people.
 3 = I feel utterly worthless.

Q.15 Loss of Energy

- 0 = I have as much energy as ever.
 1 = I have less energy than I used to have.
 2 = I don't have enough energy to do very much.
 3 = I don't have enough energy to do anything.

Q.16 Changes in Sleeping Pattern

- 0 = I have not experienced any change in my sleeping pattern.
 1a = I sleep somewhat more than usual.
 1b = I sleep somewhat less than usual.
 2a = I sleep a lot more than usual.
 2b = I sleep a lot less than usual.
 3a = I sleep most of the day.
 3b = I wake up 1-2 hours early and can't get back to sleep.

Q.17 Irritability

- 0 = I am no more irritable than usual.
 1 = I am more irritable than usual.
 2 = I am much more irritable than usual.
 3 = I am irritable all the time.

Q.18 Changes in Appetite

- 0 = I have not experienced any change in my appetite.
 1a = My appetite is somewhat less than usual.
 1b = My appetite is somewhat greater than usual.
 2a = My appetite is much less than before.
 2b = My appetite is much greater than usual.
 3a = I have no appetite at all.
 3b = I crave food all the time.

Q.19 Concentration Difficulty

- 0 = I can concentrate as well as ever.
 1 = I can't concentrate as well as usual.
 2 = It's hard to keep my mind on anything for long.
 3 = I find I can't concentrate on anything.

Q.20 Tiredness of Fatigue

- 0 = I am no more tired or fatigued than usual.
 1 = I get more tired or fatigued more easily than usual.
 2 = I am too tired or fatigued to do a lot of the things I used to do.
 3 = I am too tired or fatigued to do most of the things I used to do.

Q.21 Loss of Interest in Sex

- 0 = I have not noticed any recent change in my interest in sex.
 1 = I am less interested in sex than I used to be.
 2 = I am much less interested in sex now.
 3 = I have lost interest in sex completely.

BECK: