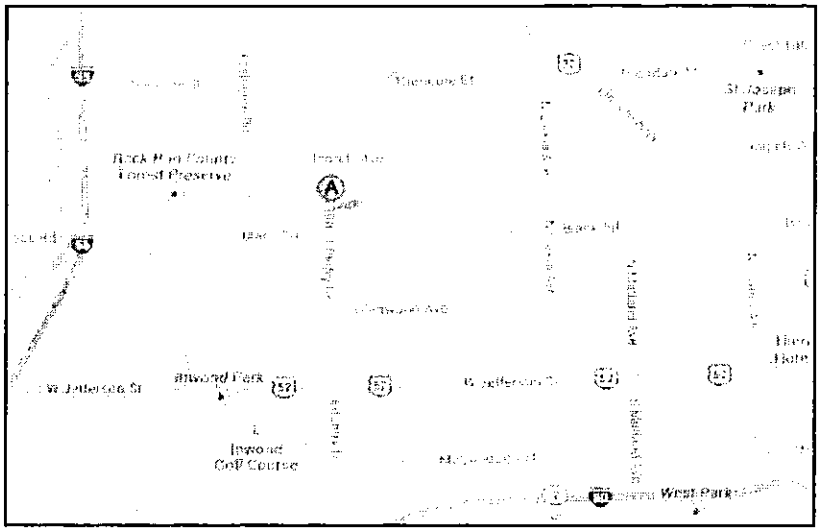
Midwest Respiratory, Ltd.

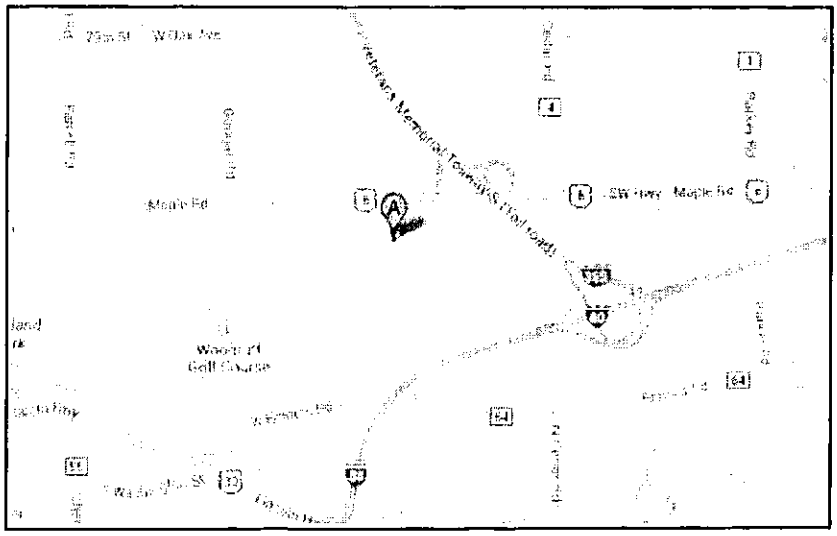
Your first appointment is: _____

- ❑ 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.
- ❑ Mohamad Al-Massalkhi, M.D.
- ❑ John M. Walsh, M.D.
- ❑ Philip S. Leung, M.D.
- ❑ Salah Lababidy, M.D.
- ❑ Visvanatha V. Giri, M.D.
- ❑ Nischal Raya, M.D.
- ❑ Jennifer Vermette, FNP-C

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



❑ 678 Cedar Crossings Dr., Ste. 201
New Lenox, Illinois 60451
Phone: 815-740-1301 Fax: 815-462-3466



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.

Midwest Respiratory, Ltd.

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

Patient Registration Form

Demographics

Name: _____

DOB: _____ *Gender*: M / F *Social Security Number*: XXX-XX-_____

Address: _____

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

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

Preferred Method of Contact: ☐ Home ☐ Cell

E-mail (for access to patient portal): _____

Employer: _____ *Race*: _____ *Preferred Language*: _____

Martial Status: _____ *Spouse's Name*: _____ *DOB*: _____

Primary/Referring Physician: _____

Pharmacy Name & Location: _____

Insurance

Primary Insurance: _____ PPO / HMO / Other

Secondary Insurance: _____ PPO / HMO / Other

Most HMO plans will require you to obtain an insurance approved authorization from your Primary Physician prior to every visit

Emergency Contacts

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

Name_____Relationship_____Phone #_____

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 insurance approved authorizations, it is the patient's responsibility to have the insurance approved authorization faxed or brought in at time of visit. If no insurance approved authorization is present, your appointment will need to be rescheduled.

Patients are responsible for bringing any recent x-rays/films/disks, 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

■ 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**

MIDWEST SLEEP DISORDERS CENTER

Name: **Date of birth:** **Date:**

Sex: **Age:** **Weight:** **Height:** **Referring MD:**

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 stay in bed with you? _____	
What do you do before bed time? _____	

Sleep Schedule:	**Regular workdays**	**Day off**
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? _____

Wakes 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	*Tell us more*
Exhausted/tired?	☐	☐	☐	
Any headaches?	☐	☐	☐	
Any nasal congestion?	☐	☐	☐	
Any dry or sore throat?	☐	☐	☐	
Any heart burn?	☐	☐	☐	
Do you snore frequently?	☐	☐	☐	
Stop breathing?	☐	☐	☐	
Wake up gasping/choking?	☐	☐	☐	
Night sweat?	☐	☐	☐	
Leg discomfort/restlessness?	☐	☐	☐	
Leg kicking?	☐	☐	☐	
Difficulty falling asleep?	☐	☐	☐	
Mind is busy at night?	☐	☐	☐	
Sleep better outside bed room?	☐	☐	☐	
Waken too early?	☐	☐	☐	
A lot of worries?	☐	☐	☐	
Using sleep aid?	☐	☐	☐	

MIDWEST SLEEP DISORDERS CENTER

PATIENT

Tell us about your daytime activities:

Job nature/Things occupy your day: _____

Start at: _____ Done at: _____

Time driving/travelling to work or back home: _____

What do you do after work? _____

	No	sometimes	Yes	*Tell us more*
Feeling sleepy/tired?	☐	☐	☐	
Fight to stay awake?	☐	☐	☐	
Drowsy after lunch?	☐	☐	☐	
Drowsy at work?	☐	☐	☐	
Drowsy driving?	☐	☐	☐	
Dose off at work?	☐	☐	☐	
Problem with memory?	☐	☐	☐	
Problem with concentration?	☐	☐	☐	
Any daytime naps?	☐	☐	☐	
Don't feel better if I sleep more?	☐	☐	☐	
Feeling depress all the time?	☐	☐	☐	
Feeling anxious all the time?	☐	☐	☐	

Some other issue during sleep time?

Sleep walking?	☐	☐	☐	
Sleep talking?	☐	☐	☐	
Clench or grind you teeth?	☐	☐	☐	
Get up and eat a snack?	☐	☐	☐	
Vivid dreams?	☐	☐	☐	
Nightmares?	☐	☐	☐	
Hallucination?	☐	☐	☐	
Awake but paralysed?	☐	☐	☐	
Paralysed after laughing?	☐	☐	☐	

How likely are you to doze off or fall asleep in the following situations?

Please use the following scale:

High chance of dozing = 3
Moderate chance of dozing = 2
Slight chance of dozing = 1
Would never doze = 0

	0	1	2	3
Sitting and reading	☐	☐	☐	☐
Watching television	☐	☐	☐	☐
Sitting inactive in a public place	☐	☐	☐	☐
Riding in a car as passenger without a break	☐	☐	☐	☐
Lying down to rest in the afternoon when circumstances permit	☐	☐	☐	☐
Sitting and talking to someone	☐	☐	☐	☐
Sitting quietly after a lunch without alcohol	☐	☐	☐	☐
In a car,while stopped in traffic for a few minutes	☐	☐	☐	☐

Rate the severity of your sleepiness on a scale of 1 to 10:
(1 being no sleepiness and 10 being very severe sleepiness) _____

COMMENT

HPI

Epworth: _____

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:	ROS

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	

Weight gain_____ pounds in the past 10 years

PATIENT			COMMENT
Marital status:			SH
Who do you live with?			
What is your occupation?			
Social habits:	**Yes/No**	**How much a day?**	
Do you smoke?			
Any alcoholic beverages?			
Any coffee or tea?			
Any caffeinated beverages?			
Any recreational drugs?			
Any health or sleep problems in your parents, brother/sister, children?			FH
Any family member has:	Heart problem	Stroke	
High blood pressure	Abnormal thyroid	Diabetes	
Sleep apnea	Restless leg	Insomnia	

Go to next page →

FOR CLINICIAN USE ONLY

PE:

Weight: **Height:** **BP:** **SaO2:** **Pulse:**

Epworth: **Beck:**

A/P:

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: