WATERBURY PULMONARY ASSOCIATES

170 Grandview Ave Waterbury CT 06708 Phone: (203) 759-3666 Fax: (203) 759-3671

David G. Hill, MD, FCCP
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Robert J. McDonald, MD, FCCP
Richard S. Silverman, MD, FCCP
Vanessa L. Yap, MD

Elizabeth Mirabile-Levens, MD
Jameel Uddeen, MD
Carolyn Roderick, PA-C

Practice Name: Waterbury Pulmonary Associates
Address: 170 Grandview Ave
City, State, Zip: Waterbury, CT 06708
Phone: 203-759-3666

Date _____
Patient _____
DOB _____
ID# _____
Group# _____

I, _____, understand that services rendered to me by _____ are my financial responsibility and that the Provider will bill my insurance company, _____ as a courtesy. I authorize my insurance company to pay my benefits directly to _____ and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of professional service charges over and above the insurance payment.

I have been given the opportunity to pay my estimated deductible and co-insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____.

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim. I also authorize provider to initiate a complaint to the insurance commissioner for any reason on my behalf.

I also understand that should my insurance company send payment to me, I will forward the payment to (Provider) within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collections process; I will be responsible for any cost incurred by the office to retrieve their monies. In the event Patient receives any check, draft, or other payment subject to this Agreement, I will immediately deliver said check, draft, or payment to Provider. Any violations of this agreement will, at Provider's election, terminate Patient charge privileges with Provider and bring any balance owed by Patient to Provider immediately due and payable.

Dated _____

Witness _____

_____
Signature of Policyholder

_____
Patient / Guardian Patient Name

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Name _____ Date _____ DOB _____

WHAT'S YOUR EPWORTH SCORE?

Take this simple test to get your sleepiness scale. How likely are you to doze off in the following situations, in contrast to feeling just tired? This refers to your usual way of like in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale and circle the most appropriate number for each situation. Add the total of each circled number to get your score.

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

1. Sitting reading
   0 1 2 3
2. Watching TV
   0 1 2 3
3. Sitting inactive in a public place (i.e. theater or meeting)
   0 1 2 3
4. As a passenger in a car for an hour without a break
   0 1 2 3
5. Lying down to rest in the afternoon when circumstances permit
   0 1 2 3
6. Sitting and talking to someone
   0 1 2 3
7. Sitting quietly after lunch without alcohol
   0 1 2 3
8. In a car, while stopped for a few minutes in traffic
   0 1 2 3

Total Score: _____

PATIENT NAME:_____DATE:_____

REASON FOR VISIT:_____

FAMILY HISTORY

	ALIVE/ DECEASED	HIGH BP	DIABETES	CANCER	ALLERGIES	ASTHMA	EMPHYSEMA	ECZEMA	HEART DISEASE	TB
FATHER										
MOTHER										
BROS/SIS										
BROS/SIS										
CHILDREN										
CHILDREN										

YEAR	HOSPITAL ADMISSION/REASON	YEAR	SURGERY

DATE AND PLACE OF LAST CHEST X-RAY_____
DRUG ALLERGIES:_____
LAST TB SKIN TEST:_____**YR**_____**RESULTS: +/-**
HAVE YOU HAD A RECENT HIV TEST?_____**RISK FACTOR: +/-**
ALCOHOL CONSUMPTION:_____**OZ. PER DAY**_____**WK**_____**YRS**
SMOKING:_____**PACKS PER DAY**_____**YEARS**
COFFEE/TEA:_____**CUPS PER DAY**

MEDICAL HISTORY – CHECK ANY THAT APPLY

GENERAL ☐ Fever ☐ Chills ☐ Night Sweats ☐ Weight Loss ☐ Weight Gain ☐ Decreased Appetite ☐ Fatigue	**EYES** ☐ Visual Disturbance ☐ Discharge ☐ Redness ☐ Itchy Eyes	**SKIN** ☐ Rash ☐ Eczema ☐ Dryness ☐ Itching ☐ Hives	**SLEEP** ☐ Snoring ☐ Daytime fatigue ☐ Insomnia ☐ Restless legs
NEURO ☐ Headache ☐ Seizure ☐ Numbness ☐ Dizziness ☐ Unsteady Gait ☐ Memory Loss	**ENT** ☐ Nose Bleeds ☐ Nasal Congestion ☐ Post Nasal Drip ☐ Sinus Congestion ☐ Hoarseness ☐ Hearing Impairment ☐ Sore Throat	**PSYCH** ☐ Depression ☐ Anxiety ☐ Excessive Stress	**MUSCULOSKELETAL** ☐ Back pain ☐ Muscle pain ☐ Joint pain ☐ Weakness
HEART ☐ Chest pain ☐ Palpitations ☐ Shortness of breath lying flat ☐ Leg Swelling ☐ Pain in legs on exertion	**LUNGS** ☐ Shortness of breath ☐ Wheeze ☐ Cough ☐ Coughing up blood ☐ Chest Pain ☐ Chest Tightness	**URINARY** ☐ Pain w/urine ☐ Blood in urine ☐ Waking up to urinate ☐ Frequent urination ☐ Incontinence ☐ Difficulty urinating	**Heme** ☐ Anemia ☐ Blood Clots ☐ Bleeding Problems ☐ Swollen Glands
GI ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Blood in stool ☐ Heartburn ☐ Difficulty Swallowing ☐ Abnormal Pain	**Endocrine** ☐ Low Glucose ☐ High Glucose		

PATIENT NAME:_____DATE:_____

To the best of your knowledge please fill in medication chart below.

MEDICATIONS	DOSE

PATIENT INFORMATION REGISTRATION FORM

(PLEASE PRINT CLEARLY)

Patient's Full Name:_____DOB:_____Sex: ☐M ☐F

Address:_____City & State:_____Zip:_____

Home Phone:_____ ☐Married ☐Single ☐Divorced ☐Separated ☐Widowed

Social security No:_____ Driver's License No:_____

Patient's Employer:_____Phone No:_____

Address:_____City & State_____Zip_____

Occupation:_____

Spouse/Parent/Guardian_____Social Security No:_____DOB:_____

Address:_____Phone No:_____

Employer & Address:_____

Occupation_____Driver's License No:_____

Family Physician:_____Phone No:_____

In case of emergency, contact (other than spouse):_____

Address:_____City & State:_____Zip:_____

Relationship:_____Phone No:_____

How were you referred to our practice?

Family Physician ☐ Insurance Company ☐ Employer ☐ Hospital ☐ Other Source:_____

INSURANCE INFORMATION (We ask all patients to show their insurance cards so that we may copy them)

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insurance Co:_____	Name of Insurance Co:_____
Identification No:_____	Identification No:_____
Group No:_____	Group No:_____
Subscriber:_____	Subscriber:_____
Effective Date:_____	Effective Date:_____

Are you covered by Medicare? ☐ Yes ☐ No Medicare No:_____Railroad?_____

Are you covered by Medicaid? ☐ Yes ☐ No

Is your illness work related: ☐ Yes ☐ No

Is your illness due to an automobile accident? ☐ Yes ☐ No

CLAIMS AND PAYMENT AUTHORIZATION

I VERIFY THE ACCURACY OF THE ABOVE INFORMATION AND I AUTHORIZE THE RELEASE OF INFORMATION AS PROVIDED ON THIS FORM. I AGREE TO PAY ALL COSTS OF COLLECTION, INCLUDING REASONABLE ATTORNEY FEES INCURRED IN THE COLLECTION OF ANY DELINQUENT AMOUNTS NO PAID, AS REQUIRED.

I HEREBY AUTHORIZE RELEASE OF ALL MEDICAL INFORMATION NECESSARY TO FILE A CLAIM WITH MY INSURANCE COMPANY AND ASSIGN ALL BENEFITS OTHERWISE PAYABLE TO ME DIRECTLY TO THE PHYSICIAN FOR TREATMENT RENDERED TO ME.

Patient or Responsible Party's Signature_____**Date**_____

WATERBURY PULMONARY ASSOCIATES, LLC

REQUEST FOR RESTRICTIONS AND SHARING OF INFORMATION WITH PERSONS OTHER THAN THE PATIENT

I,_____ _____/_____/_____
(Print Name) (Date of Birth)

Request the following restrictions to the use or disclosure of my protected health information:

Waterbury Pulmonary Associates, LLC may discuss my medical condition/information with the following people:

Spouse YES NO Name:_____

Parents YES NO Name:_____

Children YES NO Name:_____

YES NO Name:_____

YES NO Name:_____

Friends YES NO Name:_____

YES NO Name:_____

YES NO Name:_____

Patient Signature:_____Date:_____

SUMMARY OF
NOTICE OF PRIVACY PRACTICES

By law, we are required to provide you with our Notice of Privacy Practices. This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will ensure that your information remains private.

If you have any questions about this Notice, the name and phone number of our contact person is listed on page one.

MY SIGNATURE ACKNOWLEDGES THE FACT THAT I HAVE RECEIVED THIS INFORMALTION FROM WATERBURY PULMONARY ASSOCIATES ON THE DATE INDICATED BELOW.

PATIENT SIGNATURE:_____DATE:_____

WITNESS SIGNATURE:_____

OFFICE POLICY REGARDING NO SHOW/NO CALL APPOINTMENTS BY PATIENTS IS AS FOLLOWS:

- **First no show/no call – a letter is sent**
- **Second no show/no call - $35.00 charge is assessed on your account. This charge is not the responsibility of the insurance company, but rather the patient. Under no circumstance will a patient be allowed to schedule additional appointments until this fee is paid in full.**
- **Third or any additional no show/no call – results in a $35.00 charge each time and /or can result in being discharged from the practice.**

Thank you for your attention to this matter.

Sincerely,

Waterbury Pulmonary Associates

X _____
Patient Signature

X _____
Date

Effective March 1, 2013

For Our Valued Patients

The Federal Trade Commission (FTC), in conjunction with other agencies, published the Red Flag Rules defining what a creditor and financial institution must do to implement an Identify Theft Prevention Program. The Red Flag Rules require those covered, including medical practices, to identify at-risk accounts and to define, detect, and respond to Red Flags to prevent or mitigate identity theft. Healthcare providers meet the quality criteria and must comply with the Red Flag Rules beginning May 1, 2009.

The World Privacy Forum (WPF), and organization committed to research, analysis, education in the area of privacy, has been focused on identity theft matters specific to health care providers and medical identity theft. The WPF defines medical identity theft as follows:

"Medical Identity theft occurs when someone uses a person's name and sometimes other parts of their identify – such as insurance information – without the person's knowledge or consent to obtain medical services or good, or uses the person's identity information to make false claims for medical services or goods. Medical identity theft frequently results in erroneous entries being put into existing medical records, and can involve the creation of fictitious medical records in the victim's name."

The WPF promotes awareness of potential 'red flags' for both patients and healthcare providers. If you feel that you may have been a victim of medical identity theft, the WPF suggests the following:

- Closely monitor your "explanation of benefits"
- Annually, request a listing of benefits paid in your name by a health insurer
- Obtain an "accounting of disclosures" from health care providers and health insurers
- Keep an eye on your credit report

If you would like additional information, please feel free to visit the World Privacy Forum website: http://www.worldprivacyforum.org/medicalidentitytheft.html

We are committed to mitigating the potential of medical theft. Thank you for your assistance in helping us comply with our Identity Theft Prevention Program. We will be requesting that each time you have an appointment with us, you bring:

- Photo identification
- Insurance card
- Other identifying documents

If you have any questions regarding our program please ask to speak with our Practice Manager.