Facesheet

Patient's Name:_____ DOB: _____

Address:_____ SSN:_____

(Street) (City, State, ZIP)

Cell Phone:_____ Home Phone: _____

E-Mail: _____ PCP:_____

Emergency Contact:_____ Phone:_____ Relation:_____

Emergency Contact:_____ Phone:_____ Relation:_____

Pharmacy: _____

Allergies:_____

Primary Insurance:_____ Policy #: _____

Insured's Name: _____ Group#: _____

Secondary Insurance:_____ Policy #: _____

Insured's Name: _____ Group#: _____

Who referred you to Montgomery Pulmonary Consultants?_____

Advanced Care Plan: Power of Attorney or Decision Maker

Name: _____ Relationship:_____

Montgomery Pulmonary Consultants Missed Appointments Fee Agreement

MPC will be charging a $25.00 missed appointment fee for all no-shows and last-minute cancellations. All patients, new or established, must provide a 24-hour notice for a cancellation or to reschedule.

By signing below, you are attesting that you understand you will be charged a $25 fee that must be paid before you are seen by our providers.

I authorize Montgomery Pulmonary Consultants, P.A. to furnish information to Insurance Carriers concerning my illness and treatments and I hereby assign the physician(s) all payment for medical services rendered to myself if my dependents. I understand that I am responsible for all charges whether or not covered by insurance.

Patient Signature:_____ **Date:**_____

MEDICAL RELEASE FORM

Effective April 14, 2003 (due to federal guidelines under HIPPA) we are now required to have a release form signed by the patient before we can give out any medical or financial information to any person other than the patient.

Please List Below the names, relationship, and phone numbers for any authorized individual (spouse, family members, friends, caregiver, etc.) that we may discuss your medical or financial information with.

	NAME	RELATIONSHIP	PHONE NUMBER
1.			
2.			
3.			

May we leave medical information on "home" answering machine? _____ YES _____ NO

Signature of Patient/Caregiver: _____ **Date:** _____

If you **DO NOT** want your medical or financial information discussed with anyone other than yourself, please sign here: _____ Date: _____

The above is private and confidential and will be placed in your medical chart. The information on the form will remain valid until we are notified otherwise.

Acknowledgement of Receipt of Notice of Privacy Practices

(To be filed in patient's medical record)

I have been presented with a copy of the Notice of Privacy Practices, detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

Signature of Patient/Caregiver: _____ **Date:** _____

Relationship (if not signed by patient): _____

Internal Use Only: If patient/patient's representative refuses to sign acknowledgment, please document date and time notice was presented and sign below.

Presented on (Date and Time):_____ Presented by (Name and Title):_____

Sleep Questionnaire

Name:_____ Today's Date:_____

Date of Birth:_____ Sex (circle one): Male / Female Age:_____

Have you even had a sleep study? Yes / No If yes, where? _____ When? _____

Sleep Pattern:

1. What time do you usually go to sleep? _____ What time do you usually arise? _____
2. How many hours at night on average do you sleep? _____
3. Are you having trouble falling asleep?..... YES or NO
4. How often do you wake up at night? (Check) _____ RARELY _____ 2 or less times/night _____ Frequently
5. Do you wake up early and have trouble going back to sleep?..... YES or NO
6. Do you feel rested after a good night of sleep?..... YES or NO

Sleep Symptoms:

1. Have you been told that you snore loudly?..... YES or NO
2. Have you been told that you stop breathing while asleep?..... YES or NO
3. Do you wake up with gasping or chocking at night?..... YES or NO
4. Do you wake up in the morning with headaches?..... YES or NO

Related Symptoms:

1. Have you ever been told that you have Narcolepsy?..... YES or NO
2. When you are angry or laughing, do you feel weak or like you may fall?..... YES or NO
3. Do you have unusual dreams or feel as though you are paralyzed when you just go to sleep or wake up?..... YES or NO
4. Do you find that your mind is not working as quickly or effectively as it used to be?..... YES or NO
5. Do you suffer with anxiety or depression?..... YES or NO

Epworth Sleepiness Scale:

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

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

SITUATION	CHANGE OF DOZING			
Sitting and Reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in public place (meeting, theater)	0	1	2	3
As a passenger in a car for an hour with no break	0	1	2	3
Lying down to rest in afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after a lunch without alcohol	0	1	2	3
In a car while stopped for a few minutes in traffic	0	1	2	3

SMOKING/ALCOHOL USE:

Have you ever smoked? _____ Yes _____ No Do you currently smoke? _____ Yes _____ No

If you answered Yes to either question, please circle the form of tobacco you use:

Cigarette Cigar Pipe Vape Chewing Tobacco Marijuana Cocaine

Other: _____

Frequency: I smoke/smoked _____/day for _____ years. I quit in _____.

How much and often do you drink? _____

PAST MEDICAL HISTORY:

_____

_____

ALLERGIES TO MEDICATION OR FOOD:

_____

PHARMACY: _____ **Phone Number:** _____

MEDICATIONS CURRENTLY TAKING (List name, strength, and frequency):

1._____/_____ Frequency?_____

2._____/_____ Frequency?_____

3._____/_____ Frequency?_____

4._____/_____ Frequency?_____

5._____/_____ Frequency?_____

6._____/_____ Frequency?_____

7._____/_____ Frequency?_____

8._____/_____ Frequency?_____

9._____/_____ Frequency?_____

10._____/_____ Frequency?_____

11._____/_____ Frequency?_____

12._____/_____ Frequency?_____

13._____/_____ Frequency?_____

14._____/_____ Frequency?_____

MEDICARE

PARTB

EXTENDED PATIENT SIGNATURE AUTHORIZATION

To Be Completed by Providers of Service **Please** print or type

Provider's Name*	Provider's I.I . Code
MONTGOMERY PULMONARY CONSULTANTS, P.A.	

Provider's Address (Street, City, State, Zip)

1440 NARROW LANE PARKWAY, MONTGOMERY, AL 36198

Beneficiary's Name	Health Insurance Number

Statement for payment of Medicare Benefits

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Montgomery Pulmonary Consultants, P.A. (the Supplier) for any services or items furnished me by that physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services."

Statement for payment of MEDIGAP Benefits

"I request that payment of authorized Medicare benefits be made either to me or on my behalf to Montgomery Pulmonary Consultants, P.A. for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release to (name of MEDIGAP insurer) _____ any information needed to determine these benefits or the benefits payable for related services.

X _____ _____

Signature of Beneficiary or person signing for Beneficiary — Date signed

Address of person signing for Beneficiary (Street, City, State, Zip) — Relationship

Reason Beneficiary is unable to sign

In submitting claims under this procedure. PHYSICIANS undertake:

1. To complete and submit promptly the appropriate Medicare billing form for all services covered by the request for payment - **even those in which the physician has not accepted assignment.**
2. To incorporate, by stamp or otherwise, information to the following effect on any bills they send to Medicare patients. **"DO NOT USE THIS BILL FOR CLAIMING MEDICARE BENEFITS. A CLAIM HAS BEEN OR WILL BE SUBMITTED TO MEDICARE ON YOUR BEHALF.** "This requirement is necessary to prevent patients from submitting duplicate claims.
3. To cancel the authorization on request by the patient.
4. To make the patient signature files available for carrier inspection upon request.

In submitting claims under this procedure. SUPPLIERS agree to:

1. Only usc the extended patient signature authorization for assigned claims.
2. Renew the patient signature agreement if a new item is rented or purchased.
3. Place alongside the beneficiary's signature the following statement:
   "RESPONSIBILITY FOR OVERPAYMENT ON ASSIGNED CLAIMS ACCEPTED"

NOTE: THE FOLLOWING STATEMENT MUST BE SIGNED BY THE DME SUPPLIER PRIOR TO AUTHORIZATION OF PAYMENT FOR RENTAL OF DURABLE MEDICAL EQUIPMENT IN ASSIGNMENT CASES.

***FOR SUPPLIERS OF DURABLE MEDICARE EQUIPMENT ONLY:**

"This supplier assumes unconditional responsibility for refunding of all overpayments for assigned claims for rental of durable medical equipment that may result from the failure of the Carrier to receive prompt notice of the return of or the end of need for the rental of equipment, or the death or institutionalization of the Beneficiary."

_____ _____

Signature of Supplier — Date Signed