Pulmonary & Sleep Medicine Associates, LLP

6572 River Park Drive, Ste 101
Riverdale GA 30274

1100 Hospital Drive
Stockbridge, GA 30281

132 Old Norton Road, Ste 101
Fayetteville, GA 30214

Date: _____ **Referring Physician:** _____

Patient Information

Name: _____ SS# _____
Mailing Address: _____ Date of Birth: _____
_____ Age: _____
Street Address (if different):_____ Home Phone: _____
_____ Cell Phone:_____
Sex: M ___ F ___ Marital Status: S __ M __ W __ D __ ***Primary Pharmacy**:_____
Email: _____ ***Pharmacy Number**: _____
Employer: _____ Work Phone:_____
Employer Address: _____

***Race**: American Indian\Alaska Nat___ Asian ___ Black\African American ___ Hawaiian\Pacific Islander ___
Other ___ White/Caucasian _____

***Ethnicity**: Hispanic or Latino___ Not Hispanic or Latino ___ *__Pref. Comm__.: Phone___ Email___ Mail___

Spouse's Name _____ Employer: _____
SS# if they are the insured: _____ Work Phone:_____

Nearest Relative (Not living at the above address) _____
Relationship: _____ Address: _____
Home Phone: _____ Cell Phone: _____
Emergency Contact (other than a relative): _____
Address:_____
Home Phone: _____ Cell Phone: _____

Insurance Information

Insurance Co. #1: _____ Policy #: _____
Address: _____ Group #: _____
_____ Phone No. _____
Insured Name: _____ Date of Birth:_____

Insurance Co. #2: _____ Policy #: _____
Address: _____ Group #: _____
_____ Phone No. _____
Insured Name: _____ Date of Birth: _____

Insurance Co. #3: _____ Policy #: _____
Address: _____ Group #: _____
_____ Phone No._____
Insured Name: _____ Date of Birth: _____
Relationship: _____

I authorize the following:

Release of Medical Information: I authorize the release of any medical or other information necessary to process the claim pertaining to my medical treatment.

Assignment of Benefits: I authorize payment of medical benefits to Pulmonary & Sleep Medicine Associates, LLP.
Collections Notice: I will be responsible for any legal cost, court cost, and any collection fees incurred in collecting my debt.
Medication History: I authorize the electronic retrieval of my Medication History for adequate care.
Signature: _____ Date: _____

OFFICE POLICIES

Appointments are seen by appointment time, not by the arrival time. If you are sick, please call our office as early in the morning as possible, we will make every effort to see you that day. However, please remember that we must try to work you in with all of the patients that have previously scheduled appointments and you may experience a longer than normal wait. All regularly schedule appointments will be taken before you. Please do not just walk in and expect to be seen. You may make the trip only to find that we do not have a doctor in the office. There are multiple providers seeing patients during regular office hours.
NOSHOW - patients will be responsible for a $50.00 No-show fee. The office also requires a patient to notify us of any cancellation within 24 hours prior to the appointment or the patient will be responsible for a $50.00 cancellation fee.

Insurance will be filed on all verified policies. Since many insurance benefits change frequently, we ask that you present your current insurance card at each visit. Failure to give the proper insurance information may result in the patient being responsible for the entire visit.
You are responsible for knowing your insurance benefits and following them. If your insurance company requires you to have a referral to see us, you are responsible for obtaining that referral. Our office will try to remind and assist you, but ultimately it is your responsibility.

I understand that it is my responsibility to pay my co-pay, co-insurance, deductible, and/ or all other balances deemed patient responsibility at the time of service. We accept VISA, MASTERCARD, DISCOVER, PERSONAL CHECKS, and CASH. Please make sure you have one of these with you at each visit.

Financial responsibility is the patient's, parent of a minor and / or the legal guardian. Pulmonary and Sleep Medicine Associates wants to give our patient's the very best care possible. We do not want our patients to go without medical care due to financial reason. If you feel cannot pay for the medical care, you may call our Patient Account Reps prior to a visits and they will be happy to discuss payment options with you.

Check return policy, we understand that from time to time everyone makes mistakes. Due to the fact that the bank is now accessing a fee on us for each returned check; we must pass that fee on to you. In the event your check in returned to us, our Patient Account Rep will call you and a $25.00 fee will be added to your account. If it a second check is returned, you will be asked for credit card or cash payments only.

Prescription Refills will not be authorized after hours. Have the pharmacy call our office if a refill is required. They have all the information we need to assure that proper medication is prescribed. Do not go to the pharmacy and have them call us wanting the immediate approval. Only your doctor can approve your refills and he/she may not be in the office or may be with a patient. Call your pharmacy before you run out of your medication.

Physician Assistants are used in daily patient care at Pulmonary and Sleep Medicine Associates. The PA's are supervised by physicians and are here to help provide our patients with the best possible patient care.

I acknowledge that I have read and understand the above office policies.

Patient Signature: _____ ***Date:*** _____

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Date: _____

Name: _____Date of Birth: _____

How did you hear about our physician?
Physician __ Friend __ Hospital __ Insurance Directory __ Yellow Pages __ Internet __

Were you referred to our office: Yes __ No __ If yes, who referred you? _____

Are you allergic to any medications? Yes __ No __ If yes, what medication: _____
_____

Are you taking any medications now? Yes __ No __ If yes, please list:

Name	Strength	How often taken	Comments

Please read the following carefully before signing:
For your privacy we do not leave detailed messages on recorders or with anyone other than yourself. If you would like to give us permission to leave a detailed message on your recorder, please sign below. Please know that if you do not complete this portion and sign permission for each option, those that are not signed will tell us you decline permission.

I give my permission for Pulmonary & Sleep Medicine Associates to leave detailed messages on my answering machine.

Patient Signature: _____ **Date:** _____

I give my permission for Pulmonary & Sleep Medicine Associates to discuss my medical information with the following individuals:

Name	Phone Number

Patient Signature: _____ **Date:** _____

I give my permission for Pulmonary & Sleep Medicine Associates to discuss my financial information with the following individuals:

Name	Phone Number

Patient Signature: _____ **Date:** _____

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Patient Notification of Privacy Practices Form

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I must inform you that our Notice of Privacy Practices is posted for your review. Please sign below to acknowledge that you have been notified of our privacy practices.

_____
Print Patients' Name

_____ _____
Patient's Signature Date

_____ _____
Employee's Signature Date

Patient Assessment (New Patient)

Name: _____ **Today's Date** _____

Date of Birth: _____

Circle all the symptom you are currently experiencing and all significant problem you have or had in the past.

GENERAL - CONSTITUTIONAL:
- Weight Loss
- Weight Gain
- Fever
- Night Sweats
- Swelling of the Lower Extremities

EYES:
- Glaucoma
- Cataract
- Use Glasses
- Blurring of Vision

HENT:
- Decreased Hearing
- Earache
- Ear Draining
- Sinus Congestion
- Allergy
- Hay Fever
- Nosebleed

CARDIC:
- Chest Pain
- Angina
- Palpitation
- Heart skipping or racing
- High blood pressure

RESPIRATORY:
- Cough
- Sputum
- Coughing up blood
- Wheezing
- Shortness of breath

GI:
- Indigestion
- Heartburn
- Nausea
- Vomiting
- Vomiting blood
- Stomach Ulcer
- Stomach Pains
- Bleeding from rectum
- Blood in stools
- Hemorrhoids
- Significant change in bowel habits
- Diarrhea
- Constipation
- Hernia

GU:

Male
- Burning on Urination
- Blood in Urine
- Difficulty Urinating
- Dificulty Controlling Urination
- Prostate Problem

Female
- Burning on Urination
- Blood in Urine
- Difficulty Urinating
- Vaginal Bleeding
- Abnormal Menstrual Periods

SKIN - INTEGUMENT:
- Rash
- Itching
- Lumps or bumps
- Moles

CNS - NEUROLOGIC:
- Dizziness
- Seizures
- Fainting spells
- Strokes
- Weakness or numbness of extremities

MUSCULOSKELETAL:
- Arthritis
- Joint Pain
- Joint Swelling
- Joint Stiffness
- Back Pain
- Muscle Pain

ENDOCRINE:
- Diabetes
- Thyroid Problem
- Intolerance to hot or cold weather
- Increased thirst with frequent urination

PSYCHOLOGICAL:
- Anxiety
- Depression
- Hallucinations

HEME - LYMPH:
- Anemia
- Bleeding problems
- Easy bruising
- Leukemia
- Lymphoma
- Glad Enlargement

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SLEEP APNEA SCREENING QUESTIONNAIRE

Date: _____

Name: _____ **DOB:** _____

(PLEASE CHECK IF STATEMENT APPLIES TO YOU)

1. _____ I snore or I have been told I snore.
2. _____ I feel sleepy or tired during the day.
3. _____ I have been told that I hold my breath when I sleep.
4. _____ I wake up gasping or choking for breath.
5. _____ I get morning headaches.
6. _____ I have leg jerks in my sleep.
7. _____ I have memory problems.
8. _____ I have high blood pressure.
9. _____ I have almost fallen asleep while driving.
10. _____ I wake up still sleepy or tired.
11. _____ I go to the restroom a lot during the night.
12. _____ Sometimes I have an urge to move my legs, due to an uncomfortable feeling.
13. _____ I get relief, at least temporarily, from the uncomfortable feeling when I move.
14. _____ My leg symptoms begin or get worse when I am resting or inactive.
15. _____ My leg symptoms get worse in the evening or at night.

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Date: _____

Name: _____ **DOB:** _____

Sleep Questionnaire

1. Please describe in your own words your sleep problem or the reason you are having a sleep consultation:

   How long have you had these sleep problems: _____ weeks/months/years

   Circle any that apply to you:

loud snoring	inability to fall asleep or stay awake	restless legs
witnessed apnea	excessive daytime sleepiness	disturb sleep
acting out dreams		

2. Have you ever had a sleep study before? □ Yes □ No When? _____

   Location? _____

3. Have you ever been diagnosed with any of the following?

   □ Sleep Apnea
   □ Insomnia
   □ Narcolepsy
   □ Restless leg syndrome
   □ Periodic Limb Movements
   □ Other sleep disorder _____
   □ REM Sleep Behavior Disorder

4. Do you have a prior history of sleep apnea ? □ Yes □ No

   If YES check treatment if applicable:

   □ Treated with CPAP (pressure _____)
   □ Oral appliance
   □ Surgery (indicate below)

5. Please check if you have had any of the following surgeries:

   □ Tonsils and/or adenoids Date: _____
   □ Laser-assisted uvuloplasty or radio-frequency ablation Date: _____
   □ Nasal septoplasty and/or turbinectomy Date: _____
   □ Tongue or hyoid procedure Date: _____
   □ Uvulopatopharyngoplasty Date: _____
   □ Maxillary-mandibular advancement Date: _____

Date:_____

Patient Name: _____ DOB: _____

Obstructive Sleep Apnea

□ Yes □ No I have been told that I snore.
□ Yes □ No I have been told that I stop breathing while I sleep.
□ Yes □ No I feel sleepy during the day even though I slept through the night.
□ Yes □ No I have high blood pressure.
□ Yes □ No I have fallen asleep while driving.
□ Yes □ No I have been told that I am a restless sleeper, I toss and turn at night.
□ Yes □ No I wake up tired in the morning.
□ Yes □ No I have to go to the bathroom to urinate at night on average ____ times per night.
□ Yes □ No I frequently wake with a headache.
□ Yes □ No I am overweight or have gained weight. _____lbs in the past 5 years.
□ Yes □ No I have trouble concentrating or remembering things.
□ Yes □ No I have trouble at work/school because of sleepiness.
□ Yes □ No I have been told I kick and/or parts of my body jerk at night.
□ Yes □ No I seem to be losing my sex drive.
□ Yes □ No During the night I wake up choking/gasping for air and/or notice my heart pounding.
□ Yes □ No I frequently wake up during the night or in the morning with a sore/dry throat.
□ Yes □ No I feel like I am going around in a daze.

Insomnia

□ Yes □ No I have difficulty falling asleep.
□ Yes □ No I have difficulty staying asleep.
□ Yes □ No I lie awake for half an hour or more before falling asleep.
□ Yes □ No I wake up during the night and unable to go back to sleep.
□ Yes □ No I wake up earlier in the morning than I would like to.
□ Yes □ No Thoughts race through my mind and prevent me from sleeping.
□ Yes □ No I feel afraid to go to sleep.
□ Yes □ No I worry about my sleep during the day.
□ Yes □ No I worry about things and have trouble relaxing.
□ Yes □ No I feel sad or depressed.
□ Yes □ No My bedroom environment is uncomfortable for me to get a good night sleep.
□ Yes □ No I work afternoon or night or rotating shifts.
□ Yes □ No I have aches/pains or other discomfort which prevents me from getting a good night sleep.
□ Yes □ No I have restless legs which effects my sleep.
□ Yes □ No When I am unable to fall asleep, I stay in bed for extended period (more than 30 minutes) trying to fall asleep.
□ Yes □ No I sleep better when I am away from home.
□ Yes □ No I fall asleep on the couch/recliner watching TV, etc., but unable to stay in the bed.
□ Yes □ No I frequently take sleeping pills to help me sleep.

Hypersomnia

□ Yes □ No When I am angry, surprised, or laughing I feel like parts of my body or my whole body goes limp.
□ Yes □ No I have experienced vivid dreams like scenes soon after falling asleep or an awakening.
□ Yes □ No I feel like I am hallucinating when I am falling asleep or waking up.
□ Yes □ No When I am drifting off to sleep or waking up in the morning I feel like I am unable to move/paralyzed even though I am wake. It sometimes scares me.

Date:_____

Patient Name: _____ DOB: _____

□ Yes □ No I am too sleepy during the day.
□ Yes □ No I do not sleep well and have disturbed sleep.
□ Yes □ No I sleep well (like a log).
□ Yes □ No Sometimes no matter how hard I try to stay awake I fall asleep.
□ Yes □ No I have sleep attacks.
□ Yes □ No I fall asleep at inappropriate times.
□ Yes □ No I have fallen asleep during physical effort.
□ Yes □ No I have vivid nightmares soon after falling asleep.
□ Yes □ No I do routine tasks/chores and do not remember doing them.
□ Yes □ No If I take naps they are usually long (lasting >1-2 hours) and not refreshing.
□ Yes □ No Short power naps of 10-15 minutes refreshes me for 2-3 hours and improves my sleepiness.
□ Yes □ No I have very difficult time waking up in the morning.
□ Yes □ No If allowed I will typically sleep for more than 10 hours at night.

Restless Leg Syndrome

□ Yes □ No I have aching, crawling, or fidgety, restless sensation in my legs in the evening time while I am still watching TV or lying in bed, etc.
□ Yes □ No I normally do not have this sensation (mentioned above) in the morning or during the day.
□ Yes □ No When I move or get up and walk this sensation normally immediately goes away.
□ Yes □ No This sensation in my legs sometimes prevents me from sleeping.
□ Yes □ No I have noticed (or others have commented) that parts of my body jerk when sleeping.
□ Yes □ No I experience leg pains during the night.
□ Yes □ No Sometimes I just cannot keep my legs still at night. I just have to move them.
□ Yes □ No I frequently experience leg cramps at night.

Nasal Congestion

□ Yes □ No I have chronic/recurrent nasal and sinus allergic/congestion.
□ Yes □ No My nose gets stopped up at night.
□ Yes □ No I am a mouth breather.
□ Yes □ No My nose remains stopped up all the time
□ Yes □ No I cough at night.
□ Yes □ No I have a constant urge to clear my throat.
□ Yes □ No I am hoarse in the morning.
□ Yes □ No I have an allergy to dust mites.

Parasomnia/Sleep Hyigene

□ Yes □ No I have to use antacids (Rolaids, Maalox, Tums, Alka-Seltzer) almost every week for stomach trouble.
□ Yes □ No I do eat or drink within 2 hours prior to bed time.

Please check if you do any of these behaviors in your sleep (maybe observed by others).

_____ Grinding teeth
_____ Sleep walking
_____ Sleep talking
_____ Having nightmares
_____ Acting out dreams that may or may not result in some injury to yourself or your bed partner

Date:_____

Patient Name: _____ DOB: _____

6. Has anyone in your family been diagnosed with a sleep disorder(s)? □ Yes □ No (If yes, please explain.)

   Relationship: _____ Describe problem:_____

   Relationship: _____ Describe problem:_____

7. □ Yes □ No Do you watch the clock at night?
8. □ Yes □ No Do you exercise within 3 hours of bedtime?
9. □ Yes □ No Do you take a hot shower/bath within 3 hours of bed time?
10. Is your present work situation satisfactory? □ Yes □ No
    What are you current working days/nights and hours? _____
11. Is your present social life satisfactory? □ Yes □ No Does your sleep problem require you to cut back on social activity? □ Yes □ No
    If yes, how? _____
12. Have you had any types of accidents due to sleepiness? □ Yes □ No
    If yes, please describe _____
13. Sleep Habits:
    How many hours of sleep do you usually get per night? _____
    What time do you usually go to bed? _____
    How long does it take you to fall asleep? _____
    How many times do you typically wake up at night? _____
    What time do wake up in the morning? _____
14. Do you watch TV, read, or listen to music in bed? _____
15. Do you usually? (check all that apply)
    □ sleep with someone else in your bed
    □ sleep with someone else in your room
    □ provide assistance to someone during the night (child, invalid, bed partner, animal)
16. Is your sleep often disturbed by? (check all that apply)
    □ heat □ light
    □ cold □ bed partner
    □ noise □ not being in your usual bed
    □ other _____
17. Do you smoke or have you ever smoked? □ Yes □ No
    If you currently smoke, how many packs per day and for long have you smoked? _____
    _____
    If a prior smoker, how long ago did you quit? _____
    How long did you smoke before quitting? _____
18. How many cups of caffeinated beverages do you drink a day? _____
19. How many alcoholic beverages do you drink a week? _____

Center for Sleep Disorders
Pulmonary & Sleep Medicine Associates, LLP
Epworth Sleepiness Scale

Date: _____

Patient Name: _____ DOB: _____

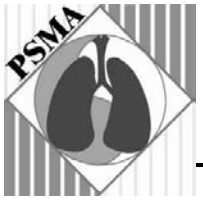
Wt: _____ Ht: _____ Neck Size: _____

Directions:
Please read the list of situations and answer how likely you would be to doze off or fall asleep, but not just feel tired, at these times.
This refers to the past three weeks. Even if you have not done, or been in some of these situations, please try to guess how they would have affected you. Use the scale beside each question to choose the most appropriate answers.

SITUATION	CHANCE OF DOZING
Sitting and reading	☐ 0. Would never doze. ☐ 1. Slight chance of dozing. ☐ 2. Moderate chance of dozing. ☐ 3. High chance of dozing.
Watching television	☐ 0. Would never doze. ☐ 1. Slight chance of dozing. ☐ 2. Moderate chance of dozing. ☐ 3. High chance of dozing.
Sitting quietly in a public place, (ex: in a theater or meeting)	☐ 0. Would never doze. ☐ 1. Slight chance of dozing. ☐ 2. Moderate chance of dozing. ☐ 3. High chance of dozing.
As a passenger in a car for an hour without a break	☐ 0. Would never doze. ☐ 1. Slight chance of dozing. ☐ 2. Moderate chance of dozing. ☐ 3. High chance of dozing.
Lying down to rest in the afternoon	☐ 0. Would never doze. ☐ 1. Slight chance of dozing. ☐ 2. Moderate chance of dozing. ☐ 3. High chance of dozing.
Sitting and talking with someone	☐ 0. Would never doze. ☐ 1. Slight chance of dozing. ☐ 2. Moderate chance of dozing. ☐ 3. High chance of dozing.
Sitting quietly after a lunch without alcohol	☐ 0. Would never doze. ☐ 1. Slight chance of dozing. ☐ 2. Moderate chance of dozing. ☐ 3. High chance of dozing.
In a car, while stopped for a few minutes in the traffic	☐ 0. Would never doze. ☐ 1. Slight chance of dozing. ☐ 2. Moderate chance of dozing. ☐ 3. High chance of dozing.

Total Score: _____

Reviewed by: _____ Date: _____



PAIN MEDICATION AND PRESCRIPTION REFILL POLICY

1. I agree to allow 72 hours for prescription refills.
2. I understand that prescription refills requested after 4:00 pm will not be called in until the next business day.
3. I understand that a follow-up visit may be required from my physician in order to obtain refills.
4. I agree to take all medication exactly as instructed. I am **NOT** allowed to change the dosage amount or alter the time schedule of taking the medication without first speaking to my physician.
5. Narcotics and non-narcotic medications will **NOT** be phoned in after hours or on the weekends.
6. PSMA will **NOT** refill prescriptions that have been lost or misplaced.
7. I must keep all appointments recommended.
8. I will not give, trade, or sell medications.
9. Altering or forging a prescription is a felony and will be reported.
10. Grant PSMA the right to pull medication history from pharmacies to provide quality health care.
11. I will not combine any narcotic medications with the consumption of alcohol.

I have read, understand and agree to the policies above. I understand that if I do not sign this document, my physician may refuse to prescribe me pain medications.

Patient Name:_____ DOB:_____
(Please Print)

Patient Signature_____Date:_____