Lake Pulmonary Critical Care, P.A.
New Patient History Questionnaire

Patient Name_____ Date_____

DOB: _____ Age: _____ Referring Physician _____

Primary Physician_____Consulting Physicians_____

Allergies_____Type of reaction_____

Please check any medical problems you have had:

- ☐ Arthritis
- ☐ asthma
- ☐ cancer; type_____ treatment_____ year diagnosed_____
- ☐ chronic bronchitis
- ☐ COPD
- ☐ coronary artery/heart disease
- ☐ degenerative joint disease
- ☐ diabetes; ? insulin_____
- ☐ heart attack
- ☐ high blood pressure
- ☐ lung collapse
- ☐ pleurisy
- ☐ pneumonia
- ☐ problem w/ circulation
- ☐ atrial fibrillation
- ☐ any other pulmonary disease _____
- ☐ reflux disease (GERD)
- ☐ sleep apnea
- ☐ stroke or mini stroke (TIA)
- ☐ hypo/hyper thyroid
- ☐ tuberculosis
- ☐ **ANY OTHER PROBLEMS NOT LISTED ABOVE** _____

_____

Please check or list any surgeries:

- ☐ angioplasty/stent in heart
- ☐ appendectomy
- ☐ bronchoscopy
- ☐ bypass surgery, # of vessels ____
- ☐ pacemaker
- ☐ spinal/back/thoracic/cervical/lumbar surgery
- ☐colonoscopy
- ☐gall bladder removal
- ☐facial trauma
- ☐heart valve surgery
- ☐tonsillectomy
- ☐hysterectomy
- ☐lung surgery, lobectomy
- ☐sinus surgery
- ☐stomach or bowel surgery
- ☐ **ANY OTHER SURGERIES NOT LISTED ABOVE** _____

_____

Please list your family history:

Mother: ☐ alive or ☐ deceased; **age** _____ medical problems: _____
Father: ☐ alive or ☐ deceased; **age** _____ medical problems: _____
Siblings: _____

Please tell us about your social history:

Smoking:
- ☐ Never smoked
- ☐ Current smoker _____ packs per day. Start date: _____.
- ☐ Previous smoker _____ packs per day. Start date: _____ Quit date _____

Alcohol: ☐ Currently drink _____ glasses per day ☐ I do not drink at all. ☐ Drink only at social events/ holidays

Where do you work **OR** what are you retired from? _____

Have you had, or do you have now, any of the following symptoms:

- ☐ shortness of breath at rest
- ☐ shortness of breath with activity
- ☐ cough
- ☐ phlegm production; color_____
- ☐ bloody phlegm
- ☐ sleepiness or exhaustion
- ☐ headaches, sinus problems
- ☐ fever, chills, or sweats
- ☐ wheezing
- ☐ swelling in feet or ankles
- ☐ heartburn or reflux
- ☐ post nasal drip
- ☐ decreased appetite
- ☐ other: _____
- ☐ chest pain or pressure
- ☐ nausea, vomiting, diarrhea
- ☐ headaches, sinus problems
- ☐ weight loss or gain
- ☐ change in voice/hoarseness
- ☐ change in hearing or vision

Lake Pulmonary Critical Care Medication Record

Patient Name: _____ DOB _____

ALLERGIES: _____ Primary Care Doctor: _____

Have you had a Pneumonia Vaccine: Yes /No Date of last One: _____ Administered by_____
Have you had a Flu Vaccine Yes / No Date of last One: _____ Administered by _____

Date:	Medication/Dosage/ Frequency	Reviewed

Are you on:
Oxygen and/or CPAP/BIPAP(circle any/all that apply):_____Company: _____

Lake Pulmonary Critical Care

Patient Name: _____ Date of Birth_____

General/Constitutional		
Fatigue or loss of energy	O No	O Yes
Fever	O No	O Yes
Weight loss	O No	O Yes
Allergy/Immunology		
Rash	O No	O Yes
Seasonal allergies	O No	O Yes
Nasal congestion	O No	O Yes
ENT		
Hoarseness	O No	O Yes
Difficulty swallowing	O No	O Yes
Sinus headache	O No	O Yes
Endocrine		
Cold intolerance	O No	O Yes
Thyroid problems	O No	O Yes
Heat intolerance	O No	O Yes
Respiratory		
Cough	**O** Non-productive or **O** Productive	O No cough
Wheezing	O No	O Yes
Sputum production	O No O Yes	O with blood
Cardiovascular		
Awakening due to Shortness of breath	O No	O Yes
Chest pain with exertion	O No	O Yes
Shortness of Breath on exertion	O No	O Yes
Gastrointestinal		
Change in bowel habits	O No O Constipation	O diarrhea
Decreased appetite	O No	O Yes
Heartburn	O No O Yes	O controlled with meds
Hematology		
Blood clots	O No	O Yes
Swollen glands	O No	O Yes
Breast lump	O No	O Yes
Genitourinary		
Frequent urination	O No	O Yes
Difficulty urinating	O No	O Yes
Musculoskeletal		
Arthritis	O No	O Yes
Back problems or pain	O No	O Yes
Neurologic		
Headache	O No	O Yes
Memory loss	O No	O Yes
Psychiatric		
Mood swings	O No	O Yes
Difficulty sleeping	O No	O Yes

Lake Pulmonary Critical Care

Patient Name: _____ DOB: _____ Today's date: _____

Epworth Sleepiness Scale

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3 with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you doze or fall asleep in that situation.
Use this scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of dozing (0-3)
Sitting and reading	0 1 2 3
Watching Television	0 1 2 3
Sitting inactive in a public place—for example, a theater or meeting	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've not had alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3
Total Score	

Total: _____

Score: 0-10 within normal limits
>12 pathological sleepiness

LAKE PULMONARY CRITICAL CARE

Frank J. Montoya, M.D. Rosemary A. Cirelli, M.D., FCCP

SLEEP HISTORY QUESTIONAIRE

Name: _____ DOB_____ Today's date: _____

Height: _____ Weight: _____ Neck Circumference: _____

Your Occupation: _____ # of hours per week _____Shift _____

Chief Compliant: _____

Have you ever had a Sleep Study? Y or N if yes Where: _____ When: _____

Sleep Patterns:

Bedtime: _____ Total Sleep time: _____ Hours What time do you fall asleep? _____

Wake up time: _____ Get up time: _____ Do you wake up with a Headache? _____

Do you feel refreshed? Y or N Do you have a dry mouth: Y or N

Do you have a bed partner? Y or N (if yes) Do they tell you that you snore? Y or N

What is your sleeping position? Side Back Prone (stomach)

Do you stop snoring if you change your sleep position? Y or N, if yes, please explain: _____

_____

If you snore have you been told you can be heard in other rooms of the house? Y or N

Have you been told that you stop breathing while you sleep? Y or N

Do you have excessive daytime sleepiness? Y or N

Do you take naps? Y or N if yes how many times?

Per week _____ Duration _____ Do you feel refreshed? Y or N

Did you have sleep problems in your youth? Y or N

While sleeping do you have any of the following?:

Restless Legs Y or N Bad dreams Y or N Night Terrors Y or N Walking in your sleep Y or N

Talking Y or N Have you ever injured yourself: Y or N

Lake Pulmonary Critical Care, PA
Board Certified in Pulmonary, Critical Care & Sleep Medicine
Frank J. Montoya M.D. & Dr. Rosemary A. Cirelli, M.D., FCCP
Phone 352-742-4447 Fax 352-742-4448

Date _____

Name (must be as name is listed on insurance cards) _____
Last First Middle

Mailing Address _____

_____
City State Zip Code

Home Phone ( ) _____ Work Phone ( ) _____Cell Phone ( ) _____

By suppling my home phone number, mobile phone, email address, and any other personal contact information, I authorize my healthcare provider to employ a third-party automated outreach &messaging system to use personal information, the name of my care provider, the time and place of my scheduled appointment(s) and other limited information, for the purpose of notifying me of a pending appointment, missed appointment, or any other protected health information regarding health care events unpaid balanced, missed appointments, and to leave a reminder message on my voice mail or answering system if I am unavailable at the number provider by me _____ Initial.

Social Security # _____ (If you wish our office to file to your insurance you must provide your Social Security #)

Date of Birth _____ Sex**:** Male or Female Marital Status _____Who referred you here? _____

Email Address: _____@ _____.com **(please print clearly)**

Spouse/ Significant Other _____ Cell Ph. #_____ Work _____

Name of emergency Contract (NOT living with you) _____ Ph. # _____

Relationship to Emergency Contract: _____

Family Doctor (if different from referring) _____ Phone # _____

INSURANCE INFORMATION

(Please complete even though we have a copy of your cards this helps us to know the correct order to file for those who have more than 1 insurance)

Primary Insurance Carrier**:** _____

Name of policy holder: _____ DOB**:** _____

Secondary Insurance Carrier**:** _____

Name of policy holder**:** _____ DOB**:** _____

Third Insurance Carrier**:** _____

Name of policy Holder**:** _____ DOB _____

Is this visit related to a workman's compensation claim and/or litigation? _____

Do you return north for part of the year? Yes or No

If so, please provide the address**:** _____

Phone # _____

What months are you at the above address? From**:** _____ to _____.

EMPLOYER INFORMATION

Employment Status _____ Retired _____ Full Time _____ Part Time _____ Non employed

If you are over 65 and working and have Medicare are there 20 or more employees ?_____

Employer _____ Phone # _____

Employer Address _____
City State Zip

Occupation_____ How Long Employed_____

Pharmacy	Address	City	State	Zip	Phone

Do you have an Advance Directive? Yes / No

Please Circle one under each Category there are 3 Total
These are questions the Federal Government is requesting our office to ask.

Ethnicity **(the only choices given by our software)**
I decline to specify
Non-Hispanic or Latino
Hispanic or Latino
Unknown

Primary Language
English
Spanish
Romanian

Race: (These are the Choices/wording given by our software)
White
Black or African American
American Indian or Alaska Native
Asian
Native Hawaiian or Other Pacific Islander
Hispanic
Other race
Other Pacific Islander
Unreported/Refused to report

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Authorization for treatment/release of information for Lake Pulmonary Critical Care

Consent to Treatment:
The patient and/or authorized representative hereby give consent to any and all medical treatments which may deem advisable by the physician(s) of Lake Pulmonary Critical Care, PA.

Authorization for Release of Confidential information:
I hereby authorize Lake Pulmonary Critical Care, PA to release medical information contained in my/the patient's record to any insurance carrier, employer or other third party intermediary utilized by the patient for the purpose of obtaining information and/or reviewing the record of medical care received by the patient and for the payment of all medical charges. Copies of records may also be sent to referring physicians for continuity of care. Medical records released may include any diagnostic or therapeutic information of visits and/or procedures performed in the office. **Unless initialed below the records may not include any confidential information regarding:**

- Alcohol/Substance abuse _____
- Mental Health _____
- HIV _____

According to the Health Insurance Portability and Accountability Act of 1996 (HIPPA):
The patient's medical records may be furnished to and the medical condition of the patient may not be discussed with any other person other than the patient, the patient's legal representative, or other health care practitioners involved in the care and treatment of the patient without the patient's written authorization. The patient may at this time authorize an individual to be actively involved in the patient information as mentioned above: Please note if you change to new physician or obtain any new physicians other than the ones listed on your registration we must have written consent to send your records to them.

Please list below who you give our office consent to speak too regarding your Medical care. *This does not include giving a physical copy of your records, which would require written authorization from the patient.*

Name _____ Relationship _____

Name _____ Relationship _____

Please list below your current doctors you wish to receive a copy visits with our office (please limit to 4)

_____ _____
Name Phone # Name Phone #

_____ _____
Name Phone # Name Phone #

Is there anyone you <u>do not wish</u> the office to speak with regarding your care? _____

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FINANCIAL POLICY FOR LAKE PULMONARY CRITICAL CARE

In compliance with the Federal Consumer Protection Act, Lake Pulmonary Critical Care, PA is furnishing you with information regarding your financial responsibilities.

We are pleased that you have chosen our office for your healthcare needs. We'd like to familiarize you with how our services are billed, which insurance claims we file on your behalf, when we request payment from you, and our credit policies. Please take the time to read this policy and if you have any questions please ask to speak to someone in our billing department.

Please note that due to a new Federal Law you must present our office with a valid Driver's license, in which your photo must look like you, and your name MUST match the name on the insurance cards you give us. If these items do not match we will refuse to file your insurance, and you will have to pay in full services rendered. This has been implemented to protect you from insurance fraud. We have no choice in the matter.

If you have Medicare primary: You have a deductible to pay *(or you have a supplement insurance that covers that for you)* at the beginning of each year. Once that deductible is met Medicare only pays 80% of the allowed charges. There is a 20% coinsurance due. If you do not have a secondary insurance or your secondary insurance does not cover the 20% in full, you will be responsible for that balance at the time services are rendered. Unless you sign an Advance Beneficiary notice you are not responsible for any charges NOT covered by Medicare other than the Part B deducible or the 20%. Unless, you are no longer covered by Medicare then you would be responsible.

If you have a Private Insurance as a Primary or Secondary: All of these plans differ in benefit coverage, authorization, coverage, exclusions, deductible, co-insurance and copayments. It is always the patient ultimate responsibility to know and understand your insurance coverage and its referral/authorization process, and to ALWAYS keep our office updated on any changes you have in insurance coverage.

Any deductible, Co-insurance, and/or copays that are due from you according to benefits our office obtains will be collected at the time services are rendered.

Please note we collect money and give estimate amounts due for sleep studies and other testing based on verbal communication with your insurance; if there is a mistake and the correct amount was not collected you will receive a balance bill. If we over collected you will be refunded without 30 days of the overpayment if the overpayment is due to you. We encourage all of our patients to call their insurance to verify coverage and benefits for all testing prior to having it. _____ **Initial**

Please understand that our office cannot accept responsibility for payment or nonpayment on your insurance claims. Questions about coverage and benefits should be directed to your insurance company.

APPOINTMENT POLICY

If you fail to cancel an appointment within 24 hours there could be a cancellation fee as follows:

Consult/New patient $50.00
Return/follow-up patient $25.00
Pulmonary Function Test $50.00
Sleep study $100.00

I have read, understand and agree to cooperate with the financial policy listed above and understand all amounts are only estimates and not a guarantee of benefits or coverage.

_____ _____
Patient Signature Date

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BILLING POLICY

Any invoices you receive from our office are due on the 25th of the following month. If for any reason you cannot pay the bill in full we ask that you contact our billing office to set up a payment plan. There is a return check fee of $35.00

I have read and understand the statement above: _____
Patient signature Date

COLLECTION POLICY

All charges you have been billed for are due no later than 30 days of receipt of your billing statement. I understand that any invoice over 30 days old an interest of 1.5% will apply. If you fail to respond to the billing, or fail to cooperate with the terms of your payment plan, your account may be turned over to an outside agency for resolution. If this occurs you will be charge in addition to the 1.5% interest, any and all collection fees which include but are not limited to, a 33% agency fee *(an additional 33% of what you owe*) along with any and all attorney and/or court fees.

To avoid problems due to delayed mail it your responsibility to notify our office of any changes in your name, address, phone number or change in insurance coverage.

I agree to reimburse Lake Pulmonary Critical Care the fees of any collection agency, which may be based on a percentage at the maximum of 33% of the debt, and all cost, and expenses including attorney fees, Lake Pulmonary Critical Care incur in such collections efforts _____ Initial

Assignment of Insurance Benefits
I assign payment directly to Lake Pulmonary Critical Care, PA, the insurance benefits otherwise payable to me. I understand that I am financially responsible for charges not paid by this assignment.
I will assist in the collection of my insurance should there be any delay in payment. I agree to actively pursue collection insurance payment for any claims unpaid after thirty (30) days. If after forty-five (45) days if the claim remains unpaid, I understand the balance will be due from me.

Medicare Patients
I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize Lake Pulmonary Critical, PA to release to the Health Care financial Administration or its carriers or intermediaries any information needed for this or related Medicare claims. I hereby authorize payment directly to Lake Pulmonary Critical Care, PA for medical benefits otherwise payable to me as a beneficiary of the Medicare Program and such other payments as may be due by other third party payers. I agree to execute such documents as may be necessary to apply for and obtain payment.

Patient Agreement:
I understand that Lake Pulmonary Critical Care, PA is not in the business of extending credit. Therefore, it is the policy of Lake Pulmonary Critical Care to require payment in full at the time of service. If unable to pay balance due in full at the time of service, I agree to make prior arrangements with the Billing Department.

I understand that I am financially responsible for my account with Lake Pulmonary Critical Care, PA, regardless of my insurance benefits.

_____ _____
Patient Signature Date

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Lake Pulmonary Critical Care's Notice of Privacy Practice containing a description of the uses and discloses of my health information. I further understand that Lake Pulmonary Critical Care may update its Notice of Privacy Practices at any time and that I may receive an updated cope of Lake Pulmonary Critical care Notice of Privacy Practices by submitting a request in writing for a current copy of the Lake Pulmonary Critical care Notice of Privacy Practices

By signing or initialing below, I confirm that I have received a copy of the Notice of Privacy Practices for Montoya, Cirelli Pulmonary Associates, PA.

_____ _____
Patient Signature **Date**

_____ _____
Print Patient Name **Patient Date of Birth**

If completed by a patient's personal representative, please print name and sign below.

_____ _____
Printed Patient Personnel Representative Name **Relationship to Patient**

_____ _____
Printed Patient Personnel Representative Signature **Date**

For Lake Pulmonary Critical Care Official Use Only

Complete this form is unable to obtain signature of patient or patient's personal representative.

Lake Pulmonary Critical Care made a good faith effort to obtain patient's written acknowledgement of the Notice of Privacy Practices but was unable to do so for the reasons documents below.

_____ Patient or patients' personal representative refused to sign.

_____ Patient or patient's personal representative is unable to sign.

_____ Other

_____
Employee Name (printed)

_____ _____
Employee Signature Date

The last 2 pages are Medical release forms you do not have to print or fill this out UNLESS you have seen another pulmonary/sleep medicine doctor in the past or if any doctor has records in relation as to why you being seen by our doctors.

If you have those records they are very important to your care in our office, and you should print these form out complete them in their entirety and bring or mail them to our office in enough time for our office to obtain those records so that we will have for your appointment with our office.

Thank you for your understanding in this matter.

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Board Certified in Pulmonary, Critical Care & Sleep Medicine
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Authorization for Release of Medical Records
HIPPA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 & 164***

**** 1. Authorization** Please complete**

I authorize _____(Ph. # _____ Fax# _____)
(Health care provider) to use and disclose the protected health information described below to Lake **Pulmonary Critical Care, PA**
(individual seeking the information).

****2 Effective Period** Please check one**

This authorization for release of information covers the period of healthcare from:
Please check all that apply

____ A. From _____ To _____.

OR
____ B. All past, present, and future periods.

** OR**
____ Specific Records listed below.

_____

****3 Extent of Authorization** Please check one**

____ a. I authorize the release of my complete health records (including records relating to the mental healthcare, communicable disease, HIV or AIDs, and Treatment of alcohol or drug abuse).

** OR**

____ b. I authorize the release of my complete health record with the **exception** of the following information:

___ Mental health records

___ Communicable disease (including HIV and AIDS)

___ Alcohol/drug abuse treatment

___ Other (please specify): _____

Patient Name: _____ DOB: _____

1876 Nightingale Lane Tavares, FL 32778
Phone 352-742-4447 Fax 352-742-4448

Page 2 of 2 (Continuation of medical release for Lake Pulmonary Critical Care)

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payments or other purposes as I may direct.

5. This authorization shall be in force and effective until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment or eligibility for benefits will not conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____
Signature of patient or personal representative Date

_____
Printed name of patient or personal representative and his or her relationship to patient

_____
Witness Date

Patient Name {printed}: _____ DOB: _____

Last 4 of SS# _____