PULMONARY CRITICAL CARE AND SLEEP ASSOCIATES P.A

ASHESH DESAI, M.D.

WELCOME TO OUR OFFICE

Patient's Name: First:_______________ Last:___________ Middle:__________ Date:______________

Home Address:______________________________ City:___________ State:________ Zip:___________

Telephone: Home: (_____)_____________________ Cellular:(______)___________________________

Work: (_____)_________________ May we leave a message? Yes or No – Home/ Cell / Work

E-Mail Address(Required for Patient Portal):____

DOB: _____________ Age: _____ Sex:______ SSN#_________________

Driver's License#_________________ Occupation:__________________________

According to Medicare Meaningful use of Measure (OBJ-304C), it is required to record race, ethnicity and language information.

Ethnic Background: __________ Race:_________ Language Spoken:_____________

☐ Choose not to Report

Employer's Name:____

Employer's Address:__________________________ City:_________ State:__________ Zip:___________

Name of Spouse:________________________ Birth date:___________ SS#:_____________________

Home:(____)___________ Cell: (___)____________ Work: (_______)_______________

Friend or Relative to be called in case of emergency (other than spouse)

Name____ Phone_____________________________

Address:_______________________________________ Relationship:___________________________

PULMONARY CRITICAL CARE AND SLEEP ASSOCIATES P.A

ASHESH DESAI, M.D.

Patient's Name:____________________________ **Today's Date:**____________

Insurance Information

Primary Insurance Company________________________________

Name of Policy Holder:____________________ Ins. Co. Phone:__________________

Subscriber's SSN #__________ Group Number__________ Policy #:_______________

Secondary Insurance Company _ (If Any) ________________________________

Name of Policy Holder:____________________ Ins. Co. Phone:__________________

Group Number__________ Policy #:_______________

Who may we thank for referring you? ____________________

* I HAVE RECEIVED A COPY OF THE PRIVACY POLICY OF PULMONARY CRITICAL CARE AND SLEEP ASSOCIATES, P.A (AVAILABLE UPON REQUEST) AND HEREBY AUTHORIZE ANY LISCENSED PHYSICIAN, PRACTITIONER, HOSPITAL, CLINIC OR OTHER MEDICAL FACILITY, OR IT'S REPRESENTATIVE, TO RELEASE ANY AND ALL INFORMATION WITH RESPECT TO ANY ILLNESS, INJURY, MEDICAL HISTORY, CONSULTION, PRESCRIPTION OR TREATMENT AND COPIES OF ALL MEDICAL RECORDS TO PULMONARY CRITICAL CARE AND SLEEP ASSOCIATES P.A . I ALSO AUTHIRIZE PULMONARY CRITICAL CARE AND SLEEP ASSOCIATES P.A, ITS PHYSICIANS AND PROVIDERS TO RELEASE MEDICAL RECORDS TO THE INSURANCE COMPANY THAT IS RESPONSIBLE FOR MY HEALTH COVERAGE SHOULD IT BE NECESSARY FOR PAYMENT OF SERVICES PROVIDED. A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

I HEREBY ASSIGN BENEFITS AND AUTHORIZE PAYMENT TO GO DIRECTLY TO PULMONARY CRITICAL CARE AND SLEEP ASSOCIATES P.A FOR ANY MEDICAL SERVICE PROVIDED, BUT NOT TO EXCEED THE REASONABLE AND CUSTOMARY CHARGE FOR THESE SERVICES. I AGREE THAT THE DOCTOR MAY RECEIPT FOR ANY SUCH PAYMENT AND THAT HIS RECEIPT SHALL BE A CONCLUSIVE ACKNOWLEDGMENT BY ME THAT I HAVE RECEIVED BENEFITS FROM INSURANCE COMPANY ALL THE SUM SPECIFIED IN SUCH RECEIPT AND AGREE THAT SUCH PAYMENT SHALL DISCHARGE THE SAID INSURANCE COMPANY OF ANY AND ALL OBLIGATIONS UNDER THE POLICY TO THE EXTENT OF SUCH PAYMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE DOCTOR FOR ALL CHARGES NOT COVERED BY THE AGREEMENT.

SIGNATURE: ______________________________ DATE: _______________

Pulmonary Critical Care and Sleep Associates P.A.

Ashesh Desai, M.D.

New Patient Questionnaire

Information about you, your previous health, and the health of your family enables our physicians and staff to provide effective and efficient health care. This questionnaire will become part of your medical record and will be regarded as confidential communication.

Name:____
Last *First* *Middle*

Home Telephone Number: _______________ Work Telephone Number:________________

MEDICAL HISTORY: Please check all that apply now or have applied in the past.

☐ Emphysema	☐ Pneumonia	☐ Heart Attack
☐ Blood transfusion Year _________	☐ Cystic fibrosis	☐ Thyroid Issues
☐ Blood clot	☐ Tuberculosis (TB)	☐ Asthma
☐ High blood pressure	☐ Date of last TB skin test (PPD) ____________	☐ High Cholesterol
☐ COPD	☐ TB test Result Negative or Positive	☐ Diabetes
☐ Other ___________	☐ Hepatitis	☐ Bronchitis
☐ Heart Disease		

Previous Surgery:

____

FAMILY HISTORY

	Family Member		Family Member
Diabetes	____________	Lung Disease	______________
Cancer	____________	Asthma	______________
Stroke	____________	Tuberculosis	______________
Heart Disease	____________	High Blood Pressure	______________
Other	____________________________		

SOCIAL HISTORY

Marital status: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Single

Have you **ever** worked with or been exposed to any of the following? ☐ No ☐ Yes (If yes, circle which apply): Asbestos, welding, coal mining, metals manufacturing, foundry work, grain dust grinder, silica mill

PHARMACY INFORMATION: Name:_______________________ **Phone:**____________________

Name: ______________________________

SMOKING HISTORY ☐ Currently smoke ☐ Never smoked ☐ Formerly smoked

☐ Expose to others that smoke around you

Packs per day ________ Smoked _______ years If former smoker, when did you quit? _______

Alcohol use: ________________

Review of Symptoms:

	Yes	No		Yes	No
RESPIRATORY			**SLEEP**		
Cough			Snoring		
Wheezing			Excessive Daytime Sleepiness		
Shortness of Breath			**Fatigue**		
Chest Tightness			**Choking during Sleep**		
Coughing blood			Stop Breathing during Sleep		
			Restless Sleep		
			Wake Up Fresh in Morning		
EAR, NOSE AND THROAT			**Insomnia**		
Post nasal drip					
Hoarseness					
Headaches					
Seasonal Allergies					

CURRENT MEDICATIONS

Name	Dosage/Strength	How often do you take it?
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

ALLERGIES: ____

IMMUNIZATION:

Pneumonia Vaccine: ________Month/Year Flu Vaccine: ________Month/Year

Shingles: _________Month/Year Others:____________________

PULMONARY CRITICAL CARE AND SLEEP ASSOCIATES, PA

ASHESH DESAI, MD

Please fill out this form only if you have sleep disorder or you think you may have sleep problems

BERLIN QUESTIONNAIRE

Name______________________ Height _____ Weight ______ Age ________ Male/Female

CATEGORY 1

1. Do you snore?
   - ☐ Yes
   - ☐ No
   - ☐ Don't Know

If you snore:

2. Your Snoring is:
   - ☐ Slightly louder than breathing
   - ☐ As load as talking
   - ☐ Louder than talking
   - ☐ Very loud- can be heard in Adjacent rooms
3. How often do you snore
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ Never or nearly never
4. Has your snoring ever bothered other People?
   - ☐ Yes
   - ☐ No
   - ☐ Don't know
5. Has anyone noticed that you quit Breathing during your sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never

CATEGORY 2

6. How often do you feel tired or fatigued after your sleep?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never
7. During your waking time, do you feel tired, fatigued or not up to par?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ 1-2 times a month
   - ☐ Never or nearly never
8. Have you ever nodded off or fallen asleep while driving a vehicle?
   - ☐ Yes
   - ☐ No

If Yes:

9. How often does that occur?
   - ☐ Nearly every day
   - ☐ 3-4 times a week
   - ☐ 1-2 times a week
   - ☐ Never or nearly never

CATEGORY 3

10. Do you have high blood pressure?
    - ☐ Yes
    - ☐ No
    - ☐ Don't Know

PULMONARY CRITICAL CARE AND SLEEP ASSOCIATES, PA

ASHESH DESAI, MD

Please fill out this form only if you have sleep disorder or you think you may have sleep problems

Epworth Sleepiness Scale

Name:_________________________ Date:__________

Age:__________ Sex: Male/Female

How likely are you dose off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times>
Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following 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

It is important that you answer each question as best as you can.

Situation	**Chance of Dozing (0-3)**
Sitting and Reading	
Watching TV	
Sitting, inactive in public place (e.g a theatre or a meeting)	
As a passanger in a car for an hour without circumstances permit	
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 for a few minutes in the traffic	

Score:
0-10 = NORMAL RANGE
10-12 = BORDERLINE
12-24 = ABNORMAL

TOTAL SCORE: __________

Pulmonary Critical Care and Sleep Associates
Ashesh Desai, M.D.

CONSENT FOR TREATMENT

I voluntarily give my permission to the health care providers of Pulmonary Critical Care and Sleep Associates, PA as they may deem necessary to provide medical care services to me. I understand that by signing this form, I am authorizing them to treat me as long as I seek care from Pulmonary Critical Care and Sleep Associates providers, or until I withdraw my consent.

____
Signature of Patient or Guardian   Date

____
Printed Name of Patient or Guardian   Relationship to Patient

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Please list any family member(s) and or loved one(s) that you authorize Pulmonary Critical Care and Sleep Associates to disclose information to regarding your condition, diagnosis, medications, financial information, dates of services, appointments and all other concerns:

	Name	Relationship	Date	Initial
1.				
2.				
3.				

PLEASE NOTE:
There will be times this office will call and leave messages regarding appointments and/or returned phone calls to the patient.

______________________   ______________________
Signature   **Date**

Any outside requests for medical records or other pertinent information will require a signed consent form by the patient.

Pulmonary Critical Care and Sleep Associates, PA

Financial Responsibility, Assignment of Benefits, and Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Options

I, ______________________________, hereby give my consent for Pulmonary Critical Care and Sleep Associates, PA to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO)(PCCSA's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)
I have a right to review the Notice of Privacy Practices prior to signing this consent. for Pulmonary Critical Care and Sleep Associates, PA the right to revise its Notice of Privacy Practices at any time.
I have the right to request that Pulmonary Critical Care and Sleep Associates restrict how it uses or discloses my PHI to carry out TPO.
The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Pulmonary Critical Care and Sleep Associates use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Pulmonary Critical Care and Sleep Associates may decline to provide treatment on me.

Statement of Financial Responsibility

I understand that payment is due at the time of service. I authorize the release of any information necessary for filing a claim for payment with my insurance company of record, and I will advisePulmonary Critical Care and Sleep Associates of any changes in insurance coverage. I understand that any care not paid for by my existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial. Outstanding debt past 120 days will be referred to a collection agency; in this event, I agree to pay an additional fee equal to 33% of the balance forwarded to the collection agency and any additional attorney fees or court costs. There will be a fee of $25 charged by Pulmonary Critical Care and Sleep Associates for each check returned to the office by my bank.

Missed Appointment Fee

I understand that if I do not appear for a scheduled appointment, or cancel an appointment with less than 24 hours
notice, I may be charged a fee of $20 for an office appointment or $30 for a missed Pulmonary Function Test appointment.

Statement to permit assignment of insurance benefits

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, or any other health plans, to Pulmonary Critical Care and Sleep Associates. This assignment will remain in effect until revoked by me in writing. A photocopy or scanned image of this assignment is to be considered as valid as an original. I understand that I am responsible for all charges whether or not the charges are paid by said insurance.
I have read, fully understand, and accept the terms of this consent.

Signature: ____ Date: ______________________________

HIPAA Authorization for Release of Information Form

I hereby authorize use or disclosure of protected health information about me as described below.

The following specific person or class of persons or facility is authorized to make the requested use or disclosure: ______________________________
____
____
____

The following person or class of persons may receive disclosure of protected health information about me.

RECORDS FAXED/MAILED TO: **Pulmonary Critical Care and Sleep Associates, P.A**
Ashesh Desai, MD

100 Medical Center Blvd # 224

Conroe, TX 77304 // Phone: 936-242-6957

FAX: 936-242-6958

RECORDS ON (PATIENT NAME)______________________________**(DOB)**__________

PHONE NUMBER______________________________

Specific description of information to be released (must include date(s) of service):

____

____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying **Pulmonary Critical Care and Sleep Associates, P.A** in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on ________________________, or 1 (one) year after the date of said authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Individual	Date of Signature	Date of Birth or SS Number

-- OR, if applicable --

Signature of Guardian	Date of Signature	Description of Guardian's Personal Representative's Authority to Act for the Individual

A copy of this completed, signed and dated form must be given to the Individual or person signing on the Individual's behalf.