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Schenectady Pulmonary & Critical Care Associates

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

Patient Name: _____ Date of Birth: _____

Patient Acct #: _____

Patient Address: _____

I, the authorized representative, request that health information regarding my care and treatment be released as set forth on this form.

1. This authorization may include disclosure of information relating to alcohol and drug abuse, mental health treatment, except psychotherapy notes, and confidential HIV related information only if I place my initials on the appropriate line in Item 7(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 7(a), I specifically authorize the release of such information to the person(s) indicated in Item 6.

2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212)480-2493 or the New York City Commission of Human Rights at (212)306-7450. These agencies are responsible for protecting my rights.

3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. I understand that signing this authorization is voluntary. My treatment, payment. enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient (except as noted above in Item 2), and this re-disclosure may no longer be protected by federal or state law.

6. Name and address of health provider or entity to release this information:

□ **Schenectady Pulmonary Critical Care Associates** *OR* _____
124 Rosa Rd. Ste 382 _____
Schenectady, NY 12308 _____

7. Name and address of person(s) or category of person to whom this information will be sent:

□ **Schenectady Pulmonary Critical Care Associates** *OR* _____
124 Rosa Rd. Ste 382 _____
Schenectady, NY 12308 _____

(a). Specific Information to be released:

□ Medical Record from (date) _____ to (date) _____ *OR*

□ Entire Medical Record, including patient histories, office notes (except psychotherapy notes) test results, radiology studies, films, consults, billing records, and records sent to you by other healthcare providers.

□ Other _____

□ Include: (Indicate by Initialing):
____ Alcohol / Drug Treatment ____ Mental Health Information ____ HIV-Related Information

(b). Authorization to Discuss Health Information

By initialing here _____, I authorize

_____
(Name of health care Provider)

to discuss my health information with my attorney, or a government agency, listed here:

_____
(Attorney / Firm Name or Governmental Agency)

8. Authorization is valid for one year, or: _____

9. If not the patient, name of person signing form: 10. Authority to sign on behalf of the patient:

_____ _____

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ Date: _____
Signature of patient or representative authorized by law

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FINANCIAL POLICY

TO OUR PATIENTS:

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial policy is important to our professional relationship. We make efforts to keep our fees reasonable while at the same time covering the cost of the services we provide. Payment of your bill is considered part of your overall treatment. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

PAYMENT IS EXPECTED AT THE TIME OF SERVICE:

Payment is required at the time services are provided unless other arrangements have been made in advance. This includes applicable: coinsurance and copayments for participating insurance companies. SCHENECTADY PULMONARY AND CRITICAL CARE ASSOCIATES accepts cash, personal checks (in-state only), VISA, Master Card American Express and Discover. There is a service charge for returned checks.

Patients with an outstanding balance 60 days or more overdue must make arrangements for payment.

We realize that financial difficulty is a reality. In such circumstances, we are willing to work with you to set up reasonable monthly payments to eliminate your balance.

INSURANCE:

We bill participating insurance companies. You are expected to pay your deductible and copayments at the time of service. It is imperative that you provide the most recent copy of your insurance card at every visit. If we have incomplete or inaccurate insurance information payment will be delayed, and you are responsible to be sure all charges are paid whether by you or by your insurance carrier.

We will bill secondary insurance companies after receiving payment from the primary carrier.

The clinical summary document given to you at the time of service includes all information necessary for submitting claims to your insurance company or to your FSA account.

If you need assistance or have questions, please contact the Billing Department between 9:30 AM and 4:00 PM, Monday through Friday at 518–386–3691.

REFUNDS:

Patient/guarantor credits will automatically be refunded to the patient/guarantor.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who have been seen in the time set aside for you. Cancellations are requested 48 hours prior to the appointment. We reserve the right to charge $50 for any missed or late–canceled appointments. Sleep studies, which require a technician to be reserved for an entire evening, carry a missed appointment charge of $200. Excessive abuse of scheduled appointments may result in discharge from the practice.

_____

I have read and understand the SCHENECTADY PULMONARY AND CRITICAL CARE ASSOCIATES Financial Policy. I agree to assign insurance benefits to the SCHENECTADY PULMONARY AND CRITICAL CARE ASSOCIATES practice. I also understand that if it becomes necessary to forward my account to a collection agency, that I might be discharged from the practice.

Patient Name: _____ Date of Birth: _____

Signature of Patient/Authorized Representative: _____

Date:_____

SCHENECTADY PULMONARY & CRITICAL CARE ASSOCIATES
Patient Data Sheet

DATE

In order for us to provide you with safe and effective health care, this form must be completed thoroughly.
If you need help completing this form, please ask for assistance!

NAME | DATE OF BIRTH

PHARMACY NAME, ADDRESS, AND PHONE

PRIMARY MEDICAL DOCTOR | WHY WERE YOU REFERRED TO OUR PRACTICE?

Race (circle one): Caucasian African American Asian Native American Other: _____ Declined **Ethnicity (circle one):** Hispanic Non-Hispanic Declined

Primary Language (circle one): English French Spanish Other_____

LIST YOUR OTHER DOCTORS, AND WHY YOU SEE THEM *Example: Dr. Jane Smith – Heart Disease*

MEDICAL PROBLEMS (Circle all that apply)

Anemia Arrhythmia Arthritis (Osteo or Rheumatoid) Asthma Cancer Chronic Pain
Cirrhosis COPD (Emphysema or Chronic Bronchitis) Coronary Artery Disease
Cystic Fibrosis Diabetes Diverticulitis Diverticulosis DVT (Blood Clot in Leg or Arm)
Headache Heart Failure High Cholesterol Hypertension (High Blood Pressure) HIV/AIDS
Kidney Disease Liver Disease Lupus Osteoporosis Prostate Disease
Pulmonary Embolism (Blood Clot in Lung) Pulmonary Hypertension Reflux (GERD)
Sarcoidosis Seizure Sinusitis Sleep Apnea Stroke Thyroid Disease Transplant
Trauma/Deformity Tuberculosis Ulcerative Colitis or Crohn's Disease
List Other Problems Below

*List other problems on reverse

MEDICATIONS *Example: Toprol 50 mg 2x / day.*
Include inhaled meds, oxygen, & over-the-counter meds

*List Other meds on reverse

HOSPITALIZATIONS and SURGERIES (LIST ALL DETAILS, INCLUDING DATES – *Continue on reverse if necessary)

PROBLEMS WITH ANESTHESIA? ☐YES ☐NO (Discuss details with the Doctor)

FAMILY HISTORY List major medical problems; if a family member has died, list age and cause of death

MOTHER

FATHER

SIBLINGS

CHILDREN

OTHER BLOOD RELATIVES

WORK HISTORY: List all jobs and the type of work you performed *Example: GE - Foundry Worker*

MARITAL STATUS: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

DO YOU SMOKE, or did you ever smoke regularly? ☐YES ☐NO *If yes, discuss in detail with the doctor today! Also, please be prepared to discuss alcohol and drug use and second-hand smoke exposure with the doctor today!*

PETS in home:

RECENT TRAVEL outside of state

HAVE YOU BEEN HEAVILY EXPOSED TO or USED: ☐Asbestos ☐Diet Pills ☐Heavy Metals ☐Hormone Replacement ☐Silica?

YEAR ('x' = never) of Last **Flu Shot** _____ **Pneumonia Vaccine** _____ **Tuberculosis Skin Test** _____ (☐Check if POSITIVE)

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NOT DONE YET! Please turn over

PATIENT NAME:

REVIEW OF SYSTEMS Rate Your General Health Recently ☐Excellent ☐Good ☐Fair ☐Poor

For each section, please check each of the problems you have had recently, or have had chronically

GENERAL
- ☐ Fever
- ☐ Chills
- ☐ Night Sweats
- ☐ Fatigue
- ☐ Weight Gain
- ☐ Weight Loss

EYES
- ☐ Blindness
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Double Vision
- ☐ Glaucoma
- ☐ Other Eye Surgery (e.g., Lasik)
- ☐ Wear Corrective Lenses

ENMT
- ☐ Bad Taste in Mouth
- ☐ Bleeding Gums
- ☐ Difficulty Swallowing
- ☐ Earaches
- ☐ Ear Drainage
- ☐ Hearing Loss
- ☐ Hoarse Voice/Voice Change
- ☐ Mouth Sores
- ☐ Nasal Polyps
- ☐ Nosebleeds
- ☐ Painful Swallowing
- ☐ Post Nasal Drip
- ☐ Runny Nose
- ☐ Swollen Glands in Neck

CARDIOVASCULAR
- ☐ Angina/Chest Pain
- ☐ Ankle/Leg/Hand Swelling
- ☐ Calf Pain When Walking
- ☐ Cold Extremities
- ☐ Heart Murmur
- ☐ Lightheadedness
- ☐ Palpitations
- ☐ Shortness of Breath Lying Flat
- ☐ Waking Up Short of Breath

RESPIRATORY
- ☐ Coughing Up Blood
- ☐ Coughing Up Sputum
- ☐ Cough When Eating
- ☐ Dry Cough
- ☐ Pain with Deep Breathing/Cough
- ☐ Shortness of Breath on Exertion
- ☐ Wheezing

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Bloating
- ☐ Constipation
- ☐ Dark/Black or Bloody Stool
- ☐ Diarrhea
- ☐ Increase in Abdominal Girth
- ☐ Loss of Appetite
- ☐ Painful Bowel Movements
- ☐ Vomiting or Retching
- ☐ Vomiting Blood

GU: General
- ☐ Blood In Urine
- ☐ Burning or Pain with Urination
- ☐ Incontinence / Dribbling
- ☐ Kidney Stones
- ☐ Sexual Difficulty
- ☐ Sexually Transmitted Disease

GU: Female
- ☐ Hot Flashes
- ☐ Irregular Periods

Last Pap Smear _____
# of Pregnancies _____
# of Abortions/Miscarriages _____

- ☐ Painful Periods
- ☐ Post-Menopausal
- ☐ Vaginal Discharge

GU: Male
- ☐ Difficulty Starting Urine Flow
- ☐ Testicular Pain

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Difficulty Walking
- ☐ Joint Injury
- ☐ Joint Pain
- ☐ Joint Stiffness
- ☐ Joint Swelling or Redness
- ☐ Muscle Aches
- ☐ Muscle Cramps
- ☐ Muscle Weakness
- ☐ Sciatica

INTEGUMENTARY
- ☐ Breast Lump
- ☐ Breast Pain or Swelling
- ☐ Change in Hair
- ☐ Change in Nails
- ☐ Change in Skin Color
- ☐ Eczema

Female: Last Mammogram _____

- ☐ Itching
- ☐ Rash
- ☐ Skin Cancer

NEURO
- ☐ Balance Problems
- ☐ Dementia (e.g., Alzheimer's)
- ☐ Dizziness
- ☐ Headache (Migraine or Other)
- ☐ Head Injury
- ☐ Numbness
- ☐ Paralysis
- ☐ Seizure / Epilepsy
- ☐ Tingling/Burning (Neuropathy)
- ☐ Tremor/Tic

PSYCH
- ☐ Anxiety
- ☐ Confusion
- ☐ Depression
- ☐ Memory Loss
- ☐ Severe Stress or Recent Loss
- ☐ Suicidal Thoughts / Attempts

ENDOCRINE
- ☐ Change in Hat/Glove Size
- ☐ Cold Intolerance
- ☐ Dry Skin
- ☐ Excessive Thirst
- ☐ Excessive Urination
- ☐ Goiter
- ☐ Heat Intolerance
- ☐ Other Endocrine Disease

HEMATOLOGIC
- ☐ Anemia
- ☐ Bleeding or Bruising Tendency
- ☐ Phlebitis
- ☐ Poor Wound Healing
- ☐ Swollen Glands
- ☐ Transfusion

ALLERGY
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other Antibiotics (Specify):

- ☐ Aspirin
- ☐ IV Contrast
- ☐ Morphine or Demerol
- ☐ Tetanus
- ☐ Environmental (Specify):

- ☐ Foods (Specify):

- ☐ Other (Specify):

SLEEP
- ☐ Excessive Daytime Sleepiness
- ☐ Morning Headache
- ☐ Poor Sleep Quality
- ☐ Snoring

*Use this space to complete information from other side, or for additional medical information

Do Not Write Below This Line – DOCTOR'S NOTES

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Obstructive Sleep Apnea Screening Assessment

Date _____ Patient Name: _____ Date of Birth: _____

1. Waking Assessment (Epworth Sleepiness Scale)
   a. How likely are you to fall asleep or doze in the circumstances listed below? When rating these situations, give highest consideration to recent events. If you have never experienced one of the situations, estimate how you might have reacted.

0	1	2	3
No Chance	Slight Chance	Moderate Chance	High Chance

Chance of Dozing	**Situation**
_____	Sitting and reading
_____	Watching TV
_____	Sitting inactive in a public place (theater or meeting)
_____	As a passenger in a car for an hour without a break
_____	Lying down to rest in the afternoon
_____	Sitting and talking to someone
_____	Sitting quietly after lunch, without alcohol
_____	In a car, stopped for a few minutes in traffic
_____	
TOTAL	Total Score>> Points

>>>>>>> 0-6 > 0 pts. 7-15 > 5 pts. 16-18 > 10 pts. 18+ > 15 pts. 1a Total _____

   b. How often do you fall asleep or fight the urge to sleep while driving?
Seldom >> 0 pts. Sometimes >> 5 pts.
Often >> 10 pts. Must pull off the road >> 15 pts. 1b Total_____
Section 1 Total (1a +1b) = _____

2. Sleeping Assessment:

   a. Do you snore?
Yes (1 pt.) No (0 pts.) _____
Quiet snore, slightly louder than breathing (0 pts.) _____
Moderate snore, as loud as talking (4 pts.) _____
Severe snore, heard through door (10 pts.) _____

2a Total_____

b. Do you awaken startled, gasping, or choking?

Yes (1pt) No (0pts.)	_____
Occasionally (9 pts.)	_____
Nightly (14 pts.)	_____

2b Total_____

Section 2 Total (2a +2b) = _____

3. Patient Assessment

a. Patient Assessment – Uncomplicated

Sex male (5 pt.) female (3 pts.)	_____
Neck Size _____ (>16=15 pts.)	_____
Weight _____ Height _____	
Treated hypertension (5 pts.) BP _____/_____	_____

3a Total_____

b. Patient Assessment – Complicated

Nocturnal angina* (5 pts.)	_____
Cor Pulmonale (5 pts.)	_____
On O2* (5 pts.)	_____
Morbid obesity* (100 lb. over ideal body weight (5pts.)	_____

* Qualifies for Plan III if yes

3b Total_____

Section 3 Total (3a +3b) = _____

Total Waking, Sleeping, and Patient Assessment Scores

Add sections 1, 2 and 3 _____

Total Qualifying Points (Probable severity of OSA)

0-10	OSA very unlikely	>>>	No intervention required - Consider Sleep Hygiene Tx
11-20	Mild or no OSA	>>>	Plan I: Oximetry Screen
21-50	Moderately severe OSA	>>>	Plan II: Diagnostic Polysomnogram
51+	Severe or complicated OSA	>>>	Plan III: Cardiopulmonary Sleep Study

The physician's subjective judgment with regard to a patient's special circumstances should always be considered int eh final selection of the plan to follow rather than relying solely on the numerical rating system which is intended to provide guidelines only for the typical patient. If consideration is given to a diagnosis other than OSA, you may prefer to schedule a consultation with a panel physician at the Sleep Disorders Center.