Thank you for scheduling an appointment with Lung Associates of Sarasota. It is our pleasure to welcome you in advance of your first visit. Enclosed, you will find some patient information that will help familiarize you with the practice and how we operate. If you have any questions after reading the material, please feel free to contact us. Please complete the enclosed forms and either fax them to us or bring them in with you to your appointment. If you are being seen for a sleep disorder, please complete the Sleep Questionnaire as accurately as possible prior to your visit.
It is very important that all the medications you are taking are listed on the last page of the Health Questionnaire and are inclusive of the dosage and frequency. If you are unsure of this information, please bring your medications in with you at the time of your visit.

With recent changes in government guidelines regarding confidentiality issues and insurance policies, we request the following information at every visit:

- ***A copy of your most recent insurance card.***

- ***An HMO authorization. If you have an insurance that requires prior authorization, please be sure that your primary care physician has sent it. If we do not have your authorization at the time of your visit, you will be responsible for payment. To avoid this situation, please call us the day before your appointment and be sure your authorization is here.***

- ***All co-payments are due at the time of service. This is part of your contract with your insurance company.***

With consideration to our patients with sensitive airways, we ask that you please refrain from wearing any perfumes or colognes when visiting our office.

If for any reason you need to cancel your appointment, we require 24 hours' notice, or a charge may incur. The doctors can help other patients if extra time on their schedules becomes available through cancellations.

We appreciate the opportunity to assist you in your medical care and will work diligently to provide you with professional and quality service.

Sarasota Office: Free parking for our office is available in the Waldemere Garage. You may also choose to use the valet service for a nominal cost. Please allow 10 minutes for valet or garage parking and getting to our office on the 7th floor.

Venice Office: Free parking is available directly in front of the medical office building connected to Sarasota Memorial Hospital – Venice.

Weapons of any kind are not permitted in the building or in our office.

LUNG ASSOCIATES OF SARASOTA
NEW PATIENT INFORMATION RECORD

PATIENT INFORMATION (PLEASE PRINT OR WRITE LEGIBLY)

PATIENTS NAME | MARITAL STATUS S M W | GENDER | DATE OF BIRTH | SOCIAL SECURITY NO.

LOCAL ADDRESS | CITY AND STATE | ZIP CODE | HOME PHONE NO.

OUT OF STATE ADDRESS | CITY AND STATE | ZIP CODE | HOME PHONE NO.

PATIENT'S EMPLOYER | ADDRESS | BUSINESS PHONE NO.

IN CASE OF EMERGENCY CONTACT: | RELATIONSHIP TO PATIENT | PHONE NO.

SPOUSE'S NAME | EMPLOYER | ADDRESS | BUSINESS PHONE NO.

WHO MAY WE THANK FOR REFERRING YOU TO US? | FAMILY PHYSICIAN

E-mail Address for Patient Portal:

INSURANCE INFORMATION

I understand I am responsible for authorizations required by my insurance company for follow-up testing and office visits. Initials: _____ Date: _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? | STREET ADDRESS, CITY, STATE AND ZIP CODE | HOME PHONE NO.

I WILL BE PAYING TODAY BY: ☐ CASH ☐ CHECK ☐ VISA/MASTERCARD

PRIMARY INSURANCE | NAME OF POLICYHOLDER | CERTIFICATE NO. | GROUP NO.

SECONDARY INSURANCE | NAME OF POLICYHOLDER | POLICY NO.

OTHER INSURANCE | NAME OF POLICYHOLDER | POLICY NO.

MEDICARE NO. | MEDICAID NO. | PROGRAM NO. | COUNTY NO. | ACCOUNT NO.

MEDICARE SIGNATURE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to LUNG ASSOCIATES for any services furnished by the group. I authorize any holder of medical information to release to the Health Care Financing Administration and its agent any information necessary to determine these benefits or the benefits payable for related services.

SIGNATURE: _____ DATE:_____

As it appears on your card

FINANCIAL POLICY

Full payment is due at time of visit. We accept cash, checks, or VISA/Mastercard. We offer an extended payment plan with prior credit approval. We accept Medicare Assignment. All deductibles and the 20% co-pay are the responsibility of the guarantor. As a courtesy, we will bill your insurance company for you, but you are responsible for payment if the insurance company hasn't paid within 45 days. Regarding insurance companies with whom we are participating providers, all co-pays and deductibles are to be paid at time of visit. There is a $15.00 service fee for any returned check and an 18% service fee for balances over 120 days. Our detailed financial policy is available for review at your request.

I understand that I am financially responsible for all charges rendered. I have read this information and understand it.

SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

Notice to Patient:

We are required by law to provide a copy of our Notice of Privacy practice to you, which states how we may use and or/disclose your health information. Please sign the form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment if you wish.

_____
Please print your name here

_____
Signature of Patient

_____
Date

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Your PHI maybe be disclosed to the individuals you list below. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone_____

2. Name _____ Relationship _____ Phone_____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

- ☐ The patient refused to sign
- ☐ Due to an emergency it was not possible to obtain acknowledgment
- ☐ We were not able to communicate with the patient.
- ☐ Other (Please provide specific details)

_____
_____
_____

_____ _____
Employee Signature Date

HEALTH QUESTIONNAIRE

NAME: _____ DOB: _____

Reason for your visit: _____DATE_____

How long have you had this problem? _____ Week(s) _____ Month(s) _____ Year(s)

Pharmacy name and address_____

PLEASE ANSWER *ALL* QUESTIONS ON EVERY PAGE – THANK YOU!

Have you been experiencing any of the following over the past 2 weeks?

(Check all that apply)

___Fever/chills or sweats
___Weight loss or gain
___Fatigue/tiredness
___Headaches
___Allergies/hay fever
___Eye/vision problems
___Ear/hearing problems
___Nose/nasal problems
___Postnasal drip
___Swollen glands
___Coughing spells
___Coughing up phlegm
___Coughing up blood
___Shortness of breath
___Wheezing
___Chest tightness
___Pain with breathing
___Snoring
___Calf or leg pain
___Chest pain/angina
___Dizzy spells
___Stomach trouble
___Indigestion
___Constipation/diarrhea
___Heartburn
___Ulcers
___Vomiting or nausea
___Dark or bloody stools
___Frequent urination
___Burning urination
___Easy bruising
___Aching muscles
___Anxious feelings
___Frequent thirst/hunger
___Blood in urine
___Other _____

Do you have a problem now or in the past with any of the following?

(Check all that apply)

___ Anemia
___ Arthritis
___ Asthma
___ Bone fractures
___ Bronchitis
___ Cancer
___ Depression
___ Diabetes
___ Emphysema
___ Gastric reflux
___ Gout
___ Hay fever
___ Heart attack/Angina
___ Heart disease
___ Heart murmur
___ Heart valve disease
___ High blood pressure
___ Irregular heartbeat
___ Kidney stones
___ Nervousness
___ Osteoporosis
___ Pneumonia
___ Phlebitis, blood clots
___ Prostate problems
___ Rashes
___ Rheumatic fever
___ Seizures
___ Sinusitis
___ Sleep problems
___ Stroke or TIA's
___ Thyroid problems
___ Ulcers
___ Urine infections

ALLERGIES

Are you allergic to any medications? ☐ YES ☐ NO If yes, please list below:

Medicine: _____ Reaction: _____

Medicine: _____ Reaction: _____

Medicine: _____ Reaction: _____

Medicine: _____ Reaction: _____

Are you allergic to any foods, dyes, or other?

Please explain:

_____

_____

_____

IMMUNIZATIONS

Do you get the Influenza vaccine every year? ☐ YES ☐ NO Date last received: _____

Have you ever had the Pneumonia vaccine? ☐ YES ☐ NO Date last received: _____

Have you ever had the TB skin test? ☐ YES ☐ NO Date last received: _____

FAMILY HISTORY

	Age	Alive (yes or no)	Medical Problems	Cause of Death
Father:				
Mother:				
Sibling:				
Sibling:				
Sibling:				
Child:				
Child:				
Child:				

NAME: _____ DOB: _____

SOCIAL HISTORY

Birthplace: _____

Marital Status: □ Single □ Married □ Divorced □ Widowed □ Separated

Pets at home: □ NO □ YES _____

Alcohol use: Now? □ YES □ NO In the past? □ YES □ NO

How many drinks? ___ Day ___ Week ___ Month

Smoking: Now? □ YES □ NO In the past? □ YES □ NO

Age started _____ Age Quit _____ Packs per day _____

Any use of weight loss medications? _____

Occupation: _____

Have you ever been exposed to the following? Please check all that apply.

□ Asbestos □ Dust □ Metal □ Mining □ Wheat dust □ Chemicals

Have you ever had a positive TB skin test? □ YES □ NO

Have you ever been exposed to TB (tuberculosis)? □ YES □ NO

Where have you lived? _____

Have you traveled abroad? If so, where? _____

_____

MEDICATIONS

Please list ALL medications: Dose How often?

_____

_____

_____

_____

_____

_____

(Additional lines next page)

SURGERIES

Year Where

HOSPITALIZATIONS

Year Where

MEDICAL PROBLEMS

NAME: _____ DOB: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information, to notify you of our legal duties and privacy practices with respect to your health information, and to notify affected individuals following a breach of unsecured health information. This Notice summarizes our duties and your rights concerning your information. Our duties and your rights are set forth more fully in 45 CFR Part 164. We are required to abide by the terms of our Notice that is currently in effect.

1.Uses and Disclosures We May Make Without Written Authorization. We may use or disclose your health information for certain purposes without your written authorization, including the following:

Treatment. We may use or disclose your information for purposes of treating you. For example, we may disclose your information to another health care provider so they may treat you; to provide appointment reminders; or to provide information about treatment alternatives or services we offer.

Payment. We may use or disclose your information to obtain payment for services provided to you. For example, we may disclose information to your health insurance company or other payer to obtain pre-authorization or payment for treatment.

Healthcare Operations. We may use or disclose your information for certain activities that are necessary to operate our practice and ensure that our patients receive quality care. For example, we may use information to train or review the performance of our staff or make decisions affecting the practice.

Other Uses or Disclosures. We may also use or disclose your information for certain other purposes allowed by 45 CFR § 164.512 or other applicable laws and regulations, including the following:

- To avoid a serious threat to your health or safety or the health or safety of others.
- As required by state or federal law such as reporting abuse, neglect or certain other events.
- As allowed by workers compensation laws for use in workers compensation proceedings.
- For certain public health activities such as reporting certain diseases.
- For certain public health oversight activities such as audits, investigations, or licensure actions.
- In response to a court order, warrant or subpoena in judicial or administrative proceedings.

For certain specialized government functions such as the military or correctional institutions.
For research purposes if certain conditions are satisfied.
In response to certain requests by law enforcement to locate a fugitive, victim or witness, or to report deaths or certain crimes.

To coroners, funeral directors, or organ procurement organizations as necessary to allow them to carry out their duties.

2. Disclosures We May Make Unless You Object. Unless you instruct us otherwise, we may disclose your information as described below.
To a member of your family, relative, friend, or other person who is involved in your healthcare or payment for your healthcare. We will limit the disclosure to the information relevant to that person's involvement in your healthcare or payment.

3.Uses and Disclosures with Your Written Authorization. Other uses and disclosures not described in this Notice will be made only with your written authorization, including most uses or disclosures of psychotherapy notes; for most marketing purposes; or if we seek to sell your information. You may revoke your authorization by submitting a written notice to the Privacy Contact identified below. The revocation will not be effective to the extent we have already acted in reliance on the authorization.

4. Your Rights Concerning Your Protected Health Information. You have the following rights concerning your health information. **To exercise any of these rights, you must submit a written request to the Privacy Officer identified below.**
You may request additional restrictions on the use or disclosure of information for treatment, payment, or healthcare operations. We are not required to agree to the requested restriction except in the limited situation in which you or someone on your behalf pays for an item or service, and you request that information concerning such item or service not be disclosed to a health insurer. We normally contact you by telephone or mail at your home address. You may request that we contact you by alternative means or at alternative locations. We will accommodate reasonable requests. You may inspect and obtain a copy of records that are used to make decisions about your care or payment for your care, including an electronic copy. We may charge you a reasonable cost-based fee for providing the records. We may deny your request under limited circumstances, e.g., if we determine that disclosure may result in harm to you or others. You may request that your protected health information be amended. We may deny your request for certain reasons, e.g., if we did not create the record of if we determine that the record is accurate and complete. You may receive an accounting of certain disclosures we have made of your protected health information. You may receive the first accounting within a 12-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that 12-month period. You may obtain a paper copy of this Notice upon request. You have this right even if you have agreed to receive the Notice electronically.

5. Changes to This Notice. We reserve the right to change the terms of this Notice at any time, and to make the new Notice effective for all protected health information that we maintain. If we materially change our privacy practices, we will post a copy of the current Notice in our reception area and on our website. You may obtain a copy of the operative Notice from our receptionist or Privacy Officer.

6. **Complaints**. You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying our Privacy Officer. All complaints must be in writing. We will not retaliate against you for filing a complaint.

7. Contact Information. If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact:

Courtney Wade, MBA-HM
Practice Administrator
Phone: (941) 366-5864 ext. 810
Address: 1921 Waldemere St., Ste. 705
Sarasota, FL 34239
E-mail: cwade@lung-associates.com

Effective Date. This Notice is effective as of March 15, 2021

Lung Associates of Sarasota Follow My Health Patient Portal

A patient portal is a web-based pathway that gives existing patients access to a secure, convenient way to manage their personal health care information at Lung Associates of Sarasota.

How Can the Portal Help Me?

The patient portal allows you to view, track, and update your medical record.
Request appointments and prescription refills
Communicate non-urgent messages

How Do I Start?

1. Invitation E-mail - Let the staff know your email address and you will receive a portal invitation. You will also be informed of your security code to set up your user name and password. If you do not get the email, check your junk or spam folder. In the email will be a link to the Follow My Health Portal. Keep the email open until you are completely registered. This link ties and transmits your medical health record to the new portal account.

2. Lung Associates Website – If you go to our website at www.lung-associates.com, you will find a link to register for the portal.

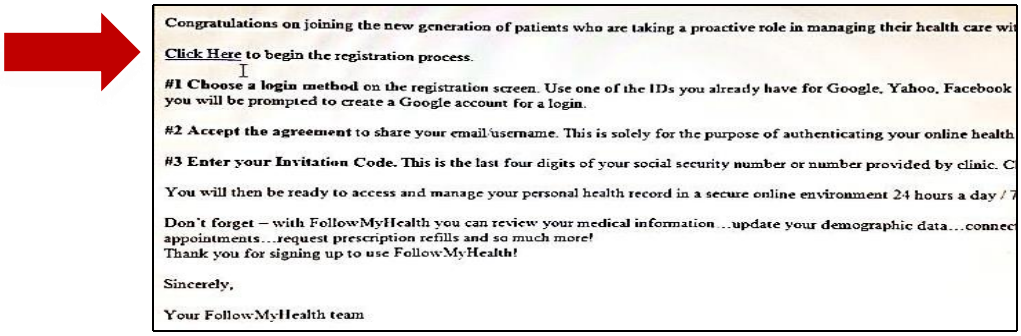
Follow My Health Requirements:

Supported browers: Internet Explorer 8.0 or higher, Modern versions of Chrome, Firefox, and Safari.

Welcome to a new way of keeping track of your health status at Lung Associates of Sarasota!

Steps to Set-up Patient Portal

1. Patient receives an e-mail titled "FollowMyHealth - Invitation to join Lung Associates of Sarasota". Open this e-mail. Click "Click Here" to begin the registration process.



Congratulations on joining the new generation of patients who are taking a proactive role in managing their health care wit

Click Here to begin the registration process.

#1 Choose a login method on the registration screen. Use one of the IDs you already have for Google, Yahoo, Facebook you will be prompted to create a Google account for a login.

#2 Accept the agreement to share your email/username. This is solely for the purpose of authenticating your online health

#3 Enter your Invitation Code. This is the last four digits of your social security number or number provided by clinic. C

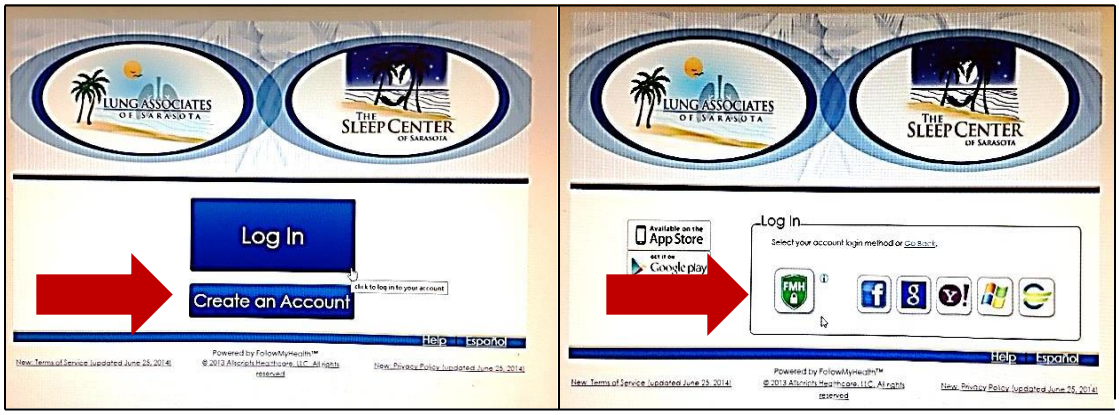
You will then be ready to access and manage your personal health record in a secure online environment 24 hours a day / 7

Don't forget – with FollowMyHealth you can review your medical information…update your demographic data…connec appointments…request prescription refills and so much more!
Thank you for signing up to use FollowMyHealth!

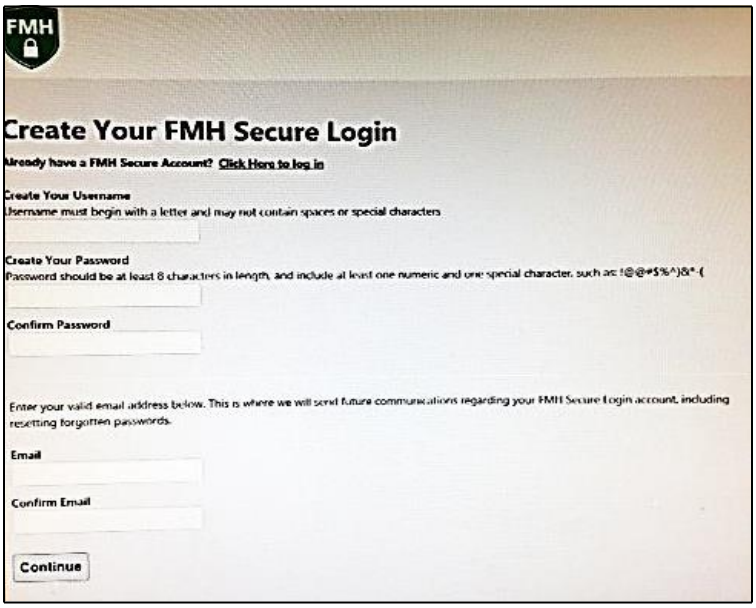
Sincerely,

Your FollowMyHealth team

2. Click "Create an Account". Pop-up appears. Click "FMH" icon.



3. Pop-up appears titled "Create Your FMH Secure Login". Create a username and password. Password needs 8 characters minimum with one numeric and one symbol. Write username and password down. FollowMyHealth and Lung Associates don't have access to password if forgotten. Enter your e-mail address & click "Continue".



4. Pop-up appears prompting agreement acceptance. Click "Accept" and follow prompts. During the process, an invitation code will be requested. This code is the last four digits of your social security number.

5. To confirm account link is correct, a pop-up will show files transferring from a building to a file. Once this process is completed, you will see a "Home" page. Take the time to view "First Walk Through" tutorial.

6. To complete set-up, send an e-mail to your physician to confirm the connection. Email can be sent from "Inbox".

Designation of Health Care Surrogate

Name: _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: _____
Address: _____
City: _____ State: _____
Phone: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: _____
Address: _____
City: _____ State: _____
Phone: _____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: _____

Name: _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf, or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.
Additional instructions (optional):

_____
_____
_____
_____

Signed _____ Date: _____

Witnesses: 1. _____

2. _____

At least one witness must not be a husband or wife or a blood relative of the principal.

THE EPWORTH SLEEPINESS SCALE

Name:_____

Today's Date:_____ Your Age: (years)_____

How likely are you to doze off or just fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent time. Even if you have not 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

Situation	**Chance of dozing**
Sitting and Reading	_____
Watching T.V.	_____
Sitting, inactive in a public Place (theater or a meeting)	_____
As a passenger in a car for 1 hour without a break	_____
Lying down to rest in The afternoon when Circumstances permit	_____
Sitting and Talking to someone	_____
Sitting quietly after lunch Without alcohol	_____
In a car, while stopped For a few minutes in Traffic	_____

Thank you for your cooperation!

LUNG ASSOCIATES OF SARASOTA
Associates in Sleep Medicine

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION

I hereby request and authorize Lung Associates of Sarasota to obtain the health records of:

Name: _____ DOB: _____

( ) All general medical records, including HIV/AIDS, substance abuse, and psychiatric records.

( ) Limited records (i.e. lab results, EKG, MRI, X-rays, CT, etc.) _____

Please Fax Records To (For Staff Use): _____

PROHIBITION ON RE-DISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosures of such information without the express written consent of the person to who such information pertains, or as otherwise permitted by state law. With regard to HIV/AIDS, substance abuse, or psychiatric records; a specific written consent is required – a general authorization for the release of medical or other information is NOT sufficient for this purpose.

In the event these records are being requested other than for the personal use of the patient or an attending physician, a charge may be assessed in accordance with Florida State Statute 395.3025.

_____ _____

Date signed Signature or patient or authorized representative

Authorized Representative: ( ) Parent ( ) Surviving Spouse
( ) Legal Guardian/Administrator/Executor*

*If Legal Guardian, Administrator, or Executor, legal proof of this status must accompany this authorization.

The patient or authorized representative may revoke this authorization at any time after it is signed by submitting a written request to the facility.