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

This form does not constitute legal advice and covers only federal, not state, law.

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

Name:____ DOB:____________

First Middle Last

Pharmacy Name and Address: ____

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

(Check all that apply)

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

ALLERGIES

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

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:				
Child:				
Child:				

Birthplace: ______________________________

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

Occupation: ______________________________

MEDICAL PROBLEMS

____

____

____

SURGERIES

	Year	Where

HOSPITALIZATIONS

	Year	Where

Initials: ____________ Date: ______________

How did you first hear about our sleep center?

- ❑ Physician
- ❑ Relative
- ❑ Friend
- ❑ Newspaper/Journal/Magazine/T.V. ________________________________
- ❑ Radio
- ❑ Seminar
- ❑ Sleep Society
- ❑ Other: ______________________

1. Describe your main problem(s) in your own words, including when and how this began and what treatment you have received for this in the past.

2. How often does this problem occur?

   - ❑ Almost every night
   - ❑ For periods of at least one week
   - ❑ Irregularly
   - ❑ Other______________________

3. How long has this problem bothered you?

   - ❑ Longer than 2 years
   - ❑ 1 to 2 years
   - ❑ Several months
   - ❑ Within the last 3 months
   - ❑ Within the last month

4. On the scale below, please estimate the severity of your problem(s)

________	________	________	________	________
Mildly Upsetting	Moderately Upsetting	Very Severe	Extremely Severe	Totally Incapacitated

5. How strongly do you want help with your sleep problems?

________	________	________	________
Very Much	Much	Moderately	Could do Without

Initials: ___________ Date: _____________

6. How do you describe your sleep problems? (Check all that apply)

- ❑ Difficulty falling asleep
- ❑ Wake up during the night
- ❑ Wake up early in the morning
- ❑ Excessive daytime sleepiness
- ❑ Difficulty awakening

7. Do any other members of your family have sleep problems? Please explain:

8. Have you ever consulted with any of the following to help you with a sleep problem or daytime sleepiness?

- ☐ General Practitioner
- ☐ Obstetrics/Gynecology
- ☐ Cardiologist
- ☐ Other Internist
- ☐ Psychiatrist
- ☐ Other Physician
- ☐ Clinical Psychologist
- ☐ Chiropractor
- ☐ Osteopath
- ☐ Nutritionist
- ☐ Counselor
- ☐ Social Worker
- ☐ Nurse
- ☐ Clergyman

- ☐ Other_____________________

9. What treatments have you received?

10. Please rate how often you do the following:

	Never	Rarely	Sometimes	Frequently	Constantly
Awaken from sleep Short of breath	______	_______	________	_______	_______
Awaken at night with Heartburn, belching, or Cough	______	_______	________	_______	_______

Initials: ___________ Date: _____________

	Never	Rarely	Sometimes	Frequently	Constantly
Snore	______	______	______	______	______
Snore loudly enough That others complain	______	______	______	______	______
Have trouble sleeping When you have a cold	______	______	______	______	______
Suddenly wake up Gasping for breath During the night	______	______	______	______	______
Have breathing problems At night (observed by self Or others)	______	______	______	______	______
Sweat excessively at Night	______	______	______	______	______
Notice your heart pounding Or beating irregularly during The night	______	______	______	______	______
Fall asleep during the day	______	______	______	______	______
Fall asleep involuntarily	______	______	______	______	______
Fall asleep while Driving	______	______	______	______	______
Fall asleep during Physical effort	______	______	______	______	______
Fall asleep when laughing Or crying	______	______	______	______	______
Experience loss of Muscle tone when Extremely emotional	______	______	______	______	______
Have trouble at school Or work because of Sleepiness	______	______	______	______	______
Feel unable to move (paralyzed) when waking or falling asleep	______	______	______	______	______

Initials: ____________ Date: ______________

Experience vivid dream-
Like scenes upon
Awakening or falling asleep ______ ______ ______ ______ ______

Feel afraid of going to sleep ______ ______ ______ ______ ______

Have nightmares ______ ______ ______ ______ ______

Remember your dreams ______ ______ ______ ______ ______

Have thoughts racing
Through your mind ______ ______ ______ ______ ______

Feel sad and depressed ______ ______ ______ ______ ______

Have anxiety (worry
About things) ______ ______ ______ ______ ______

Have muscular tension ______ ______ ______ ______ ______

Notice parts of your
Body jerk ______ ______ ______ ______ ______

Experience crawling and
Aching feelings in your
Legs ______ ______ ______ ______ ______

Experience any type of leg
Pain during the night ______ ______ ______ ______ ______

Have morning jaw pain ______ ______ ______ ______ ______

Grind teeth during sleep ______ ______ ______ ______ ______

Are bothered by pain
During the day ______ ______ ______ ______ ______

Are awakened by pain
During the night ______ ______ ______ ______ ______

Wake up feeling stiff
In the mornings ______ ______ ______ ______ ______

Wake up with sore or
Achy muscles ______ ______ ______ ______ ______

Wake up with pain in
Neck, spine or joints ______ ______ ______ ______ ______

Initials: ____________ Date: ______________

11. Is your present work situation satisfactory?

12. Check any of the following that apply to you

- ☐ Headaches
- ☐ Palpitations
- ☐ Bowel Disturbances
- ☐ Nightmares
- ☐ Feel tense
- ☐ Depressed
- ☐ Unable to relax
- ☐ Don't like weekends and vacations
- ☐ Can't keep a job
- ☐ Financial problems
- ☐ No Appetite
- ☐ Alcoholism
- ☐ Take drugs
- ☐ Can't make decisions
- ☐ Unable to have a good time
- ☐ Take antacids regularly (tums, tagamet, etc)
- ☐ Dizziness
- ☐ Stomach trouble
- ☐ Fatigue
- ☐ Take sedatives
- ☐ Feel panicky
- ☐ Suicidal thoughts
- ☐ Sexual problems
- ☐ Overambitious
- ☐ Memory Problems
- ☐ Inferiority feelings
- ☐ Fainting spells
- ☐ Insomnia
- ☐ Tremors
- ☐ Shy with people
- ☐ Home conditions bad
- ☐ Concentration difficulties
- ☐ Other

13. Circle any of the following words that apply to you:

Worthless Useless a "nobody" "life is empty" Inadequate stupid

Incompetent naïve "can't do anything right" Guilty Evil Morally wrong

Horrible thoughts Hostile full of hate Anxious Agitated Cowardly

Unassertive Panicky Aggressive Ugly Deformed Lonely Unloved

Misunderstood Bored Restless Confused Unconfident In conflict

Full of regrets Worthwhile Sympathetic Intelligent Attractive

Confident Considerate Other____

14. Does your sleep problem disturb your sex life? (Provide any information about any significant relationships.)

Initials: ___________ Date: _____________

15. Is your present social life satisfactory? Does your sleep problem require you to cut back on social activity? If so, how?

16. How many hours do you usually sleep per night? ______________________

17. What time do you usually go to bed on Weekdays? ___________ Weekends? _____________

18. How long does it take for you to fall asleep?____

19. How many times do you typically wake up at night?____

20. If you wake up, on the average, how long to you stay awake?________________________________

21. If you do waken during the night (after you first fall asleep) which part(s) of your sleep period is it?

- ❑ Soon after falling asleep
- ❑ Middle of the night
- ❑ Early morning

22. What do you usually do when you awaken during the night?___________________________________

____

23. What time do you usually awaken in the morning on Weekdays? _________ Weekends? _________

24. On the average, how long do you stay in the bed after waking up in the morning? _________________

25. Do you usually: (check all that apply to you)

- ❑ 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)

26. Is your sleep often disturbed by?

- ❑ Heat
- ❑ Cold
- ❑ Noise
- ❑ Light
- ❑ Bed partner
- ❑ Not being in your usual bed
- ❑ Other____

Initials: ___________ Date: _____________

27. Are your sleep habits on weekends different from the rest of the week?

- ❑ No
- ❑ Yes – Please describe____

28. With whom are you now living? (spouse, children, parents, etc.) please list ages

____

____

____

29. Do you work split shifts or rotating (variable) shifts?____

30. Do you usually drink coffee or tea within 2 hours before you go to bed? ☐ Yes ☐ No

31. Do you perform physical exercise before going to bed? ☐ Yes ☐ No

32. Do you read before falling asleep? ☐ Yes ☐ No

33. Do you watch T.V. in bed before falling asleep? ☐ Yes ☐ No

34. Do you take naps during the afternoon or evening? ☐ Yes ☐ No

35. Do you feel refreshed after a short (10-15) min nap? ☐ Yes ☐ No

36. Do you feel rested after an average night of sleep? ☐ Yes ☐ No

37. Do you feel better during:

- ❑ Morning
- ❑ Afternoon
- ❑ Evening

38. Please list all medications you are currently taking:

Medication	Amount	Frequency	Reason

Initials: ____________ Date: ______________

39. List your consumption of the following per day:

Coffee______________ Colas_____________ Teas______________

Nicotine_____________ Alcohol____________ Chocolate__________

Other_______________ Over the counter medications__________________

40. Have you had a car accident or near-miss crash associated with drowsiness/excessive sleepiness?

Yes ______________ No _______________

41. What is your personal interpretation as to why you have your particular sleep/wake problems?

42. Please describe any other information pertinent to your sleep wakefulness not previously described.

Initials: ______________ Date: _______________

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!

SF-12 Health Survey This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. **Answer each question by choosing just one answer**. If you are unsure how to answer a question, please give the best answer you can.

Patient name: ____

Date: ___________________________

1. **In general, would you say your health is**:

☐1 Excellent ☐2 Very good ☐3 Good ☐4 Fair ☐5 Poor

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	YES, limited a lot	**YES, limited a little**	**NO, not limited at all**
2. **Moderate activities** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	☐1	☐2	☐3
3. Climbing **several** flights of stairs.	☐1	☐2	☐3

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities because of your physical health?

	YES	**NO**
4. **Accomplished less** than you would like.	☐1	☐2
5. Were limited in the **kind** of work or other activities.	☐1	☐2

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities because of any emotional problems (such as feeling depressed or anxious)?

	YES	**NO**
6. **Accomplished less** than you would like.	☐1	☐2
7. Did work or activities **less carefully than usual**.	☐1	☐2

8. **During the past 4 weeks, how much did pain interfere with your normal work (including work outside the home and housework)?**

☐1 Not at all ☐2 A little bit ☐3 Moderately ☐4 Quite a bit ☐5 Extremely

These questions are about how you have been feeling during the past 4 weeks.
For each question, please give the one answer that comes closest to the way you have been feeling.
How much of the time during the past 4 weeks?

	All the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm & peaceful?	☐1	☐2	☐3	☐4	☐5	☐6
10. Did you have a lot of energy?	☐1	☐2	☐3	☐4	☐5	☐6
11. Have you felt downhearted and blue?	☐1	☐2	☐3	☐4	☐5	☐6

12. **During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?**

☐1 All of the time ☐2 Most of the time ☐3 Some of the time ☐4 A little of the time ☐5 None of the time

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.

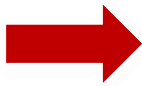
Follow My Health Requirements:

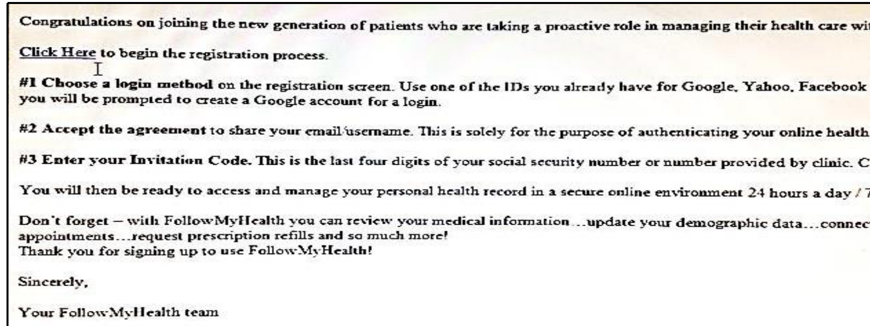
Supported browers: Internet Explorer 8.0 or higher, Modern versions of Chrome, Firefox, and Safari.

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 wi

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

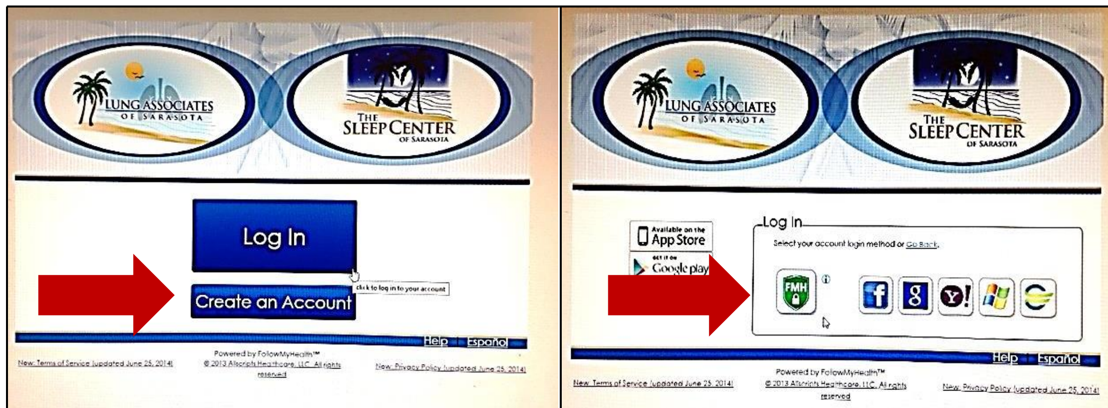
You will then be ready to access and manage your personal health record in a secure online environment 24 hours a day / 7

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.

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.