

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 7<sup>th</sup> 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	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: <input type="checkbox"/> CASH <input type="checkbox"/> CHECK <input type="checkbox"/> 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)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Fever/chills or sweats | <input type="checkbox"/> Coughing up blood     | <input type="checkbox"/> Heartburn              |
| <input type="checkbox"/> Weight loss or gain    | <input type="checkbox"/> Shortness of breath   | <input type="checkbox"/> Ulcers                 |
| <input type="checkbox"/> Fatigue/tiredness      | <input type="checkbox"/> Wheezing              | <input type="checkbox"/> Vomiting or nausea     |
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Chest tightness       | <input type="checkbox"/> Dark or bloody stools  |
| <input type="checkbox"/> Allergies/hay fever    | <input type="checkbox"/> Pain with breathing   | <input type="checkbox"/> Frequent urination     |
| <input type="checkbox"/> Eye/vision problems    | <input type="checkbox"/> Snoring               | <input type="checkbox"/> Burning urination      |
| <input type="checkbox"/> Ear/hearing problems   | <input type="checkbox"/> Calf or leg pain      | <input type="checkbox"/> Easy bruising          |
| <input type="checkbox"/> Nose/nasal problems    | <input type="checkbox"/> Chest pain/angina     | <input type="checkbox"/> Aching muscles         |
| <input type="checkbox"/> Postnasal drip         | <input type="checkbox"/> Dizzy spells          | <input type="checkbox"/> Anxious feelings       |
| <input type="checkbox"/> Swollen glands         | <input type="checkbox"/> Stomach trouble       | <input type="checkbox"/> Frequent thirst/hunger |
| <input type="checkbox"/> Coughing spells        | <input type="checkbox"/> Indigestion           | <input type="checkbox"/> Blood in urine         |
| <input type="checkbox"/> Coughing up phlegm     | <input type="checkbox"/> Constipation/diarrhea | <input type="checkbox"/> Other _____            |

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

(Check all that apply)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anemia         | <input type="checkbox"/> Hay fever           | <input type="checkbox"/> Phlebitis, blood clots |
| <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Heart attack/Angina | <input type="checkbox"/> Prostate problems      |
| <input type="checkbox"/> Asthma         | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Rashes                 |
| <input type="checkbox"/> Bone fractures | <input type="checkbox"/> Heart murmur        | <input type="checkbox"/> Rheumatic fever        |
| <input type="checkbox"/> Bronchitis     | <input type="checkbox"/> Heart valve disease | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Cancer         | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sinusitis              |
| <input type="checkbox"/> Depression     | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Sleep problems         |
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Kidney stones       | <input type="checkbox"/> Stroke or TIA's        |
| <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Thyroid problems       |
| <input type="checkbox"/> Gastric reflux | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> Ulcers                 |
| <input type="checkbox"/> Gout           | <input type="checkbox"/> Pneumonia           | <input type="checkbox"/> 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  SeparatedPets 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  ChemicalsHave you ever had a positive TB skin test?  YES  NOHave 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:DoseHow often?

<u>Please list ALL medications:</u>	<u>Dose</u>	<u>How often?</u>

(Additional lines next page)

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

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**SURGERIES**

Year

Where

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**HOSPITALIZATIONS**

Year

Where

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**MEDICAL PROBLEMS**

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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 or 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](mailto: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](http://www.lung-associates.com), you will find a link to register for the portal.

### Follow My Health Requirements:

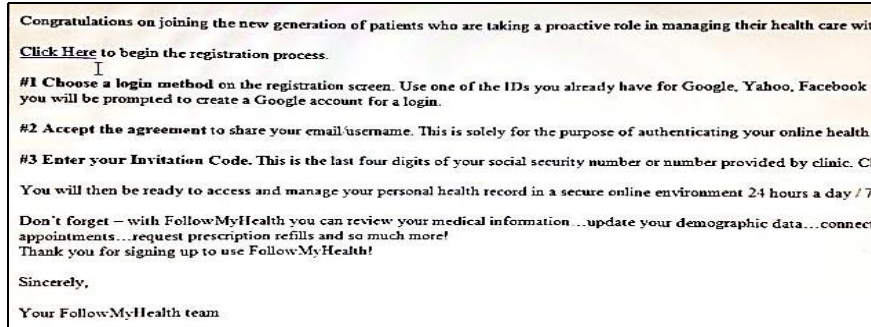
Supported browsers: Internet Explorer 8.0 or higher, Modern versions of Chrome, Firefox, and Safari.

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

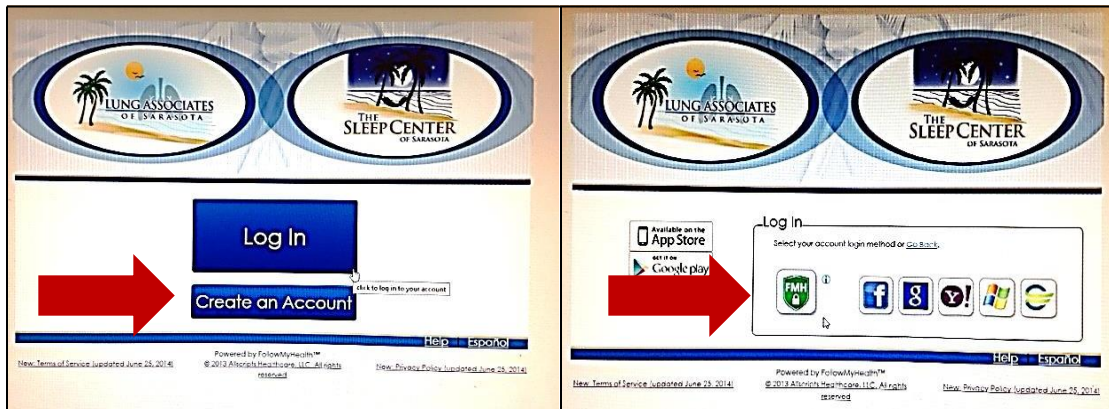


## Steps to Set-up Patient Portal

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.



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".

**FMH**

### Create Your FMH Secure Login

Already have a FMH Secure Account? [Click Here to log in](#)

**Create Your Username**  
Username must begin with a letter and may not contain spaces or special characters.

**Create Your Password**  
Password should be at least 8 characters in length, and include at least one numeric and one special character, such as: !@#%&^)\*&\*(

**Confirm Password**

Enter your valid email address below. This is where we will send future communications regarding your FMH Secure Login account, including resetting forgotten passwords.

**Email**

**Confirm Email**

**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!**