Chest & Sleep Medicine Consultants, PLC

2284 S. Ballenger Hwy Ste. H-2, Flint, MI 48503
Telephone (810) 720-1144 Fax (810) 720-1166

Joseph K. Varghese, MD., FCCP, Venkat K. Rao MD., FCCP, John Youssef, MD., Abhijeet Ghatol, MD., Anas Moughrabieh MD., Peter Sabbagh MD. & Dr. Emad Alkhankan MD

Insurance Authorization

Date of Birth_____/_____/_____ Social Security Number_____-____-_____

Name_____

Address_____ City_____

State_____ Zip _____

Phone (____) _____ Cell Phone (____)_____

Email address (for confirming appts) _____

Pharmacy (address, phone #) _____

Primary Care Physician (address, phone #)_____

Medicare Authorization for Signature on File:

I request that payment of authorized Medicare Benefits be made on my behalf to Chest and Sleep Medicine Consultants, PLC for any services furnished me by the physician when submitted on approval claim forms or electronically submitted claims. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services (CMS) and its agent any information needed to determine these benefits payable to related services.

Signature_____ Date_____

Private Insurance Authorization for Assignment of Benefits and Release of Information:

I, hereby instruct and direct my insurance company for payment for payment of medical benefits to Chest and Sleep Medicine Consultants, PLC for services rendered to me by the physician. This is a direct assignment of my rights and benefits under the policy. This payment will not exceed my indebtedness to the above mentioned assignee and I have agreed to pay, in a current manner, any balances of said professional services charges over and above this insurance payment. A photocopy of this agreement shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to any insurance company or person involved in my case.

Signature_____Date_____

Referral Agreement:

This physician's office has notified me that my insurance requires authorization to be seen by a physician specialist. My insurance is likely to deny payment for the services rendered to me if I do not provide a referral from my primary physician. The physician specialist will bill my insurance for the services, but if my insurance denies payment, I agree to be personally and fully responsible for payment.

Signature_____Date_____

History and Physical

Name _____ **Date** _____

DOB _____

Marital Status: **Single** **Divorced** **Married** **Widow**

What sex were you assigned at birth? **Male** **or** **Female**
What is your current gender identity? _____

Past Medical History (Place a check mark)

__ COPD
__ Emphysema
__ Asthma
__ Chronic Bronchitis
__ Arthritis
__ Blood Clots
__ Hiatal Hernia
__ Heart Disease
__ Seizures
__ Diabetes
__ Stroke
__ Heart Attack
__ Breast Bx
__ Thyroid
__ Other Cancers
__ Sleep Apnea
__ C-Pap Machine
__ Other

Surgical History (Place a check mark)

__ Heart Bypass/Date _____
__ Heart Stents
__ Angioplasty
__ Carotid Endarterectomy
__ Appendix
__ Gall Bladder
__ Hysterectomy
__ Aneurysm
__ Mastectomy
__ Tonsillectomy
__ Other Surgeries
_____
__ Breast Bx
__ Hernia Repair
__ "C" Section
__ Lung Resection

Family History (Place a check mark and state who had the disease)

__ Asthma _____
__ Heart Disease _____
__ High Blood Pressure _____
__ Diabetes _____
__ Stroke _____
__ Blood clots _____
__ COPD _____
__ Lung Cancer _____
__ Other Cancer _____
__ Heart Attack _____

Social History

Do you smoke now? YES or NO
If yes, how many pack per day _____ for how many years _____
Did you smoke in the past? _____ If yes, when did you quit? _____
If yes, how many packs per day _____ for how many years _____
How much beer or alcohol do you drink daily? _____
How much do you drink per week? _____
Do you use recreational drugs? _____ what and how often _____

Work History

What do you do for a living? _____
If retired, what type of work did you do? _____
Do you have any pets in home? Yes or No (Example/Amount)_____
Hobbies _____

History and Physical

Name _____ **Date** _____

DOB _____ **Race** _____

Your main concern for seeing the doctor today:

_____

Symptoms and Complaints you currently have:

_____

Lung/Heart:

__ Shortness of breath at rest
__ Shortness of breath with activity
__ Shortness of breath at night
__ Shortness of breath when lying flat
__ Wheezing at rest
__ Wheezing at night
__ Wheezing with activity
__ Chest pain (Describe type: sharp, burning, heavy)
__ Coughing (how much) _____
__ Any blood in sputum
__ Sputum (color & amount) _____

How far can you walk before you have to stop?
_____

How many flights of stairs can you go up without stopping? _____
_____

Stomach:

__Heartburn
__ Nausea
__ Vomiting
__ Loss of appetite
__ Weight Loss/Gain
__ Constipation
__ Diarrhea
__ Abdominal Cramps

Head/Neck:

__ Sinus Drainage (how often) _____
__ Sinus Headache
__ Nasal Drainage (what color) _____
__ Nasal Stuffiness

Other:

__ Sweating at night
__ Sweating during the day
__ Fevers
__ Chills
__ Weight loss (how much) _____
__ Leg Swelling
__ Weakness
__ Headache
__ Sleepy during the day
__ Dizziness
__ Difficulty getting to sleep
__ Wake up gasping for breath
__ Stop breathing during sleep
__ Feeling tired in morning
__ Snoring How Loud _____
__ Wake up with Dry mouth
__ Difficulty sleeping

ALLERGIES TO MEDS	
MEDICATIONS	**DOSAGE**

NAME_____

Chest & Sleep Medicine Consultants, PLC

Pulmonary, Critical Care & Sleep Medicine
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PERMISSION TO DISCUSS/RELEASE PATIENT HEALTH INFORMATION

(PLEASE PRINT)

Patient Name:_____ DOB:_____

I hereby give my permission to the person(s) listed below to receive any information including but not limited to x-rays, prescriptions, itemized bills or appointments, etc about the care of the above named patient.

NAME	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____
Signature of Patient, Parent, or Guardian

_____
Date

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CONSENT FOR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION

Our purpose in asking you to sign this form is to document that we have informed you that this office may use and disclose all your health information in our possession (collectively "Protected Health Information").

The uses and disclosures by this office of your Protected Health Information are necessary and will be used by this office in connection with your treatment, our obtaining payment for treatment and services that this office provides to you and so that this office can conduct its health care operations.

For a more complete description of how this office may use or disclose your Protected Health Information, please carefully review that Notice of Privacy Practices Form that this office has prepared and is furnishing to you today. Please also see our Notice of Privacy Practices Form for a more detailed discussion of the meanings of "treatment", "payment" and "health operations".

YOU HAVE THE RIGHT TO REVIEW OUR NOTICE OF PRIVACY PRATICES FORM PRIOR TO SIGNING THIS CONSENT. PLEASE BE ADVISED THAT THE NOTICE OF PRIVACY PRACTICES FORM MAY BE REVISED BY THIS OFFICE FROM TIME TO TIME. ANY SUCH REVISED NOTICE OF PRIVACY PRACTICES FORM WILL BE MADE AVAILABLE TO YOU BY CONTACTING CHEST& SLEEP MEDICINE CONSULTANTS, PLC

YOU SHOULD ALSO REVIEW CAREFULLY THE NOTICE OF PRIVACY PRACTICES FORM BECAUSE IT CONTAINS A LIST OF RIGHTS THAT ARE AVAILABLE TO YOU WITH RESPECT TO THIS OFFICES'S USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. THESE RIGHTS INCLUDE YOUR RIGHT TO REQUEST RESTRICTIONS ON OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION.

YOU HAVE THE RIGHT TO REVOKE THIS CONSENT AT ANY TIME. IF YOU WISH TO REVOKE THIS CONSENT, YOU MUST DO SO IN WRITING.

BY SIGNING BELOW, YOU ACKNOWLEGDE THAT YOU HAVE READ AND UNDERSTAND THIS CONSENT AND THIS OFFICE'S NOTICE OF PRIVACY PRACTICES FORM. YOU FURTHER ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF THIS OFFICES'S NOTICE OF PRIVACY PRACTICES FORM TO TAKE WITH YOU.

Patient Signature _____ Date Signed by Patient _____

Witness Signature _____ Date Signed by Witness _____

Release of Medical Information

Patient:_____

Address:_____

DOB:_____ SS#_____

Released From:
*
*

Released to: Chest & Sleep Med Consultants PLC
2284 S. Ballenger Hwy. Ste H-2 Flint, MI 48503
Tel (810) 720-1144 – Fax (810) 720-1166

SPECIFIC INFORMATION TO BE DISCLOSED:
_____All records
_____Other _____

- Communicable disease and infection information as defined by statue and Michigan Department of Public Health rules (which includes Venereal disease "VD", tuberculosis "TB", hepatitis B, human immuno deficiency virus "HIV", acquired immuno deficiency syndrome "AIDS" , and AIDS related complex "ARC")
- Alcohol and / drug abuse treatment information protected under regulations in 42 Code of Federal Regulations, Part 2.
- Mental health treatment records, psychological services and social services information, including communications made by me to a social worker or psychologist.

The purpose and need for disclosure:_____Transfer of Care
_____Attorney Request_____Disability_____Worker's Comp.
_____Social Security_____Insurance_____Other_____

I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing at any time by sending notification to the Privacy officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.

I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under Federal and state laws (HIPPA)

I understand the Practice will not condition my treatment, payment. Enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization on the requested use or disclose. Further, if the practice will receive payment for obtaining this information, I understand that I will be notified of the same.

I understand that information used or disclosed pursuant to this may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Without expressed written revocation, this consent expires in one year.

_____ _____
Signature of ___Patient___Personal Representative Printed Name

_____ _____
Date If signed by representative person, Relationship to patient