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________________

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

Chest & Sleep Medicine Consultants, PLC

Pulmonary, Critical Care & Sleep Medicine

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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

McLAREN FLINT
SLEEP DIAGNOSTIC CENTER

Beech-Hill Centre · G-3200 Beecher Road, Suite z z z · Flint, MI 48532 · (810) 342-3900

PATIENT ASSESSMENT

Please complete the following questionnaire and return as soon as possible in the enclosed envelope.

Call if you have any questions (810) 342-3900.

Today's Date: ______________________ Usual Bedtime: ______________________

Name: ______________________ Date of Birth: ______________________

Best time of day and number to reach you: __________ AM/PM Phone #: ______________________

Current Weight: __________ Height: __________ Sex: ☐ Male ☐ Female

"X" OR CIRCLE THE CORRECT ANSWER OR WRITE REQUESTED INFORMATION

1. Describe the sleep or wake problem that concerns you.

____

____

____

*Do any other members of your family have sleep problems? If yes, explain.

____

____

2. How long have you had this problem? ______________________

3. Have you had a sleep evaluation or study before this? ☐ Yes ☐ No

3a. When? ______________________

3b. What kind? ______________________

3c. Where? ______________________

3d. Treatment? ______________________

3f. Are you currently using it? ☐ Yes ☐ No

3g. How many night(s) per week: __________

680b

PT.

MR.#/P.M.

DR

4. What is your occupation? ______________________________

Do you work rotating shifts? ☐ Yes ☐ No Third Shift? ☐ Yes ☐ No

5. What time do you usually go to bed? Weekdays: ____________ AM / PM

Weekends: ____________ AM / PM

6. What time do yo usually get up? Weekdays: ____________ AM / PM

Weekends: ____________ AM / PM

7. How long does it take you to fall asleep at night? ____________ minutes

8. Do you awake during your sleep? ☐ Yes ☐ No

If yes, do you know why you awaken? ______________________________

How long does it take you to get back to sleep? ____________ minutes

9. How long altogether are you awake during your night's sleep time? ____________ minutes

10. What is the total number of hours of sleep that you usually get at night? ____________ hours
(do not include time that you spend awake in bed)

Describe how you feel when you get up: ______________________________

____

11. Do you ever continue sleep in spite of your alarm sounding? ☐ Yes ☐ No

	Never	***Occasionally***	***Often***
12. Do you snore?	☐	☐	☐
13. Have you been told you stop breathing in your sleep?	☐	☐	☐
14. Do you gag, choke, or cough during sleep?	☐	☐	☐
15. Do you ever feel short of breath during sleep?	☐	☐	☐

PT.

MR.#/RM.

DR

	Never	Occasionally	Often
16. Do you have a headache when you awaken?	☐	☐	☐
17. Do you have nasal stuffiness or congestion during sleep?	☐	☐	☐
18. Are you sleepy during the day?	☐	☐	☐
19. Are you sleepy when driving?	☐	☐	☐
20. Are you restless during sleep?	☐	☐	☐
21. Do you or have you been told that you frequently kick your legs during sleep?	☐	☐	☐
22. Do you experience restless legs *(crawling or aching feelings, and inability to keep legs still)*?	☐	☐	☐

If you answered "occasionally" or "often", please answer the following as well:

Are your symptoms worse at rest?	☐ Yes	☐ No
Do your symptoms improve by moving?	☐ Yes	☐ No
Are your symptoms worse during the evening?	☐ Yes	☐ No

	Never	Occasionally	Often
23. Do you experience vivid, dream-like scenes even though you think that you are awake?	☐	☐	☐
24. Do you fall asleep unintentionally?	☐	☐	☐
25. Do you have weak knees or episodes of muscular weakness *(paralysis or inability to move)* when laughing, angry, or in other emotional situations?	☐	☐	☐
26. Do you wake feeling unable to move *(paralyzed)* when awaking?	☐	☐	☐
27. Do you experience any kind of pain or physical discomfort?	☐	☐	☐

PT.

MR.#/P.M.

	Never	Occasionally	Often
28. Do you have persistent, repeating or violent dreams?	☐	☐	☐
29. Have you ever acted out your dreams or woke up doing so?	☐	☐	☐
30. Do you walk in your sleep?	☐	☐	☐
31. Do you awaken from sleep screaming, violent and confused?	☐	☐	☐
32. Have you ever had seizures or epilepsy?	☐	☐	☐

32a. When? ______________________________

	Never	Occasionally	Often
33. Have you been told that you grind your teeth while asleep?	☐	☐	☐
34. Do you have a sour or acid taste in your mouth during sleep?	☐	☐	☐
35. Do you have heartburn or chest pain during sleep?	☐	☐	☐
36. IS YOUR SLEEP DISTURBED DURING THE NIGHT BECAUSE OF?			
36a. Having thoughts racing through your mind?	☐	☐	☐
36b. Feeling sad and depressed?	☐	☐	☐
36c. Anxiety (worry about things)?	☐	☐	☐
36d. Do you have a fear of not being able to sleep once you have awakened during the night?	☐	☐	☐
37. How much of a problem do you have with FATIGUE *(tiredness, exhaustion, lethargy)* even when you are NOT sleepy?	☐	☐	☐

38. Do you feel you have a sexual concern? ☐ Yes ☐ No

39. How MUCH stress do you have at the present time? ☐ Not Much ☐ Some ☐ A Lot

40. Are you claustrophobic? ☐ Yes ☐ No

40a. If yes, please explain: ______________________________

____

PT.

MR.#/P.M.

41. Please describe your medical history: ***Explain***

			Explain
Hypertension	☐ Yes	☐ No	______
Heart Problems	☐ Yes	☐ No	______
Lung Problems	☐ Yes	☐ No	______
Diabetes	☐ Yes	☐ No	______
Thyroid Problems	☐ Yes	☐ No	______
Stroke or other neurological Problems	☐ Yes	☐ No	______
Sinus or nose problems	☐ Yes	☐ No	______
Heart burn	☐ Yes	☐ No	______
Depression	☐ Yes	☐ No	______
Hallucinations	☐ Yes	☐ No	______
Mood swings	☐ Yes	☐ No	______
Arthritis	☐ Yes	☐ No	______
Chronic pain	☐ Yes	☐ No	______
Allergies	☐ Yes	☐ No	______

42. List surgies: ______

______

______

______

43. Are you now or have ever been under the care of a Psychiatrist or other mental health professional? ☐ Yes ☐ No

If so, who? ______ when? ______

What treatment did you receive? *(ie. medication, counseling)*:

______

______

PT.

MR.#/PM.

44. Do you take any prescribed medication?

Name:	*Amount:*	*How Often:*	*Reason:*

45. Do you smoke or have you smoked? ☐ Yes ☐ No

45a. If Yes, how long have you or did you smoke? ____________________

45b. How many packs per day? ____________________

45c. When did you quit? ____________________

46. Do you drink alcohol? ☐ Yes ☐ No

46a. How much per week? ____________________

47. Do you use recreational drugs? ☐ Yes ☐ No

47a. Which ones? ____________________

48. Do you use caffeinated beverages? ☐ Yes ☐ No

What type? ____________________

How much per day? ____________________

Time of last cup or glass? ____________________

49. Regarding drownsiness rather than just fatigue, enter the number that corresponds to how likely drowsiness is to occur to you in the following situation:

0 = **NEVER OCCURS**

1 = **OCCASIONALLY OCCURS** ***(less than 50% of the time)***

2 = **OFTEN OCCURS** ***(50% of the time)***

3 = **USUALLY OCCURS** ***(more than 50% of the time)***

________ **A.** Sitting and Reading

________ **B.** Watching TV

________ **C.** At a public place like a theater or meeting

________ **D.** While a passenger in a car riding for one hour

________ **E.** Lying down in the afternoon

________ **F.** Sitting and talking to someone

________ **G.** Sitting down after lunch

________ **H.** While driving a car and stopped at a traffic light

________ **Total**

PT.

MR.#/P.M.

THIS PAGE IS TO BE COMPLETED BY YOUR BEDPARTNER, IF APPLICABLE.

We often find that the information provided by the patient's bedpartner can be vital in assisting in the diagnosis of sleep disorders. Your cooperation is greatly appreciated.

	Never	*Occasionally*	*Often*
1. Snore?	☐	☐	☐
2. Snore loudly enough to disturb your sleep?	☐	☐	☐
3. Stop breathing during his/her sleep?	☐	☐	☐
4. Gasp for breath, cough, choke?	☐	☐	☐
5. Kick during sleep?	☐	☐	☐
6. Fall alseep before going to bed?	☐	☐	☐
7. Start to doze off while driving?	☐	☐	☐
8. Appear sleepy during the day?	☐	☐	☐
9. Toss and turn while sleeping?	☐	☐	☐
10. Act out his/her dreams?	☐	☐	☐
11. Talk in his/her sleep?	☐	☐	☐
12. Walk in his/her sleep?	☐	☐	☐
13. Get out of bed during the night?	☐	☐	☐

14. Have you noticed any personality changes? ____________________

____

____

____

15. Please use the space below to report any information you believe to be pertinent. ____________________

____

____

____

PT.

MR.#/P.M.

DR.

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
__ High Blood Pressure
__ 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 ✔ & <u>who had the disease</u>)

__ 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 your home? YES or NO
(Example/Amount Cat 2, Dog 1 & Bird 3)______________________________
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

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

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

__ Chest pain (Describe type: sharp, burning, heavy) ______________________
__ Coughing (how much) ______________________
__ Any blood in sputum
__ Sputum (color & amount) ______________________

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