Chest & Sleep Consultants PLC
Pulmonary, Critical Care & Sleep Medicine
2284 S. Ballenger Hwy Ste H-2 Flint, MI 48503
Office: (810)-720-1144 Fax: (810)-720-1166

Joseph K. Varghese, MD., FCCP, John Youssef, MD., Abhijeet Ghatol, MD, Anas Moughrabieh MD
Peter Sabbagh MD., Emad Alkhankan, MD. Abdulghani Sankari, M.D.

Insurance Authorization

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

Name_____

Address_____

City_____ State_____ Zip_____

Cell Phone(_____)_____Can we ***TEXT*** you? **YES** **NO** Phone(_____)_____

Email address (for confirming appts only)_____

Pharmacy (Address & Phone #) _____

Primary Care Physician (Address & Phone #) _____

Emergency Contact_____Phone Number(_____)_____

Relationship_____

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 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_____

Name_____

Date_____

DOB_____

Marital Status: **Single** **Married** **Divorced** **Widow**
What sex were you assigned at birth? Male or Female
What is your current gender identity?_____

Past Medical History: Please place a checkmark ✔ next to your medical problems.

____ COPD
____ Emphysema
____ Asthma
____ Chronic Bronchitis
____ Arthritis
____ Diabetes Mellitus
____Sleep Apnea**Machine: **Yes** **No**

____Hiatal Hernia
____Heart Attack
____Heart Disease
____High Blood Pressure(HTN)
____Stroke
____Blood Clots

____Seizures
____Thyroid
____Lung Cancer
____OtherCancer/Type
Other Medical Problems
_____
_____

Surgical History: Please place a checkmark ✔ next to the procedures performed.

____Heart Bypass/Date_____
____Heart Stents
____Angioplasty
____Carotid Endarterectomy
____Appendix
____Gall Bladder/Cholecystectomy

____Hysterectomy
____Aneurysm
____Mastectomy
____Tonsillectomy
____"C" Section
____Hernia Repair

____Breast Biopsy
____Lung Resection
____Sleep Study
____Other Surgeries
_____
_____

Family History: Please place a checkmark ✔ next to the medical problems & what family members
(**NOT YOURSELF.** EX: MOTHER, FATHER, BROTHER, SISTER, AUNT, UNCLE, GRANDPARENT)

____Asthma _____
____Heart Disease _____
____High Blood Pressure_____
____Diabetes _____
____Heart Attack _____

____Blood Clots _____
____COPD _____
____Lung Cancer _____
____Stroke _____
____Cancer*who & type_____

____Other Family Medical Problems_____

Social History

Do you smoke currently: YES NO
If **YES**, how many packs a day for how long: _____ packs a day for _____years.
Did you smoke in the past? YES NO
If **YES**, how many:_____packs a day for_____years. Age Started _____
If **Yes**, when did you quit? _____
How much beer or alcohol do you drink per day/week? _____
Do you use recreational drugs? YES NO
If **YES**, what do you use and how often: _____

Work History

What do you do/what have you done to make a living? _____
Pets and Hobbies - Please List any pets/birds and any hobbies:
_____

Name:_____ **DOB:**_____

Please list ALL prescribed and over the counter medications, vitamins and supplements.

ALLERGIES TO MEDICATIONS: YES NO
If **YES** list below:

_____

_____

_____

MEDICATION NAME	STRENGTH	HOW OFTEN	REASON FOR TAKING

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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 bill or appointments, ETC about the care of the above named patient. ***<u>EXCLUDING DOCTORS</u>***

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 of 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 operation.

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 PRACTICES 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 AND 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’ 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 ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND THIS CONSENT AND THIS OFFICES NOTICE OF PRIVACY PRACTICES FORM. YOU FURTHER ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF THIS OFFICES 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 Medicine Consultants, PLC

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SPECIFIC INFORMATION TO BE DISCLOSED:

⬜ ALL RECORDS

⬜ OTHER_____

‣Communicable disease and infection information as defined by statute and Michigan Department of Public Health rules which includes Venereal disease (VD), tuberculosis (TB), hepatitis B, human immunodeficiency virus (HIV), acquired immunodeficiency 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 Compensation
⬜ Social Security
⬜ Insurance
⬜ Other

I understand, as set forth in the Practices Notice of Privacy Practices, I have the right to revoke this authorization, in writing at any time by sending notifications 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 (HIPAA).

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.

_____ _____

Signature of Patient or Personal Representative Printed Name

_____ _____

Date If signed by representative person, relationship to the PATIENT

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SLEEP MEDICINE QUESTIONNAIRE

NAME:_____

DOB:_____

DATE:_____

1. Briefly describe your sleep or sleep problem(s):

_____

_____

2. When did the sleep problem(s) begin?

_____

_____

3. Have you ever been treated for snoring, insomnia or sleepiness? ◯**YES** ◯**NO**

4. Have you ever had a sleep study? ◯**YES** ◯**NO**

If YES, when and where?_____

5. Do you currently use any of the following? ◯**CPAP Machine** ◯**BIPAP Machine** ◯**Oxygen**

6. If **YES**, who is your **Durable Medical Equipment Company (DME)** that you currently use?

_____

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Use the following scale to choose the most appropriate number for each situation.

0=NEVER doze 1=SLIGHT chance of dozing 3=HIGH chance of dozing

Situation	Chance of Dozing
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (example a theater or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car, while stopped for a few minutes while in traffic	_____
Total Score	_____

STOP-BANG Sleep Apnea Questionnaire

STOP QUESTION	YES	NO
Do you **SNORE** loudly (louder than talking or loud enough to be heard through closed doors)?		
Do you often feel **TIRED**, fatigued, or sleepy during the daytime?		
Has anyone **OBSERVED** that you stop breathing in your sleep?		
Do you have or are you being treated for **HIGH BLOOD PRESSURE?**		

BANG QUESTION	YES	NO
BMI more than 35 kg/m2?		
Age over 50 years old?		
Neck circumference > 16 inches (40 cm)?		
Gender: Male?		

High risk of OSA: Yes 5-8
Intermediate risk of OSA: Yes 3-4
Low risk of OSA: Yes 0-2

TOTAL_____

Name:_____

Weight:_____ Height:_____ Has your weight changed? ◯**YES** ◯**NO**

If YES, how much?_____ How long?_____

Do you consume caffeinated beverages? ◯**YES** ◯**NO**

Type & how much_____

Sleep Symptoms

QUESTION	**YES**	**NO**
Do you snore?		
Do you toss and turn?		
Does your snoring or kicking prevent somebody from sleeping in the same bed as you?		
Do you wake up gasping or feeling like you cannot breathe?		
Has your bed partner ever told you that you stop breathing during sleep?		
Does your bed partner ever notice leg movements while sleeping?		
Does your bed partner complain that you kick them during the night?		
Do you get up more than once a night to go to the bathroom?		
Do you grind your teeth at night?		
Do you ever find yourself somewhere and you do not know how you got there?		
Do you have vivid dreams shortly after falling asleep at night?		
Do you ever feel that you cannot move after lying down or just after you awaken?		
Do you ever feel sudden weakness in your limbs when laughing emotionally?		
When you awaken, are you short of breath or wheezing?		
Do you feel refreshed when you wake up?		
Do you wake up with a headache?		
Do you have a problem with sleepiness while driving?		
Have you ever had an automobile accident related to sleepiness?		
Does sleepiness interfere with work or school?		
Have you ever had accidents at work that are related to sleepiness?		
Do you have a restless or creeping feeling in your legs that decrease by moving your legs or walking?		

Sleep Habits

QUESTION	WORK DAYS	WEEKENDS
What time do you go to bed?		
What time do you get up?		
How long does it take you to fall asleep?		
On average, how many times do you wake up during the night?		
Do you return to bed after waking up in the AM?		
What time do you go to work or school?		
What time do you return home?		

QUESTION	YES	NO
Do you have trouble going to sleep?		
Do you have frequent awakenings during the night?		
Do you awaken during the night and have trouble going back to sleep?		
Do you awaken during the night with thoughts racing through your mind?		
Do you watch T.V., read, eat, etc. in bed?		
Do you feel frustrated or tense when seeing your bed or bedroom?		
Do you fall asleep more easily on the couch than bed?		
Do you have difficulty falling asleep or awaken frequently throughout the night because of pain?		
Have you felt depressed recently?		
Are you easily awakened by noise or light?		
Have you been having any relationship conflicts lately?		
Do you have a lot of job stress?		
Do you find it difficult to get out of bed in the morning?		
Is your job or school performance affected by your sleep problem?		