Chest and Sleep Medicine Consultants, PLC

Pulmonary, Critical Care, and Sleep Medicine
2284 S. Ballenger Hwy. Suite H 2 Flint, MI
Phone (810) 720-1144 Fax (810) 720-1166

Joseph Varghese, M.D., FCCP□John Youssef, M.D.,FCCP□Abijeet Ghatol, M.D.
Anas Moughrabieh, M.D.□Peter Sabbagh, M.D.□Emad Al Khankan, M.D.□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:_____ **DATE:** _____

DOB: _____ **RACE:**_____

Your main concern for seeing the doctor today: _____

_____

Symptoms and Complaints you currently have: _____

_____

LUNG/HEART: Please place a checkmark ✔ next to your medical problems.

____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)
____Cough (how much)
____Any blood in sputum
____Sputum (color and amount)

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

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

Stomach: Please place a checkmark ✔ next to your medical problems.

____Heartburn
____Nausea
____Vomiting
____Loss of appetite
____Head/neck
____Sinus Drainage (how often)
____Sinus headache
____Nasal Drainage (what color)
____Nasal Stuffiness
____Weight loss
____Weight gain
____Constipation
____Diarrhea

Other: Please place a checkmark ✔ next to your medical problems.

____Sweating at night
____Sweating during the day
____Fevers
____Chills
____Weight loss (how much)
____Leg swelling
____Weakness
____Headache
____Sleepy during the day
____Dizziness
____Difficulty getting sleep
____Wake up gasping for breath
____Stop breathing during sleep
____Feeling tired in morning
____Snoring
____Wake up with dry mouth
____Difficulty sleeping

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
2284 S. Ballenger Hwy. Ste H2 Flint, MI 48503
Ph (810)720-1144 Fax (810) 720-1166

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