M. Qadoom, M.D.
Diplomate American Academy of Sleep Medicine
American Board of Pulmonary & Critical Care Medicine

PATIENT INFORMATION: (please print clearly – **black ink only please**)

NAME: ____
Last *First* *Middle Initial*

MAILING ADDRESS: ____

CITY/STATE: ______________________________ ZIP: ____________

HOME PHONE: ____________________ CELL PHONE: ____________________
WORK PHONE: ____________________ EMAIL: ____________________
DATE OF BIRTH: ____________________ SEX: __________
SOCIAL SECURITY NUMBER: ____________________

RACE: ____ African American ____ Hispanic
____ Asian ____ Native American
____ Caucasian ____ Other

MARITAL STATUS: ____ Single ____ Separated/Divorced
____ Married ____ Widowed

PHARMACY: ____
Name Address -OR- Phone Number

EMPLOYER NAME: ______________________________ PHONE: ____________________

EMERGENCY CONTACT: ______________________________PHONE: ____________________

PATIENT RELATIONSHIP TO CONTACT: ____SPOUSE ____ CHILD ____ OTHER

PRIMARY CARD HOLDER INFORMATION:

	PRIMARY	SECONDARY
INSURANCE:	____________________	____________________
CARD HOLDER NAME:	____________________	____________________
CARD HOLDER DOB:	____________________	____________________

Primary Care or Family Doctor: ____

Referring Doctor (if different from PCP): ____

Other Physicians Currently Seeing: ____
____

______
Initial here

If you are being evaluated for sleep related disorders *and/or* breathing difficulties, your future therapy may involve using a DME company for PAP equipment/ supplies and/or oxygen equipment.

Please indicate your preference for a DME provider:
Lincare, Apria, Dasco, Good Night Medical, Hook's/Rotech, Medical Service Company, CPAP Central, Cornerstone/Aerocare, Advanced Home Medical/Total Respiratory, N/A

M. Qadoom, M.D.
Diplomate American Academy of Sleep Medicine
American Board of Pulmonary & Critical Care Medicine

Patient Name: ____

Please check if you have any of the following symptoms:

Cough	□ No	□ Yes	Chest pain when breathing	□ No	□ Yes
Coughing up blood	□ No	□ Yes	Shortness of breath	□ No	□ Yes
Wheezing	□ No	□ Yes	Short of breath with exercise	□ No	□ Yes
Sputum Production	□ No	□ Yes	Short of breath when lying flat	□ No	□ Yes

What triggers your breathing symptoms?

□ animals □ tobacco smoke □ perfumes □ paints/solvents
□ cold air □ exercise □ aspirin □ air pollution
□ dust □ pollens and molds □ other ___________________________

What time of day are your breathing symptoms worse? ________________________________

Do you awaken from sleep with breathing problems?	□ No	□ Yes
Have you ever gone to the emergency room with breathing problems?	□ No	□ Yes
Have you ever been on a mechanical ventilator (respirator)?	□ No	□ Yes
Did you have asthma or lung disease as a child?	□ No	□ Yes

Medical History:

1. Please check any medical illness you have previously been treated for:

□ emphysema/COPD □ heart attack or MI □ cancer ___________ □ stroke or TIA
□ asthma □ high cholesterol □ lung mass □ HIV
□ sarcoidosis □ diabetes □ reflux/hiatal hernia □ chronic anxiety
□ pulmonary fibrosis □ high blood pressure □ peptic ulcers □ depression
□ tuberculosis (TB) □ CHF (heart failure) □ liver disease □ chronic pain
□ obstructive sleep apnea (OSA) □ heart disease □ thyroid disease □ epilepsy or seizures
□peripheral vascular disease □ kidney disease □ sinus problems □ arthritis

List any other medical illnesses you have/surgeries/hospital admissions (including date):

____________________ ____________________ ____________________
____________________ ____________________ ____________________
____________________ ____________________ ____________________

2. Please list any prescribed or over-the-counter (including herbals, vitamins) medications you are presently using, dosage, and frequency:

Medication	Dose	Times a day	Medication	Dose	Times a day

3. Please list any medications you are allergic to and the reaction you have had:

Medicine	Reaction	Medicine	Reaction

Health Maintenance:

Do you get a yearly influenza vaccine? □ No □ Yes

Have you ever had a pneumococcal vaccine? □ No □ Yes If yes, date ______________

Have you ever had a tuberculosis skin test (PPD)? □ No □ Yes If yes, date ______________
Was it: □ positive □ negative

Have you ever had a COVID vaccine (first/second dose)? □ No □ Yes If yes, date _____________

Family History:

	Age	Deceased	Medical Illnesses / Cause of Death
Father	________	□ No □ Yes	______________________________
Mother	________	□ No □ Yes	______________________________
Siblings:			
□ Brother	________	□ No □ Yes	______________________________
□ Sister	________	□ No □ Yes	______________________________
□ _______	________	□ No □ Yes	______________________________
□ _______	________	□ No □ Yes	______________________________
□ _______	________	□ No □ Yes	______________________________
□ _______	________	□ No □ Yes	______________________________

Social History:

What is your present job/occupation? ______________________________

Other occupations in the past (that may have negatively impacted your health)? ______________________________

Have you ever been in the military? □ No □ Yes

Please list the ages of any children you have: ______________________________

Environmental History:

Habits:	*Yes*	*No*	
1. Current smoker?	□	□	______ packs for ______ years (including electronic cigarettes/vaping)
2. Smoking in the past?	□	□	______ packs for ______ years
3. Second-hand smoke?	□	□	______ years
4. Consume caffeine?	□	□	______ drinks per day
5. Drink alcohol?	□	□	______ drinks per day
6. Illicit drugs?	□	□	______ smoked ______ injected ______ snorted
7. Risk for AIDS?	□	□	______ blood transfusion ______ unprotected sex ______ other ______________________________

Exposures:

1. Do you have animals in your home now? □ dog □ cat □ bird □ other _______________
2. Are your animals: □ indoors □ outdoors □ both
3. Are you exposed to any of the following at home or work?
   □ mold □ cockroaches □ humidifier □ hot tub □ fumes □ farm animals □ dust □ grain silos
4. Have you been exposed to asbestos? □ No □ Yes

Sleep

Do you snore more than 2 times per week or is your snoring extremely loud? □ No □ Yes

Has anyone ever told you or noticed that you stop breathing when you sleep? □ No □ Yes

Do you have excessive sleepiness or fall asleep easily during the day? □ No □ Yes

Do you get an uncomfortable, crawling, or strange sensation in your legs that is relieved by moving or walking? □ No □ Yes

Have you ever had episodes where you screamed out in the middle of the night but did not remember it the next day? □ No □ Yes

Do you regularly or frequently wake up during the night? □ No □ Yes

Is difficulty falling asleep a recurring or bothersome problem for you? □ No □ Yes

Do you frequently have headaches in the morning? □ No □ Yes

Have you ever been told that you struck someone, became violent, or threatening while you slept? □ No □ Yes

Have you or do you lose muscle control or go limp when you are surprised, are laughing or get angry? □ No □ Yes

Use this scale to choose the most appropriate number for each situation listed below:

0: would never doze, 1: slight chance of dozing, 2: moderate chance of dozing, 3: high chance of dozing

Situation	Chance of Dozing (0-3)			
Sitting and Reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place (e.g. a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch, when you have had no alcohol	0	1	2	3
In a car, stopped in traffic	0	1	2	3

Total Score: ___________

Physician Signature ____ Date ________________________

Patient Name: ____

Are you a: ___ current, ___ former, ___ never smoker? If current smoker, how much do you smoke per day? ____
If former smoker, did you quit: more than 10 ___ *OR* less than 10 ___ years ago? How many smoked per day? ____

Do you drink alcohol? ___ yes ___ no
If yes, how much do you drink per day/week/month? _____ How often did you have more than 6 drinks per day? _____

Have you had any falls in the past year? ___ yes ___ no
If yes, did you have injury? ___ yes ___ no Brief details: ____________________________________

Review of Systems (please check any of the following that you have):

Allergy
- Congestion □ No □ Yes
- Sneezing □ No □ Yes
- Watery/Itchy Eyes □ No □ Yes

Ophthalmologic/Eyes
- Vision loss/Blurred vision □ No □ Yes
- Flashes/Floaters □ No □ Yes
- Dry Eye/Red Eye □ No □ Yes

ENT (Ears/Nose/Throat)
- Sore throat □ No □ Yes
- Hearing loss □ No □ Yes
- Mouth sores □ No □ Yes
- Nose bleeds □ No □ Yes

Endocrine
- Uncontrolled blood sugars □ No □ Yes
- Excessive thirst/Sweating □ No □ Yes
- Weakness □ No □ Yes
- Cold/Heat intolerance □ No □ Yes

Cardiovascular
- Chest pain □ No □ Yes
- Palpitations/Heart Racing □ No □ Yes
- Passing out spells □ No □ Yes
- Heart murmur/Irregular Heartbeat □ No □ Yes

Gastrointestinal
- Heartburn □ No □ Yes
- Nausea/Vomiting □ No □ Yes
- Stomach pain □ No □ Yes
- Diarrhea/Rectal Bleeding □ No □ Yes

Hematology
- Easy bruising/Bleeding □ No □ Yes
- Anemia □ No □ Yes
- Swollen glands □ No □ Yes
- Transfusion □ No □ Yes

Genitourinary
- Blood in urine □ No □ Yes
- Frequent urination □ No □ Yes
- Painful urination □ No □ Yes

Musculoskeletal/Rheumatologic
- Arthritis/Joint stiffness □ No □ Yes
- Muscle aches/Swelling □ No □ Yes
- Weakness □ No □ Yes
- Swelling of ankles □ No □ Yes

Peripheral Vascular
- Pain/cramping in legs □ No □ Yes
- Painful extremities □ No □ Yes
- Ulceration of feet □ No □ Yes

Skin
- Recent skin rash/scaly scalp □ No □ Yes
- Skin cancer □ No □ Yes
- Hives □ No □ Yes
- Itching/Dry skin □ No □ Yes

Neurological
- Headaches □ No □ Yes
- Seizures □ No □ Yes
- Strokes □ No □ Yes
- Dizziness □ No □ Yes
- Numbness/Tingling □ No □ Yes

Psychiatric
- Anxiety/Panic Attacks □ No □ Yes
- Depression □ No □ Yes
- Hallucinations/Delusions □ No □ Yes
- Eating Disorder □ No □ Yes

M. Qadoom, M.D.
Diplomate American Academy of Sleep Medicine
American Board of Pulmonary & Critical Care Medicine

Financial Policy

Pulmonary and Sleep Consultants, LLC (PSC) is committed to providing the highest quality of health care. It is important to us that you are informed about billing and payment procedures, and we hope to alleviate any misunderstanding or disagreements about financial responsibility. Any questions regarding the financial policy or claims payment should be directed to the billing office.

Billing & Collections: All patients will be required to present a valid driver's license or photo ID and current medical insurance card at every office visit. Please notify us of any changes in insurance coverage prior to the time of service. Copayments will be collected prior to your visit. Any balance due on your account must be paid prior to your visit unless other financial arrangements have been made. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, please contact the billing office to discuss payments options. We will do our best to accommodate your individual situation. Formal collection processes will begin ninety (90) days after the first statement is received unless the balance is paid or other arrangements are in place.

Patients With Insurance: PSC participates with many insurance plans. It is your responsibility to understand the terms of your insurance policy including whether PSC and any ancillary providers are in-network. It is also your responsibility to understand your Deductible, Copayment, Coinsurance and Prior Authorization requirements. If you need help understanding your benefits, contact the customer service phone number listed on your identification card.

PSC will submit claims for services rendered in accordance with the requirements of your insurance carrier. Ohio Law and our contract states that your insurance company may require copayments be collected at the time of service. We are happy to reschedule your appointment if you have questions about your insurance coverage.

Patients Without Insurance (Private Pay): Payment in full is expected at the time of service. Depending upon the level of service we provide, estimated charges for an initial visit range from $130 - $400. If you are unable to pay for medical care, please discuss this with the billing office prior to the appointment.

Sleep Studies: Although PSC will verify coverage and benefits with your insurance company prior to your sleep study, this is not a guarantee of benefits. Once your insurance company has processed your claim(s), we will send an invoice for any balance that is due from you.
Please note: If you have a Two Night Home Sleep Study, you will be charged for two (2) studies. This means that you may be responsible for two (2) copayments, deductibles and/or coinsurance.

Patients With Medicare: PSC participates with and will bill directly to Medicare and your secondary insurance (if provided). If your secondary insurance does not respond in a reasonable time frame, a bill may be sent directly to you for payment. Please be prepared to pay deductibles and coinsurance promptly.

No-Show/Late Cancellation: In order to better serve all patients, appointments must be cancelled or rescheduled at least 48 hours before your scheduled appointment. A patient will be considered a 'no-show' if an appointment is missed or cancelled with less than 48 hours' notice. When this occurs, our facility loses the opportunity to care for other patients. If 48 hours' notice is not received, the following fees will apply:

Office Visit: $50.00 In-lab Sleep Study $250.00

These fees are not covered by insurance and are the sole responsibility of the patient.

Please note: If you are scheduled for an In-Office Sleep Study and decide to terminate the study before sleep data can be captured, this is considered a no-show and the $250.00 no-show fee will apply. If your Home Sleep Study is terminated by you with less than 2 hours of data, for non-technical reasons, the study is considered a billable service.

Patients With Worker's Compensation: It is the patient's responsibility to inform the registration staff that they are being seen due to a Worker's Compensation claim and to provide a copy of the BWC information at each visit. The billing address and phone number should be listed on the BWC information. Only work-related symptoms will be treated during a work-related visit. Other symptoms will require a separate office visit. Prior authorization must be obtained prior to your appointment, unless you are seeing your physician of record. All procedures must have prior authorization. If you are unsure about prior authorization, please contact your case manager before your appointment. Appointments will be rescheduled if you do not have an authorization.

Personal Injury/Auto Accident: It is the patient's responsibility to inform the registration staff that they are being seen due to a personal injury/auto accident and to provide sufficient information to allow us to bill the insurance. We will bill the insurance company indicated. If prompt payment is not received, the balance due will be the patient's responsibility. We do not accept Letters of Protection or Letters of Guaranteed payments from attorneys. If you do not have insurance, payment is expected at the time of service. We will provide you with an itemized statement if needed.

Returned Checks: There is a $30 fee for any check returned by the bank (e.g. non-sufficient funds, closed account, etc.). The $30 fee, along with the original check amount will be added to your balance due and must be paid prior to your next appointment. We do not rerun any check back through the bank.

Responsible Party of Minors (18 years and younger): The parent who authorizes the treatment for a child will be the parent responsible for the charges. If a divorcee decree requires the other parent to pay for all or part of the treatment, it is the authorizing parent's responsibility to collect from the other parent.

Payment Methods: We accept cash, check, Visa, MasterCard, and American Express.

FINANCIAL POLICY ACKNOWLEGEMENT

I acknowledge that I have read the financial policy from Pulmonary and Sleep Consultants, and I agree to abide by the stated policy(s) that pertains to me.

Patient Name (please print)

Patient or Responsible Party Signature | Date

Person Signing on Behalf of Patient (Print Name) | Relation and Reason Patient Cannot Sign

Relationship to patient | Address | Phone Number

RELEASE OF INFORMATION

I request that payment of authorized Medicare and commercial/government health insurance benefits be made on my behalf to Pulmonary and Sleep Consultants for any services furnished to me. I authorize any holder of medical information about me to release to CMS and its agents, or my designated insurance carrier(s), any information needed to determine these benefits or the benefits payable for related services. I authorize Pulmonary and Sleep Consultants and its physicians and employees to release medical information about me to any third party or individual from whom payment for services rendered may be obtained on my behalf to another health care provider for purposes of obtaining a consultation, making a referral to them or otherwise for continuity of my medical care or treatment or evaluation or to a quality assurance or peer review committee. With your permission below, we will file your claim with insurance if the patient is covered by an insurance with which we have a contract.

____

Patient Signature Date

RECIEPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

Due to the overwhelming response of patients, we have copies of the HIPAA Privacy Practices available for you at the front desk. Please notify the office staff if you would like a copy to take with you.

I, ____, have received/declined to receive information and access to the Notice of Privacy Practices from Pulmonary and Sleep Consultants.

____

Patient Signature Date

Refill Policy

An appointment is required for any prescription renewal. At your appointment, we will verify medications and dosages, make adjustments if needed, and answer any questions. You will either be given your prescription or it will be sent electronically to your pharmacy. Please note Ohio law requires more frequent appointments for certain medications. Please allow sufficient time to schedule appointments and receive your medication prior to running out. **Any urgent refills that are requested outside of an office visit are subject to a $20.00 convenience fee.**

INITIAL: _________ *I have read and understand the prescription refill policy of Pulmonary and Sleep Consultants*

Missed Appointment Policy

Please call our office **at least 48 hours in advance** if you are not able to make the scheduled appointment time. All missed appointments are subject to a fee as noted below. Please note, missed appointment fees are the responsibility of the patient, and are not billable to insurance.

A fee will be charged to a patient if they fail to attend a scheduled appointment.

- Office appointments cancelled less than 48 hours prior to the appointment will incur a **$50.00** fee.
- Sleep Study appointments cancelled less than 48 hours prior to their appointment will incur a **$250.00** fee.

INITIAL: _________ *I have read and understand the missed appointment policy of Pulmonary and Sleep Consultants*

Medical Information Release Form
HIPAA Release Form

Name: ____ DOB: ________________________

Release of Information

[ ] I authorize the release of information, including my diagnostic records, details regarding the examination rendered to me, and claims and payment information. This information may be released to:
[ ] Spouse/Child(ren) ____
[ ] Other ____

[ ] I **DO NOT** authorize the release of information to anyone.

This release of information will remain in effect for one year following the date on the form.

Messages
Please call:
[ ] My home: ____
[ ] My cell: ____
[ ] My work: ____

If unable to reach me:
[ ] You may leave a detailed message.
[ ] Please DO NOT leave details in the message, only the call back information
[ ] Other: ____

You may reach me by email at: ____

Print Name: ____ Date: ________________________
Signature: ____