SUFFOLK PULMONARY ASSOCIATES, L.L.P.

60 North Country Road -Suite 203

Port Jefferson, N.Y. 11777

Patient Name: _____

Date of Birth: _____ Social Security # _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____Ext. _____

Cell Phone: _____ E-mail : _____

Marital Status: _____ Spouse Name: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone: _____

Patient's Employer Name: _____ Phone: _____

Referring Doctor: _____ Primary Care Doctor: _____

Medicare #: _____ Medicaid #: _____

Other Insurance: _____ID#: _____ Group # _____

Guarantor Employer: _____Guarantor Date of Birth: _____

Guarantor Social Security # _____ Relationship to Patient: _____

Other Insurance: _____ID#: _____ Group # _____

Guarantor Employer: _____Guarantor Date of Birth: _____

Guarantor Social Security # _____ Relationship to Patient: _____

Chest X-Ray/CT Scan/PET Scan (Location and Date) _____

I request that payment of authorized Medicare/Medicaid/Insurance Company benefits be made on my behalf to Suffolk Pulmonary Associates for services furnished to me by the provider. I also authorize Suffolk Pulmonary Associates to release medical information about me to Medicare/Medicaid/Insurance Company which is necessary to determine benefits payable to them. I also grant permission for this statement to be kept on file and used in place of my signature for submission of Medicare/Medicaid/Insurance Company claims.

Signature: _____ Date: _____

SUFFOLK PULMONARY ASSOCIATES, LLP

REVIEW OF SYSTEMS

Patient Name: _____

Date: _____ Reviewed by: _____

PLEASE CHECK ANY SYMPTOMS THAT YOU ARE EXPERIENCING

CATEGORY	SYMPTOM	Yes	No	Brief Description
GENERAL/CONSTITUTIONAL				
	Weight Gain			
	Weight Loss			
	Weakness			
	Fever			
HEAD				
	Dizziness			
	Fainting			
RESPIRATORY				
	Chest Pain			
	Cough			
	Wheezing			
	Bronchitis			
	Short of Breath			
CARDIOVASCULAR				
	Chest Pain			
	Palpitations			
	Heart Murmur			
GASTROINTESTINAL				
	Abdominal Pain			
	Nausea			
	Vomiting			
ALLERGIES				
	Itchy Eyes			
	Itchy Nose			
	Runny Nose/Stuffy Nose			
SMOKING				
	Are you smoking?			
	Are you interested in smoking cessation?			
SLEEP				
	Do you snore loudly or been told you do?			
	Do you feel tired, fatigued or sleep during the day?			
	Have you stopped breathing during sleep?			
	Do you have or are you being treated for High blood pressure/Diabetes?			
	Do you ever fall asleep or nod during the day?			
	Do you wake up gasping or choking?			
	Do you wake up with dry mouth?			

SUFFOLK PULMONARY ASSOCIATES, LLP

PATIENT NAME: _____ DOB: _____

LIST ALL MEDICATIONS: (use other side, if necessary) You may attach a pre-printed list.

Medication	Dosage	Frequency

YOUR PHARMACY NAME AND LOCATION : _____

ALLERGIES: _____

MEDICAL HISTORY: (list Pulmonary problems first)

_____

_____

_____

_____

FAMILY HISTORY:

☐ Lung Cancer: ☐Father ☐Mother
☐ Other Cancer: _____ ☐ Father ☐ Mother
☐ Emphysema: ☐ Father ☐ Mother

VACCINES: Flu Vaccine ☐ Yes ☐ No Year: _____Pneumonia Vaccine ☐Yes☐No Year:____

SOCIAL HISTORY:

Smoking: ☐Yes – How long? _____#Packs/day_____ ☐Non-Smoker ☐Quit-When_____

SURGICAL HISTORY: _____

_____

Height: _____ Weight: _____

RACE: ☐White ☐African-American ☐Native American ☐Asian ☐Hispanic ☐Other

ETHNICITY: ☐Hispanic/Latino ☐ Not Hispanic/Latino

SUFFOLK PULMONARY ASSOCIATES, L.L.P.
60 North Country Road – Suite 203
Port Jefferson, NY 11777

Patient Name: _____ Date: _____

Please list your other healthcare providers. We will forward your medical information/office notes to them. (Please remember to update your information when necessary)

Doctor Name	Specialty	Phone # (if available)

SUFFOLK PULMONARY ASSOCIATES, LLP
60 North Country Road
Suite 203
Port Jefferson, New York 11777
(631)509-1888 * Fax (631)509-1893

Morton L. Glaser, M.D., FCCP
Jay M. Barbakoff, M.D., FCCP
Anthony C. Theodoris, M.D., FCCP
Sunil K. Dhuper, M.D., FCCP

SLEEP HEALTH DISORDER CHECKUP

Have you been told you snore loudly?	Yes	No
Have you been told that you stop breathing at night?	Yes	No
Are you often tired during the day?	Yes	No
Is controlling your blood pressure difficult?	Yes	No
Do you awaken with shortness of breath?	Yes	No
Do you fall asleep while reading or watching TV?	Yes	No
Do you ever have trouble concentrating?	Yes	No
Have you been diagnosed with Sleep Apnea?	Yes	No

I want to learn about how sleep problems affect my health.

I am not interested at this time.

Patient Name: _____ Date: _____

Order sleep study, titration and treatment if positive for OSA.
Do nothing at this time.

Physician Signature:_____Date: _____

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OFFICE REFERRAL POLICY

As each insurance company is different, it is the patient's responsibility to know if a referral is necessary. It is the patient's responsibility to obtain a referral from the primary care doctor for pulmonary services, prior to their appointment.

Many times a referral is assumed to be called in, when in fact, it is not done prior to the time of service. This will result in the inability to be seen in our office unless a waiver is signed. To prevent this unfortunate situation and the need to reschedule, please confirm with your primary care physician that a referral has, in fact, been issued prior to arriving at our office, or you will be responsible for payment.

Please sign below to acknowledge that you have read and understand this policy. Thank you for your cooperation.

☐ My insurance DOES require referrals

☐ My insurance DOES NOT require referrals

_____ _____

Print Name Signature

_____

Date

SUFFOLK PULMONARY ASSOCIATES, L.L.P.
SUFFOLK CRITICAL CARE ASSOCIATES, L.L.P
60 North Country Road - Suite 203
Port Jefferson, NY 11777

Patient Name: _____ Date of Birth: _____

Statement of Patient Financial Responsibility

Suffolk Pulmonary Associates, L.L.P. and Suffolk Critical Care Associates, L.L.P. appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The services you have elected to participate in, implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier/carriers on your behalf. However, you are ultimately responsible for payment in full of your bill.

Many insurance companies have additional stipulations that may affect your coverage. It is ultimately the patient's responsibility to know your coverage and benefits. By signing below, you authorize Suffolk Pulmonary Associates, L.L.P. and Suffolk Critical Care Associates, L.L.P. to furnish information to insurance carriers concerning your care. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any or part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full. It is the patient's responsibility to obtain referrals or authorizations required by the insurance carrier to be seen at Suffolk Pulmonary Associates. Full payment for services provided by Suffolk Pulmonary Associates is due at the time of services rendered; fees and interest may be charged.

If payment is denied for lack of authorization, the patient understands that they are responsible for payment in full. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Some health insurance carriers require the patient to pay a copay for services rendered. This is a contract between you and your insurance carrier. Payment of all copays is expected at the time the service is rendered to patients.

I understand that I am responsible for co-payments and deductibles or co-insurance, as dictated by my insurance carrier.

Initial _____

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all late fees, collection fees, court costs, attorney fees and any other charges incurred in the collection of any balance due. I further understand that a collection fee of 30% will be added to the outstanding balance should my account be placed in collection.

Initial _____

Statement of Patient Financial Responsibility - Page 2

I have read the above policy regarding my financial responsibility to Suffolk Pulmonary Associates/Suffolk Critical Care Associates, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Suffolk Pulmonary Associates, L.L.P./Suffolk Critical Care Associates, L.L.P. I understand that any amount remaining after such payment has been made by my insurance carrier becomes the patient's responsibility.

_____ _____

(Signature of patient OR parent/guardian if patient is under the age of 18)

(Date)

SUFFOLK PULMONARY ASSOCIATES, L.L.P.
60 North Country Road, Suite 203
Port Jefferson, New York 11777
(631) 509-1888 Fax (877) 434-7939

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Anthony C. Theodoris, M.D., F.C.C.P.
Sunil K. Dhuper, M.D., F.C.C.P.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective April 13, 2003

The privacy of your medical information is important to us. You may be aware the U.S. Government regulators established a privacy rule ("HIPAA") governing protected health information. This notice tells you about how it may be used, and about certain rights that you have.

Chris Oehler, Office Manager, is in charge of privacy matters at our office. You can contact her at (631) 509-1888 if you desire further information, or have any questions or concerns.

Use of disclosure of protected information

Federal law provides that we may use your medical information (protected health information) for treatment of you, without further specific notice to you, or written authorization by you. Example: if we refer you to another doctor, we may provide laboratory or test data to that doctor (subject to more stringent New York laws), such as restriction on disclosure of information concerning HIV/AIDS.

Federal law provides that we may use your medical information to obtain payment for our services without specific notice to you or written authorization by you. Example: Our accountants may see your name, dates of treatment and procedure codes during audits of our books, or for financial services, quality assurance, risk reduction and claim management purposes with our medical professional liability insurer. We may use or disclose your medical information, without further notice to you, or specific authorization by you, where:

1. Required by law;
2. Required for public health purposes;
3. Required by law to report child abuse;
4. Where required by a health oversight agency for oversight activities authorized by law, such as the Department of Health, Office of Professional Discipline or Office of Professional Medical Conduct;
5. Required by law in judicial or administrative proceedings;
6. Required by law enforcement purposes by law enforcement official;
7. Required by a coroner or medical examiner;
8. Permitted by law to a funeral director;
9. Permitted by law for organ donation purposes;

10. Permitted by law to avert a serious threat to health or safety;
11. Permitted by law and required by military authorities if you are a member of the armed forces of the United States;
12. Research purposes (if applicable to your practice, see details at 45 CFR ß 164.512 (i))

New York State law provides additional protection for information regarding HIV/AIDS. We will continue to follow New York State law with respect to such information.

We may contact you by mail or phone, at your residence, to remind you of appointments or to provide information about treatment alternatives. Unless you instruct us otherwise, we may leave a message for you on any answering device or with any person who answers the phone at your residence.

You can make reasonable requests, in writing, for us to use alternative methods of communicating with you in a confidential manner. Space for this is provided below.

Other uses or disclosures of your medical information will be made only with your written authorization. You have the right to revoke any written authorization that you give.

Rights that you have

You have the right to request restrictions on certain of the uses or disclosures described above. Except as stated below, we are not required to agree to such restrictions.

You have the right to inspect and obtain copies of your medical information (a reasonable fee will be charged).

You have the right to request amendments to your medical information. Such requests must be in writing, and must state the reason for the requested amendment. We will notify you as to whether we agree or disagree with the requested amendment. If we disagree with any requested amendment, we will further notify you of your rights.

You have the right to request an accounting of any disclosures we make of your medical information, except for: disclosures we make to you, or to carry out treatment, payment or health care operations, or as requested by your written authorization, or as permitted or required under 45 CFR ß 164.502, or for emergency or notification purposes, or for national security or intelligence purposes as permitted by law, or to correctional facilities or law enforcement officials as permitted by law (or for research or public health purposes after being de-identified or limited to remove personally identifiable information) or disclosures made before April 14, 2003.

If you have received this notice electronically, you have the right to obtain a paper copy from our office.

Obligations that we have

We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices.

We are required to abide by the terms of this notice as long as it is currently in effect.

We reserve the right to revise this notice, and to make a new notice effective for all protected health information we maintain. Any revised notice will be posted in our office, and copies will be available to you.

If you want to complain about violations of your privacy rights, you have the right to file a complaint with the Secretary of the Department of Health and Human Services of the United States. You may also file a complaint with us. Complaints should be directed to Chris Oehler, Office Manager, 60 North Country Road, Port Jefferson, NY 11777 (631) 509-1888.

I have received a paper copy of this notice

_____
Signature

_____
Print Name

_____
Date

I make the following special request for confidential communications:

_____
_____
_____
_____
_____
_____

_____ _____
Signature Date