Tennessee Comprehensive Lung and Sleep Center
Pulmonary Questionnaire

Name: **Date of birth:**

Please fill in the circle for any symptom you have so that we can find out more about it:

Lack of energy	O Yes	O No	Arthritis	O Yes	O No
Daytime sleepiness	O Yes	O No	Muscle Aches/Tenderness	O Yes	O No
Trouble sleeping	O Yes	O No	Gout	O Yes	O No
Snoring	O Yes	O No	Rash	O Yes	O No
Allergies	O Yes	O No	Paralysis	O Yes	O No
Hay fever	O Yes	O No	Stroke	O Yes	O No
Sinus Problems	O Yes	O No	Numbness	O Yes	O No
High Blood Pressure	O Yes	O No	Loss of Balance	O Yes	O No
Heart Problems	O Yes	O No	Seizures	O Yes	O No
Asthma	O Yes	O No	Loss of memory	O Yes	O No
Tuberculosis	O Yes	O No	Headaches	O Yes	O No
Stomach Problems	O Yes	O No	Nervousness	O Yes	O No
Heartburn	O Yes	O No	Depression	O Yes	O No
Indigestion	O Yes	O No	Suicidal Thoughts	O Yes	O No
Ulcers	O Yes	O No	Thyroid Disorder	O Yes	O No
Urinary Frequency	O Yes	O No	Diabetes	O Yes	O No
Urinary Infections	O Yes	O No	Easy Bleeding/Bruising	O Yes	O No
Night Time Urination	O Yes	O No	Risk factors for HIV	O Yes	O No
Possibly Pregnant?	O Yes	O No	Anemia	O Yes	O No
Joint pain	O Yes	O No	Cancer	O Yes	O No

Have you ever had:

A pulmonary stress test	O Yes O No
An electrocardiogram	O Yes O No
A pulmonary function or spirometry test	O Yes O No
A bronchoscopy or bronchial/lung biopsy	O Yes O No
Lung surgery, including complete or partial removal	O Yes O No
Heart Surgery	O Yes O No
Lung Cancer	O Yes O No
Exposure to tuberculosis or had tuberculosis	O Yes O No
Pneumonia	O Yes O No
Blood Clot	O Yes O No
Chest X-Ray	O Yes O No
Chest CT	O Yes O No

When was your last Flu Vaccine?____

When was your last Pneumonia Vaccine?____

REGISTRATION
(Please Print)

TENNESSEE COMPREHENSIVE LUNG AND SLEEP CENTER
102 Wessington Place
Hendersonville, TN. 37075

Date:_____________________ **Referred by:________________________**

Patient Information

Patient:____
Last Name First Name Middle Initial

Responsibly Party (if a Minor):____

Street Address:_____________________________________Email:____

City:___________________________________ State:__________________________ Zip:_______________________________

Home Phone # (___)__________________ Work Phone # (___)_________________ Cell Phone # (___)_________________

Employer:____

Social Security #_________________________________ Sex: ☐M ☐F Age:_______ Birthdate:___________________

☐Married ☐Widowed ☐Single ☐Separated ☐Divorced ☐Partnered for ____ yrs

Spouse/Responsible Party Information

____
Last Name First Name Middle Initial

Street Address:_________________________________ City:___________________ State:______ Zip:___________

Home Phone # (__)_________________ Birthdate:__________________ Social Security # _____________________________

Employer:_______________________________________ Work Phone # (__)_________________________________

Insurance Information

Primary	**Secondary**
Insurance Name:_____________________________	Insurance Name:____________________________________
ID#_______________________________________	ID#____
Group# _____________________________________	Group# ____
Policy Holder Name:__________________________	Policy Holder Name:________________________________

Emergency Contact Information

Name:_______________________________________ Relationship to Patient:______________________________

Home Phone #(___)__________________ Work Phone # (___)__________________

AUTHORIZATIONS
Insurance Assignment and Release
I certify that I have Insurance coverage with ____
Name of Insurance Company(ies)

And assign directly to Tennessee Comprehensive Lung and Sleep Center, PC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Medicare/Medigap Authorization
I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Tennessee Comprehensive Lung and Sleep Center, PC for any services furnished to me by that provider.
To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

____ ______________________________
Signature of Patient or Legal Guardian Date

____ ______________________________
Please Print name of Patient or Legal Guardian Date

Tennessee Comprehensive Lung and Sleep Center, PC

Please read carefully. This notice describes your patient rights, how your medical information may be used or disclosed, your responsibilities, and other important office policies.

The goal of our office and its employees is to take the appropriate steps to provide quality care to our patients while safeguarding medical and personal information provided to our office.

Your Patient Rights

You have the right to compassionate quality healthcare services from our office. You have the right to ask our office to restrict the ways in which we use and disclose your medical information for treatment, payment, or business operations. You have the right to restrict your information from being disclosed to family members involved in your care or payment. Your request will be considered but we are not required to accept it. You have the right to request communication restrictions. You have the right to inspect your records, arranged in advance with our office. You have the right to request a copy of your medical and billing records, this request may result in a fee to cover coping and mailing costs incurred by our office. If you determine that information in your records is incorrect or incomplete, you have the right to request in writing for our office to correct the information or add missing information. Under certain circumstances, we have the right to deny this request. You have the right to request a copy of this notice or any revisions in person at our office during business hours. You have the right to be notified if healthcare services may not be a covered benefit by your health insurance plan.

Release of your information

We may use and disclose your medical information about you in several ways. The following describes the ways in which we may use or disclose of your medical information without your written authorization.

For Treatment-We may use or disclose your medical information to provide services and/or supplies to you. Our office may disclose your medical information to other healthcare providers assisting in your treatment. Your information may also be used or disclosed to recommend possible treatment options or other health related services that might assist in your care. We may use or disclose your medical information for contact of an appointment scheduled or to schedule an appointment. We may also disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted.

For Payment-We may use or disclose your medical information to bill our services and collect payment from you or your insurance company, including workers' compensation or other similar programs. Our office may use or disclose your medical information to your insurance company to obtain prior approval, prior authorization and/or to determine if services are medically necessary.

For Public Uses-We may use or disclose your medical information when we are required to do so by Federal, state, or local law; including, but not limited to, the Center for Disease Control (CDC), the Food and Drug Administration (FDA) and the Occupational Safety and Health Administration (OSHA). We are also required to use or disclose your medical information to public health authority or other government authority authorized by law to receive reports on situations of abuse, neglect, or violence, regardless of age. We may use or disclose your medical information for the following: adverse events, product defects, enable product recalls, repair or replacements and other patient safety concerns involving products and/or appliances. We may use or disclose your information in response to warrants, subpoenas, governmental investigations, licensure investigations, to military command authorities and other law enforcement activities. We may disclose or use your information for national security and intelligence activities.

Business Associates-We may use or disclose your medical information to external individual or businesses assisting our business to perform tasks in which they are hired to do. Our external business associates must guarantee that they will also respect the confidentiality of your medical information.

Individuals Involved in your care-We may use or disclose your medical information to family members, or others individuals whom you have involved in your care or in the payment of your care.

We are required to obtain written authorization from you for any other uses and disclosure of your medical information not listed above. If you provide said permission, you may revoke the permission, in writing, at any time. Upon revoking your

permission, we will no longer use or disclose of your personal or medical information for reason(s) covered in the written authorization. However, our office will not be held responsible for information disclosed prior to the revocation.

Your Patient Responsibilities

1) You or your representative is responsible for notifying our office at least 24 hours in advance for any cancellation notice.
2) You or your representative is responsible for presenting your health insurance card at each office visit or office procedure. It is your responsibility to be familiar with your health insurance plan and its benefits.
3) You or your representative is responsible for payment (co-payment, deductible, and/or co-insurance) prior to services being rendered.
4) You or your representative is responsible for notifying our office of any changes in your medical condition, medications, and/or medical history.
5) You or your representative is responsible for notifying our office of any changes to your name, address, employer information, phone number(s), health insurance, and/or marital status.

Other Office Policies

1) Our office requires a 24-hour cancellation notice.
2) You may not be seen by the physician or mid-level provider if prior authorization, referral or pre-certification, is not obtained and is required by your health insurance plan.
3) You may be required to sign a financial obligation form indicating that you will be financially responsible for payment associated with non-covered, investigation and/or not medically necessary healthcare services.
4) Our office has the right to terminate any patient from our care for, including but not limited to, continuous non-payment on your account, continuous missed appointments, and fraud against our office or its employees. This termination must be sent via certified US mail with a 30-day notice.
5) Our office offers a 25% discount for any provider who is non participating with your health insurance plan.
6) If you arrive later than 15 minutes for your appointment, you may have to wait to be seen at the end of clinic or be asked to reschedule.
7) Request for protected health information to a third party requires written authorization by the patient or the patient's representative. Protected health information may only be released to the third party. Our office does not allow the patient to deliver protected health information to a third party.

Notice Changes

Our office reserves the right to make changes to this notice at any time. Our office is not required to notify you of any changes to this notice. Our office also reserves the right to make the revised notice effective for all personal and medical information maintained, including information received before the revision.

Please direct any comments or concerns to the Office Manager at 102 Wessington Place, Suite A, Hendersonville, TN. 37075 or (615) 822-2214.

____ ________________________

Patient/Guardian/Patient Representative Signature Date

Policy Effective Date February 1, 2008

Medical Summary

Patient Name:________________________ **Date of Birth:**______________________

Please list all your current medications.

1.________________________________ **6.**__________________________________

2.________________________________ **7.**__________________________________

3.________________________________ **8.**__________________________________

4.________________________________ **9.**__________________________________

5.________________________________ **10.**________________________________

Please list all your medical conditions:

1.________________________________ **4.**_________________________________

2.________________________________ **5.**_________________________________

3.________________________________ **6.**__________________________________

Please list all medication allergies and include the type of reaction (i.e. rash, nausea, etc.)

1.________________________________ **3.**__________________________________

2.________________________________ **4.**__________________________________

Please list all Surgeries and/or Hospitalization within the past 5 years.

1.__________________________________ **Date:**_________________________

2.__________________________________ **Date:**_________________________

3.__________________________________ **Date:**__________________________

Pharmacy Name and Address:____

Patient Name:______________________________ Date of Birth:__________________________

Legal Guardian:_____________________________

Please list names of all persons that Tennessee Comprehensive Lung and Sleep Center may discuss your treatment, payment or other healthcare information.

Person	**Relationship**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

May we leave a message on your answering machine? (Please Circle One)

Yes or No

Signature:____

Date:___________________________