PATIENT DEMOGRAPHIC INFORMATION	PATIENT CONTACT INFORMATION *(please mark preferred contact method by checking box)*
First Name: Middle Initial:	□ Home Phone:
Last Name:	□ Work Phone:
Date of Birth: Sex: □ male □ female	□ Cell Phone:
Race: □ Caucasian □ African American □ Hispanic □ Other	Email address:
Ethnicity: □ Hispanic/Latino □ NON-Hispanic/Latino	Preferred method of written contact: □ email □ postal mail
Language:	Primary Care Physician:
Social Security Number:	EMERGENCY CONTACT INFORMATION
Address:	First Name: Last Name:
	Relationship to patient:
City:	Phone:
State: Zip:	Address:
Marital Status:	City: State: Zip:
Employment Status:	RESPONSIBLE PARTY ***If same as patient check here* □
Employer Name:	First Name: Last Name:
Employer Phone:	Address:
Occupation:	City: State: Zip:
	Phone:
PRIMARY INSURANCE	SECONDARY INSURANCE
Insurance Company:	Insurance Company:
Insurance Address:	Insurance Address:
Insurance Phone:	Insurance Phone:
*Insurance ID/subscriber #:	*Insurance ID/subscriber #:
Group #:	Group #:
Policy Holder Name:	Policy Holder Name:
Policy Holder relationship to patient:	Policy Holder relationship to patient:
Policy Holder Date of Birth:	Policy Holder Date of Birth:
Policy Holder Address:	Policy Holder Address:
PREFERRED PHARMACY	
Pharmacy Name:	
Address:	
Phone:	

I hereby authorize Lake Norman Pulmonary (LNP) and/or Lake Norman Sleep Center (LNSC) to release any information acquired in the course of my examination or treatment to the insurance company. I also authorize LNP and/or LNSC to file my medical claims to my insurance company on my behalf. I do understand that I am ultimately responsible for all medical fees relating to my care. Should my insurance deny my medical claims for such reasons as an authorization, non-covered service, or deductible, I understand that I am fully responsible for my bill. I also understand that I must notify LNP/LNSC of any changes to insurance coverage or contact information. I also authorize LNP/LNSC to obtain my medication history from Surescripts. This authorization shall remain valid until revoked in writing.

Patient Signature Date

SLEEP EVALUATION Date of Appointment: _____

PATIENT: _____ DOB: _____

Who referred you to us? _____ Primary Care Physician: _____

Please check all that apply to you:

	Excessive daytime sleepiness		Waking with a dry mouth
	Difficulty falling asleep		Recent weight gain
	Nighttime awakenings		Waking with headaches
	Waking gasping for air		Waking to use the bathroom frequently
	Waking with a choking sensation		Depression
	Observed pauses in breathing while sleeping		Nighttime hallucinations
	Snoring		Awake but inability to move
	Leg movements/foot kicks while sleeping		
	Vivid dreams/nightmares		
	Restless leg		

Do you feel like you get enough sleep?	YES	NO
Is your sleep environment quiet and dark?	YES	NO
Do you sleep walk?	YES	NO
Do you talk in your sleep?	YES	NO
Do you sleep eat?	YES	NO
Do you nap? *(if yes, please give frequency and*	YES	NO
Do you ever doze off at inappropriate times?	YES	NO
Do you ever fall asleep while doing a task?	YES	NO
Do you ever fall asleep while driving?	YES	NO
Do you have decreased work performance?	YES	NO
Do you have memory loss?	YES	NO
Do you feel like you have impaired judgment?	YES	NO

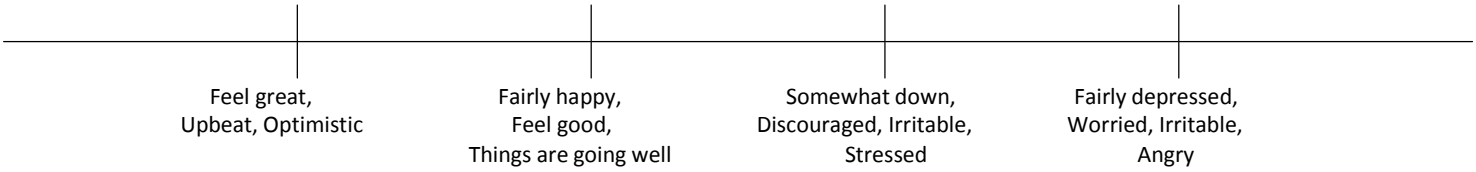
Bed time: _____ Wake time: _____

How do you feel upon waking? _____

How frequently do you exercise? _____

Name/Date of Birth: _____

How has your mood been over the last month?: (Circle only one)



SLEEPINESS SCALE:

Please circle the most appropriate answer using the scale listed below.

0 = would never	1 = slight chance	2 = moderate chance	3 = high chance

How likely are you to doze off or fall asleep while:

Sitting and reading	0 1 2 3	Resting in the afternoon	0 1 2 3
Watching television	0 1 2 3	Sitting & talking to someone	0 1 2 3
In a theater or meeting	0 1 2 3	Sitting quietly after a meal	0 1 2 3
Traveling as a passenger	0 1 2 3	Sitting in a car stopped in traffic	0 1 2 3

PAST MEDICAL HISTORY

Do you have any history of (*If you answer 'yes' to any, please explain)*:

Lung problems	YES	NO	
Heart problems	YES	NO	
Diabetes	YES	NO	
Cancer	YES	NO	
High blood pressure	YES	NO	
Stroke	YES	NO	
Digestion/stomach problems	YES	NO	
Other medical conditions:			

Name/Date of Birth: _____

SURGICAL HISTORY

Please list any surgeries you have had:

_____

_____

_____

_____

FAMILY MEDICAL HISTORY *(please list any medical conditions or health problems)*:

Mother:	
Father:	
Grandparents	
Siblings:	
Children:	

SOCIAL HISTORY

	Answers:
Marital Status	
Employment Status	
Employer and your position	
Recent travel out of the USA	
Pets at home	
Hobbies	
Alcohol intake and	
Caffeinated beverages per	

SMOKING HISTORY

☐	Non-smoker, Never been a smoker
☐	Ex-smoker: Year you started smoking?_____Year you quit?_____Amount: _____
☐	Current smoker: What year did you start smoking?_____How much do you smoke? _____
☐	Smokeless tobacco products:

Name/Date of Birth: _____

Are you currently or have you recently been experiencing any of the following *(check all that apply)*:

	Cough		**Fever**		**Nausea**		**Headaches**
	Shortness of breath		**Night sweats**		**Vomiting**		**Weakness**
	Wheezing		**Chills**		**Diarrhea**		**Numbness**
	Coughing up blood		**Weight gain**		**Heartburn**		**Memory loss**
	Sputum production		**Weight loss**		**Abdominal pain**		**Slurring speech**
			Fatigue				**Tremors**
	Chest pain		**Skin rash**		**Blood in urine**		**Back pain**
	Palpitations		**Skin lesion**		**Painful urination**		**Neck pain**
	Skipped beats				**Urinary frequency**		**Joint pain**
	Swelling in calves						**Swelling**
	Increased thirst		**Sinus pressure**		**Depression**		**Sneezing**
	Increased hunger		**Vision changes**		**Anxiety**		**Itchy eyes**
	Heat intolerance		**Hearing loss**		**Sleep problems**		**Nasal drainage**
	Cold intolerance		**Ringing in your ears**		**Hallucinations**		

MEDICATIONS

Medication Name	Dosage	Frequency

Please list any allergies to medications or food:

_____

_____

What Pharmacy do you use: _____

Financial Policy and Patient Responsibility

We would like to thank you for choosing Lake Norman Pulmonary & Sleep Medicine for your healthcare needs. Our office is committed to providing you with the best possible medical care.

The following information outlines your financial responsibilities related to payment for professional services.

- □ We participate with Medicaid, Medicare, and most major health plans. Our billing office will submit claims for any services rendered to our patients and we will assist our patients in any reasonable way to help get the claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will file that as well once your primary insurance has processed the claim. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.
- □ Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- □ Patients are required to bring their insurance card and photo identification for every visit.
- □ Copayments/Coinsurance/Deductible: If your insurance carrier requires a copayment or if the services are subject to a coinsurance or deductible, this must be paid prior to being seen by a provider or prior to any tests. For your convenience, we accept cash, checks, or major credit cards. If you do not have your copayment/coinsurance/deductible at the time of your scheduled visit, your appointment may be rescheduled.
- □ If your insurance changes, please provide us with the information as soon as possible so we can make the appropriate changes to help you receive the maximum benefits.
- □ For patients that do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit. Please note, we do offer discounted fees for patients without health insurance.
- □ COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collection agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.
- □ Because all insurance policies are different, our staff members do not know what your coverage is for certain procedures or tests. Therefore, we cannot tell you with certainty what your financial responsibility will be for any ordered services. If you have a question about what your coverage is for certain procedures, you will need to contact your insurance company directly to obtain that information.
- □ Some health insurance plans require that a referral be obtained from your primary care provider prior to being seen by one of our providers. This is the patient's responsibility. If payment is denied by your insurance carrier for not obtaining a referral, patient is responsible for payment of services.

Medical Reconciliation: I authorize Lake Norman Pulmonary & Critical Care Specialists/Lake Norman Sleep Center to access any medical data and medication.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign, transfer, and set over directly to **Lake Norman Pulmonary & Critical Care Specialists (LNPCCS) and/or Lake Norman Sleep Center (LNSC)** sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize LNPCCS/LNSC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to LNPCCS/LNSC. I authorize LNPCCS/LNSC to release all medical information requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

RELEASE OF INFORMATION: I hereby authorize the and direct **LNPCCS/LNSC** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

Patient Signature Patient Name Printed Date

Lake Norman Pulmonary & Critical Care Specialists

Lake Norman Sleep Center

Authorization for Release of Information

Patient Name:_____ Date of Birth: _____

I authorize Lake Norman Pulmonary & Critical Care Specialists (LNPCCS) and Lake Norman Sleep Center (LNSC) to release my protected health information as instructed below.

Voice Mail:

- □ Appointment Reminders
- □ Lab Test Results
- □ Other: _____

Spouse or Family Members (*Please provide names of individuals you authorize*):

- □ Appointment Reminders _____
- □ Lab Test Results _____
- □ Medical information _____
- □ Financial/Billing _____

Other: _____

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient an may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

_____
Patient Name (Printed)

_____
Patient Signature Date

ACKNOWLEDGEMENT OF RECEIPT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. It also provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices.

By signing this form, you agree that you have had the opportunity to read our Notice of Privacy Practices.

I have received a copy of the Notice of Privacy Practices for Lake Norman Pulmonary & Critical Care Specialists, PA/Lake Norman Sleep Center, PA.

_____

Patient Name (Printed)

_____

Patient Signature Date

*****NOTICE TO PATIENTS*****

Please be aware that Lake Norman Pulmonary physicians share hospital call with area pulmonologists not affiliated with Lake Norman Pulmonary; therefore, there is no guarantee that Dr. Surdulescu or Dr. Wcisel will be available for emergent hospital visits or hospital emergency room visits should an emergent situation arise.

_____

Patient Signature *Date*

LAKE NORMAN PULMONARY & CRITICAL CARE SPECIALISTS
LAKE NORMAN SLEEP CENTER
Notice of Privacy Practices

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.

If you have any questions about this Notice please contact the Privacy Officer.
704-660-4094

Effective Date: April 14, 2003 **Revised: 04/01/2015**

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- □ Posting the new Notice in our office.
- □ If requested, making copies of the new Notice available in our office or by mail.
- □ Posting the revised Notice on our website: www.lakenormanpulmonary.com

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide health care treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

EXAMPLE: Your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following:

- Billing companies
- Insurance companies, health plans
- Government agencies in order to assist with qualification of benefits
- Collection agencies

EXAMPLE: You are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

EXAMPLES:

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more

effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.
- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.

Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.

Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.

Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.

Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have certain rights related to your protected health information. All requests to exercise your rights must be made in writing. [Describe how the patient may obtain the written request document and to whom the request should be directed, i.e. practice manager, privacy officer.]

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment.

There is one exception: we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.

You may have the right to request an amendment of your health information.

You may request an amendment of your health information if you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact:

Bonnie Moore
bonnie@lakenormanpulmonary.com
704-660-4094

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us. If

you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 1, 2015.