MIDDLE TENNESSEE CENTER FOR LUNG DISEASE, P.C.

DEPAUL BUILDING BESIDE NEW MTMC HOSPITAL:

1800 Medical Center Pkwy, Ste 310 • Murfreesboro, Tennessee 37129 • (615) 849-9868

Ray C. Johnson, MD, FCCP Frank B. Louthan III, MD, FCCP Richard E. Parrish, MD, FCCP

On the day of your visit(s) to our office, you may go about your regular routine including taking medicines and meals. Any testing we do will not be affected by food or medication.

PATIENT NAME____ BIRTHDATE___________________ AGE________

ADDRESS____ SS#_______________________________ SEX: M F

CITY_______________________________ STATE ___________ ZIP __________ MARITAL STATUS M S D W

HOME PHONE__________________________ WORK PHONE_____________________ CELL PHONE_________________

PHYSICIAN REQUESTING CONSULT ____

OCCUPATION / PREVIOUS OCCUPATION (how long?)____

EMPLOYER____

EMERGENCY CONTACT_________________________ PHONE_____________________ RELATIONSHIP_____________

IF PATIENT IS NOT THE INSURED:

NAME OF INSURANCE HOLDER_______________________________ INSURED DATE OF BIRTH____________________

ADDRESS____

EMPLOYER ____ WORK PHONE_______________________

***** PROFESSIONAL ETHICS REQUIRE YOUR SIGNATURE AND PERMISSION BEFORE WE CAN RELEASE ANY INFORMATION CONCERNING YOUR HEALTH RECORDS OR APPOINTMENT TIMES TO ANYONE INCLUDING ALL FAMILY *****

IS THERE ANYONE IN YOUR FAMILY THAT WE MAY RELEASE INFORMATION TO CONCERNING YOUR HEALTH RECORDS AND APPOINTMENS? IF SO, PLEASE LIST THEIR NAMES BELOW:

NAME____ RELATIONSHIP___________________________________

NAME____ RELATIONSHIP___________________________________

NAME____ RELATIONSHIP___________________________________

NAME____ RELATIONSHIP___________________________________

I give my permission for MIDDLE TENNESSEE CENTER FOR LUNG DISEASE to release any information concerning my health records and appointments to the above-mentioned persons.

My signature also confirms that I have been given or offered a copy of the HIPPA Privacy Practices by this office.

____ ________________

YOUR SIGNATURE DATE

PLEASE COMPLETE YOUR NAME AND DATE OF BIRTH THEN SIMPLY SIGN AND DATE THE BOTTOM. LEAVE THE SHADED AREA BLANK FOR USE WITH MULTIPLE FACILITIES.
THIS FORM IS USED IF WE NEED TO REQUEST YOUR RECORDS FROM ANOTHER FACILITY.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION <u>TO</u> MIDDLE TENNESSEE CENTER FOR LUNG DISEASE

Patient Name_________________________________ Patient DOB.______________________

Person or Organization Disclosing the Information:

____
____
____
____

Person or Organization Receiving the Information:

Middle Tennessee Center for Lung Disease
1800 Medical Center Pkwy, Ste 310
Murfreesboro, TN 37129
(615) 849-9868 Fax: 615-898-1882

Specific Description of the Information to be disclosed: **<u>COMPLETE MEDICAL RECORDS</u>**

The Purpose of this request is: **<u>DIAGNOSIS AND TREATMENT BY SPECIALIST PHYSICIAN</u>**

This authorization will expire on: Date: NONE OR when the following occurs: **<u>PATIENT IS DISCHARGED</u>**

WE DO NOT USE OR RELEASE ANY INFORMATION FOR MARKETING PURPOSES.

I hereby authorize the use or disclosure of my protected health information as specified above. I understand that this authorization is voluntary and that I may refuse to sign it. I understand that I may revoke this authorization at any time by giving written notification to my provider or any member of the office staff. A revocation will not affect any action taken in reliance on the authorization prior to the revocation. Other limitations on my right to revoke this authorization may be found in my provider's Notice of Privacy Practices. I understand that, if the recipient is not a health care provider or a health plan, the information disclosed under this authorization may no longer be protected by federal privacy regulations and may be re-disclosed by the recipient. I understand that I should receive a copy of this authorization, even if I do not ask for it.

I understand that treatment may not be denied if I refuse to sign this authorization, except: (1) If the authorization is the very reason for seeking the health care (e.g., a pre-employment physical), that health care may be denied; or (2) If the authorization is for disclosure to a research study, I may be denied the treatment that is part of the study. In addition, the following consequences might occur if I refuse to sign this authorization: (1) If the authorization is to demonstrate to a health plan that a service should be paid for, the health plan may refuse to pay for it; and (2) If the authorization is sought by an insurer because I am seeking enrollment or eligibility, the insurer may deny me the coverage I am seeking. I understand that a health plan may not refuse payment or benefits if I refuse to authorize disclosure of certain psychotherapy notes.

INSURANCE AUTHORIZATION

EXTENDED PAYMENT REQUEST (ONE TIME AUTHORIZATION)

I request that payment of authorized insurance benefits be made on my behalf to Middle Tennessee Center for Lung Disease, P.C. for any services furnished me by my provider, I also authorize any holder of medical information about me to release to MTCLD and it's agent any information needed to determine these
benefits payable for related services.

____ ___________________________
Signature of Patient or Personal Representative Date

Relationship of Personal Representative to the Patient:____

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Diplomates of:
American Board of Internal Medicine
Subspecialty Board of Pulmonary Medicine
Subspecialty Board of Critical Care Medicine

Pulmonary Consultations
Diagnostic Bronchoscopy
Critical Care Medicine
Asthma

PATIENT FINANCIAL POLICY

We are happy you have chosen our practice to provide your pulmonary healthcare needs. We are committed to providing the best medical care and customer service available. As part of this commitment, it is important that you have a clear understanding of our financial policies. Our staff will be happy to answer any questions you may have.

Our physicians participate with most major insurance plans. Due to the constant coverage changes, we cannot guarantee that your insurance company will cover the services we provide. We will file your insurance as a courtesy. We will file your insurances for any services we provide in the hospital. Should the services not be covered, you will be responsible for the bill. All bills are due and payable in full upon receipt of our statement.

_______ **It is the policy of your insurance company, and of this office, that all co-pays are paid at the time Initial of service. We cannot bill you for your co-pay.**

It is your responsibility to make certain that the physician you are scheduled to see is on your insurance plan.

Unless arrangements have been made in advance, or by you having insurance coverage, payment for all services is due at the time of service. For your convenience, we accept Visa, MasterCard, and Discover.

I have read, understand and agree to abide by the financial policy of this practice. I hereby authorize the release of any and all information necessary to process my insurance. I authorize my insurance company to pay directly to the physician, any benefits due for services rendered.

Patient Name:________________________________ Date of Birth:________________________________

Signature:__________________________________ Date:______________________________________

NOTICE OF PRIVACY PRACTICES

MIDDLE TENNESSEE CENTER FOR LUNG DISEASE – PLEASE KEEP THIS FOR YOUR RECORDS

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.

This Notice is effective as of **April 14, 2003**.

We are required by law to maintain the privacy of protected health information, and must inform you of our privacy practices and legal duties. You have the right to obtain a paper copy of this Notice upon request.

We are required to abide by the terms of the Notice of Privacy Practices that is most current. We reserve the right to change the terms of the Notice at any time. Any changes will be effective for all protected health information that we maintain. The revised Notice will be posted in the waiting room. You may request a copy of the revised Notice at any time.

We have designated a Privacy Officer to answer your questions about our privacy practices and to ensure that we comply with applicable laws and regulation. The Privacy Office will also take your complaints and can give you information about how to file a complaint.

Our Privacy Officer is **SHERRY RICH**. You can contact the Privacy Officer at 615-849-9868.

Use and disclosure of your protected health information that we may make to carry out treatment, payment, and health care operations.

We may use information in your record to provide treatment to you. We may disclose information in your record to help you get health care services from another provider, a hospital, etc. For example, if we want an opinion about your condition from a specialist, we may disclose information to the specialist to obtain that consultation.

We may use or disclose information from you record to allow "health care operations." These operations include activities like reviewing records to see how care can be improved, contacting you with information about treatment alternatives, and coordinating with other providers. For example, we may use information in your record to train our staff about your condition and its treatment.

YOUR RIGHTS

You may ask us to restrict the use and disclosure of certain information in your record that otherwise would be allowed for treatment, payment, or health care operations. However, we do not have to agree to these restrictions.

You have the right to receive confidential communications from us. For example, if you want to receive bills and other information at an alternative address, please notify us.

You have the right to inspect the information in your record, and may obtain a copy of it. This may be subject to certain limitations and fees. Your request must be in writing.

If you believe information in your record is inaccurate or incomplete, you may request amendment of the information. You must submit sufficient information to support your request for amendment. Your request must be in writing.

You have the right to request an accounting of certain disclosures made by us.

You have the right to complain to us about our privacy practices (including the actions of our staff with respect to the privacy of your health information). You have the right to complain to the Secretary of the Department of Health and Human Services about our privacy practices. You will not face retaliation from us for making complaints.

Except as described in this Notice, we may not make any use or disclosure of information from your record unless you give your written authorization. You may revoke an authorization in writing at any time, but this will not affect any use or disclosure made by us before the revocation. In addition, if the authorization was obtained as a condition of obtaining insurance coverage, the insurer may have the right to contest the policy or a claim under the policy even if you revoke the authorization.

Use or disclosure of your protected health information that we are required to make without your permission.

In certain circumstances, we are required by law to make a disclosure of your health information. For example, state law requires us to report suspected child abuse or neglect. Also, we must disclose information to the Department of Health and Human Services, if requested, to prove that we are complying with regulations that safeguard your health information.

We may use or disclose information from you record if we believe it is necessary to prevent or lessen a serious and imminent threat to the safety of a person or the public. We may report suspected cases of abuse, neglect, or domestic violence involving adult or disabled victims.

We may report births and deaths to public health authorities, as well as certain types of diseases, injuries, adverse drug reactions, and product defects. We may disclose information from your record to a medical examiner or coroner. We may disclose information to funeral directors to allow them to carry your their duties upon your death. We may disclose information from you record to facilitate organ, eye, or tissue donation and transplantation.

We may assist in health oversight activities, such as investigations of possible health care fraud.

We may disclose information from your record as authorized by workers' compensation laws.

We may disclose information from your record if ordered to do so by a court, grand jury, or administrative tribunal. Under certain conditions, we may disclose information in response to a subpoena or other legal process, even if this is not ordered by a court.

We may disclose information from your record to a law enforcement official if certain criteria are met. For example, if such information would help locate or identify a missing person, we are allowed to disclose it.

If you tell us that you have committed a violent crime that caused serious physical harm to the victim, we may disclose that information to law enforcement officials. However, if you reveal that information in a counseling or psychotherapy session, or in the course of treatment for this sort of behavior, we may not disclose the information to law enforcement officials.

Under certain conditions, we may disclose information for specialized government purposes, such as the military, national security and intelligence, or protection of the President.

Your provider (or office staff) may contact you to provide appointment reminders as a courtesy. However, you are responsible for remembering your appointment.

We may contact you with information about treatment alternatives or other health-related benefits or services that may be of interest to you.

Use or disclosure of your protected health information that we are allowed to make without your permission:

There are certain situations where we are allowed to disclose information from your record without your permission. In these situations, we must use our professional judgment before disclosing information about you. Usually, we must determine that the disclosure is in your best interest, and may have to meet certain guidelines and limitations.

If you receive mental health care, including treatment for substance abuse, information related to that care may be more protected than other forms of health information. Communications between a psychotherapist and patient in treatment are privileged and may not be s\disclosed without your permission, except as required by law. For example, psychotherapists still must report suspected child abuse, and may have to breach confidentiality if you appear to pose an imminent danger to yourself or others, in order to reduce the likelihood of harm to you others.

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Name ______________________ Age _____ Sex _____ Birthdate ______________ Date ______________

Did a doctor refer you here? Y N If yes, who? ____________________________

Who is your family doctor? (if different from above) ____________________________

What is your main respiratory problem, or reason for coming here? (e.g. cough short-of breath, etc.)

____

How long have you had this problem? ____________________________

Do you also have any of these symptoms (*CIRCLE ALL THAT APPLY)*

Coughing	Wheezing	Shortness of breath	Other________________
Sneezing	Chest Pain	Nasal Congestion	Other________________

If you cough,	does mucus come up? What color? ___________	Y	N
	is it ever bloody?	Y	N
	is it worse at certain times of the day or night?	Y	N
If you have breathing problems, do they:			
	get worse when you lie down or try to sleep?	Y	N
	get worse with a change in weather or seasons?	Y	N
Do you wake up at night coughing or short of breath?		Y	N
Have you ever been a smoker (including cigars or pipe)?		Y	N
	If yes, do you still smoke? Packs per day ______	Y	N
	If you quit, when? _______________		
Are you frequently exposed to other people who smoke?		Y	N
Do you ever smoke marijuana (pot) or cocaine?		Y	N
Have you been in close contact with anyone with TB?		Y	N
Have you ever had a skin test for TB (tuberculosis)?		Y	N
	If yes when? ______________________		
	Was it positive?	Y	N
Do you have to sleep on more than one pillow to breathe?		Y	N
Do you ever wake up with severe sweating?		Y	N
Do you frequently have fevers?		Y	N
Do you have heartburn frequently?		Y	N
Have you lost weight recently? If yes, how much? ___________		Y	N
Do your ankles swell?		Y	N

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Name____ DOB______________________________

PAST MEDICAL HISTORY

Have you ever been told that you had any of these conditions?

Condition					
Asthma	Y	N			
Blood clots	Y	N	Do you use blood thinners?	Y	N
Bronchiectasis	Y	N			
Cancer	Y	N	What kind of cancer?______________________		
Cataracts	Y	N			
Chronic Bronchitis	Y	N			
COPD	Y	N			
Congestive heart failure	Y	N			
Diabetes	Y	N	Do you use insulin?	Y	N
Emphysema	Y	N			
Epilepsy or Seizures	Y	N	Osteoporosis	Y	N
Glaucoma	Y	N	Pulmonary Fibrosis	Y	N
Heart Attack	Y	N	Rheumatoid Arthritis	Y	N
Heart murmur / valve problem	Y	N	Sleep Apnea	Y	N
Hiatal hernia or "reflux"	Y	N	Strokes	Y	N
HIV or AIDS	Y	N	Stomach ulcers	Y	N
High blood pressure	Y	N	Thyroid Problem	Y	N
Lupus	Y	N			
Environmental allergies	Y	N	Have you taken allergy shots?	Y	N

Please list any other medical problems that are not addressed above: ______________________________

____

Have you had any of the following surgeries? Check the ones you have had and state when you had them.

	When?		
____Aneurysm – chest, abdomen, brain	__________	Lung-thoracotomy or thoracoscopy	__________
____Appendix	__________	Mediastinoscopy	__________
____Back/Spine	__________	Stomach	__________
____Esophagus	__________	Tonsils / Adenoids	__________
____Gallbladder	__________	Hernia - hiatal	__________
____Hip/Knee	__________	Hernia - inguinal	__________
____Heart bypass	__________	Hernia - umbilical	__________
____Heart valve replacement	__________	Hernia - ventral	__________
____Heart pacemaker	__________	Hernia - other	__________
____Heart defibrillator	__________	Other Vascular Procedure	__________

Are you allergic to any medication that you know of? (including IV contrast or "dye") If yes, please list:

If you are taking any medications, please give a complete list to the nurse.

This includes inhalers, birth control pills, vitamins, herbal medicines and over-the-counter medication.

Patient Name:____ **DOB**__________________________

FAMILY MEDICAL HISTORY

Does anyone in your immediate family have these conditions? This only applies to your parents, siblings and children.

Asthma____ Diabetes____

Emphysema or COPD_________________________________ Pulmonary Fibrosis___________________________________

Cystic Fibrosis _______________________________________ Strokes____

Coronary Disease_____________________________________

Cancer (what kind?) ____

SLEEP HISTORY

Do you snore?	Y	N
Do you have difficulty falling asleep?	Y	N
Do you have difficulty staying asleep?	Y	N
Can you fall asleep easily during the day?	Y	N
Have you been told that you hold your breath while sleeping?	Y	N
Do you thrash about while sleeping?	Y	N
Do you have vivid nightmares often?	Y	N
Do you ever drink alcohol or take medication to fall asleep?	Y	N
Do you wake up in the morning feeling like you never slept?	Y	N

SOCIAL / OCCUPATIONAL HISTORY

Marital Status: S M W D

Current employment (please be specific about what you do) ____

____

Past employment ____

____

Hobbies ____

Pets ____

Have you ever traveled over seas? If so, where and when ____

Any exposure to lung toxins, such as _____Asbestos _____Chlorine _____Welding Fumes

_____Coal Dust _____Beryllium _____Silica

Do you drink alcohol? Y N How much? ____

Do you use drugs illegal drugs? Y N What kind? ____

Do you have any risk factors for HIV / AIDS such as I.V. drugs, sex with prostitutes, multiple sex partners? Y N

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Name: ____ DOB____________________________________

REVIEW OF SYSTEMS Do you have any of these problems? If so, please • those you have.

CONSTITUTIONAL

_____ Fever
_____ Weight Loss
_____ Loss of appetite
_____ Excessive fatigue or weakness

EYES

_____ Change in vision
_____ Double vision
_____ Abnormal eye pain
_____ Glasses or Contacts
_____ Discharge from eyes

EARS, NOSE, THROAT

_____ Postnasal drip
_____ Runny Nose
_____ Nasal Polyps
_____ Frequent nosebleeds
_____ Sore throat
_____ Dental problems or dentures
_____ New hoarseness or change in voice
_____ Change in hearing
_____ Frequent ear ache or discharge
_____ Ringing in ears
_____ Bleeding gums
_____ Swollen glands in neck

CARDIAC

_____ Chest Pain
_____ Palpitations
_____ Heart Murmur

URINARY

_____ Frequent urination
_____ Pain with urination
_____ Blood in urine
_____ Frequent urination at night
_____ Bedwetting
_____ Kidney Stones
_____ Leakage of urine
_____ Hard to start urinary flow

DERMATOLOGIC

_____ Rash
_____ Abnormal Itching
_____ Skin color change
_____ Abnormal hair growth

DIGESTIVE

_____ Heartburn
_____ Sour taste in throat
_____ Frequent abdominal pain
_____ Frequent nausea or vomiting
_____ Frequent constipation or diarrhea
_____ Blood in stools or black stools
_____ Vomiting blood
_____ Gallstones
_____ Yellow Skin

MUSCULOSKELETAL

_____ Abnormal muscle or joint pain
_____ Problems walking
_____ Abnormal back pain
_____ Muscle jerking
_____ Physical handicap
_____ Swollen or red joints

HEMATOLOGIC / LYMPHATIC

_____ Anemia
_____ Abnormal bleeding
_____ Easy bruising
_____Swollen glands

NEUROLOGIC

_____ Tremors
_____ Seizures
_____ Numbness / tingling
_____ Fainting
_____ Persistent / recurrent headaches
_____ Dizziness
_____ Paralysis
_____ Speech problems

IMMUNOLOGIC

_____ AIDS
_____ Chronic steroid use
_____ Recurrent infections

PSYCHIATRIC

_____ Depression
_____ Nervous Breakdown
_____ Mental Disorders
_____ Alcohol problems
_____ Drug Problem
_____ Memory loss

WOMEN ONLY _____ Abnormal Menstrual periods
_____ Possibly pregnant

PATIENT SIGNATURE: ____

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Patient____ DOB___________________________

Pharmacy:____ Pharm Address:____ __

Pharm Phone: _____________________________________ Drug Plan? N Y Plan Name:____

DRUG ALLERGIES:____

PLEASE LIST ALL OF YOUR CURRENT MEDICATIONS. IF YOU ARE UNSURE, BRING YOUR MEDICINE WITH YOU.

BE SURE TO SPELL EXACTLY AS LISTED ON YOUR MEDICINE BOTTLE AND GIVE THE DOSAGE.

MEDICATION NAME	Strength IE: 150mg	DOSE IE: take 1 tablet 2 times per day	PRESCRIBED BY

PROB&DRU1008