LUNG ASSOCIATES P.A.

ACCREDITED MEMBER CENTER

PATIENT REGISTRATION INFORMATION

PLEASE BRING TO YOUR APPOINTMENT:

- ☐ GOVERNMENT ID
- ☐ INSURANCE CARD

DATE: _____

DEMOGRAPHICS

FIRST NAME: _____ MI: _____ LAST NAME: _____

GENDER: ☐ MALE ☐ FEMALE D.O.B.: _____

PRIMARY ADDRESS: STREET: _____

CITY: _____ STATE: _____ ZIP CODE: _____

IF YOU LIVE OUT OF STATE, PLEASE PRO IDE A SECONDARY ADDRESS:

SECONDARY ADDRESS: STREET: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PREFERRED CONTACT METHOD:

PHONE #: _____ ☐ HOME ☐ CELL ☐ WORK Ext: _____

PHONE #: _____ ☐ HOME ☐ CELL ☐ WORK Ext: _____

EMAIL: _____

PLEASE CHECK THE FOLLOWING: I give permission to receive information about appointments, testing lab results, billing information, medical information through: ☐ VOICEMAIL ☐ TEXT MESSAGE ☐ EMAIL ☐ MAIL

SIGNATURE: _____ DATE: _____

ADVANCED DIRECTIVES:

Do you have an advanced care plan or surrogate decision maker? ☐ NO ☐ YES

If *YES*, please provide a copy of your documentation or provide surrogate's name: _____

If *NO*, would you like information about an advanced care plan? ☐ NO ☐ YES *(provided at first office visit)*

EMERGENCY CONTACTS:

NAME: _____ RELATIONSHIP: _____ PHONE: _____

NAME: _____ RELATIONSHIP: _____ PHONE: _____

INSURANCE INFORMATION:

PRIMARY: _____ SUBSCRIBER: _____

GROUP: _____ MEMBER ID _____

SECONDARY: _____ SUBSCRIBER: _____

GROUP: _____ MEMBER ID: _____

ADDRESS: 203 3rd Ave East Bradenton, FL 34208
OFFICE: (941) 741-8633 | **FAX**: (941) 741-8632 |

PATIENT REGISTRATION INFORMATION

SOCIAL HISTORY

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LIFE PARTNER

DO YOU LIVE HERE YEAR-ROUND? ☐ YES ☐ NO If no, part time location? _____

OCCUPATION: ☐ EMPLOYED: _____ ☐ RETIRED ☐ DISABLED

TOBACOO USE: ☐ NEVER ☐ FORMER ☐ CURRENT

➔ IF *FORMER* USE: TYPE: _____ NUMBER OF YEARS USED: _____ QUIT DATE: _____

➔ IF *CURRENT* USE: TYPE: _____ AMOUNT PER DAY: _____

ALCOHOL USE: ☐ NO ☐ YES If yes, how many drinks/how often: _____

CAFFEINE USE: ☐ NO ☐ YES If yes; ☐ COFFEE ☐ SODA ☐ TEA ☐ ENERGY D INKS

➔ how many drinks/how often: _____

ILLICIT DRUG USE: (including marijuana, cocaine, steroids): ☐ NEVER ☐ PAST ☐ CURRENT

PAST MEDICAL HISTORY

Check if you have had any of the following

☐ COPD	☐ Atrial Flutter	☐ Diabetes	☐ Peripheral Artery Disease
☐ Asthma	☐ Lung disease	☐ Sleep Apnea	☐ Peripheral Vascular Disease
☐ Acid Reflux	☐ Right side heart disease	☐ Gout	☐ Peripheral Stents
☐ Emphysema	☐ Carotid Artery Disease	☐ Heart Attack	☐ Pulmonary Emboli
☐ Pulmonary Fibrosis	☐ Memory Issues	☐ High Blood Pressure	☐ Renal Artery Disease
☐ Angina	☐ Coronary Artery Disease	☐ High Cholesterol	☐ Rheumatic Fever
☐ Anxiety	☐ Coronary Artery Bypass	☐ Kidney Disease	☐ Stroke
☐ Arrhythmia	☐ Coronary Artery Stent	☐ Liver Disease	☐ Thyroid Disease
☐ Dementia	☐ Congestive Heart Failure	☐ Obesity	☐ TIA
☐ Arthritis	☐ Deep Vein Thrombosis	☐ Pacemaker/Defibrillator	
☐ Atrial Fibrillation	☐ Depression		

Other: _____

_____

_____

_____

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LUNG ASSOCIATES P.A.

PATIENT REGISTRATION INFORMATION

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE SLEEP — ACCREDITED MEMBER CENTER

PAST SURGICAL HISTORY

SURGICAL PROCEDURE	DATE

FAMILY HISTORY

Father: ☐ Living ☐ Deceased at age: _____ ☐ Brother ☐ Sister: ☐ Living ☐ Deceased at age: _____

Mother: ☐ Living ☐ Deceased at age: _____ ☐ Brother ☐ Sister: ☐ Living ☐ Deceased at age: _____

☐ Adopted/Family Health History Unobtainable ☐ Brother ☐ Sister: ☐ Living ☐ Deceased at age: _____

PLEASE CHECK ALL THAT APPLY

	FATHER	MOTHER	BROTHER	SISTER
ANEURYSM				
ARRHYTHMIA				
BLEEDING PROBLEMS				
DIABETES				
HEART ATTACK				
HEART DISEASE				
HIGH BLOOD PRESSURE				
HIGH CHOLESTEROL				
KIDNEY DISEASE				
STROKE				
(O):				
(O):				
(O):				

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PATIENT REGISTRATION INFORMATION

IMMUNIZATIONS

VACCINE TYPE	MONTH/YEAR
COVID VACCINE: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson	
INFLUENZA VACCINE:	
PNEUMONIA VACCINE:	

PHARMACY

LOCAL PHARMACY: _____ PHONE: _____

LOCATION: _____ CITY: _____ STATE: _____

SECONDARY PHARMACY: _____ PHONE: _____

LOCATION: _____ CITY: _____ STATE: _____

ALLERGIES

Please list any allergies to medications or foods.

☐ **No Known Drug Allergies** ☐ **No Known Food Allergies**

NAME	SYMPTOM / REACTION	SEVERITY
ALLERGY TO SHELLFISH OR IODINE? ☐ NO ☐ YES	If yes, list reaction:	☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe
		☐ Mild ☐ Moderate ☐ Severe

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PATIENT REGISTRATION INFORMATION

MEDICATIONS			
MEDICATION	DOSE	ROUTE	FREQUENCY

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LUNG ASSOCIATES P.A.

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE SLEEP — ACCREDITED MEMBER CENTER

PATIENT REGISTRATION INFORMATION

VEIN DISORDER QUESTIONNAIRE		
Do you have swollen ankles or legs?	☐YES	☐NO
Are leg symptoms worse in the evening?	☐YES	☐NO
Do you get nighttime leg cramping?	☐YES	☐NO

SYMPTOMS IN LAST 30 DAYS QUESTIONNAIRE		
In the last 30 days, have you experienced the following?		
Shortness of breath when walking 1 to 2 blocks?	☐YES	☐NO
Shortness of breath when climbing 1 flight of stairs?	☐YES	☐NO
Shortness of breath while at rest, such as lying down or sitting?	☐YES	☐NO
Lower leg cramping with walking?	☐YES	☐NO
High blood pressures?	☐YES	☐NO
Uncomfortable feeling in chest?	☐YES	☐NO
Chest pain with activity?	☐YES	☐NO
Irregular heartbeat, such as palpitations?	☐YES	☐NO
Swollen ankles or feet?	☐YES	☐NO
Weight gain between 5-10lbs?	☐YES	☐NO
Worsening fatigue?	☐YES	☐NO
Dizziness and/or lightheadedness	☐YES	☐NO
Passing out	☐YES	☐NO
Additional Symptoms:		

PRIMARY CARE PROVIDER & SPECIALISTS

Primary Care Provider: _____ Phone: _____

Address: _____

Specialist: _____ Phone: _____

Address: _____

Specialist: _____ Phone: _____

Address: _____

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LUNG ASSOCIATES P.A.

AMERICAN ACADEMY OF SLEEP MEDICINE WAKE SLEEP ACCREDITED MEMBER CENTER

ASSIGNMENT OF INSURANCE BENEFITS

MEDICAL AND SUPPLEMENTAL INSURANCE

I authorize any holder of medical information about me to release to the Centers for Medicare and Medicare Services (CMS) and its agents and/or any supplemental insurance companies any information needed to determine benefits or the benefits payable for related services. I request that payment of authorized benefits be made to Lung Associates on my behalf for any services furnished for me or by Lung Associates, including physician and midlevel services. I authorize Lung Associates to act as my agent and help me assure payment from Medicare and any supplemental insurance companies. As part of my treatment, Lung Associates may prescribe testing procedures to be performed here. **I understand that I am responsible for full payment of including services any charges, not covered, deductibles, and/or copayments due.**

_____ _____

Print Name of Patient / Legal Representative *Date*

_____ _____

Signature of Patient / Legal Representative *Description of LR's Authority*

COMMERCIAL INSURANCE

I authorize the release of medical information that is necessary to process claims. I understand that some, and perhaps all, of the services may be non-covered services and may not be considered medically necessary under my insurance contract. I request that payment of authorized benefits be made on my behalf to Lung Associates for any services provided by Lung Associates physicians or midlevel providers.

I **understand that I am responsible for full payment of any charges, including non-covered services, deductible, and or copayments due. I further understand that I am responsible to notify this office of any pre-authorization or pre- certification required by my insurance company. It is my responsibility to ensure that an authorization is on file with Lung Associates prior to having my procedure performed. When applicable, I understand that I am responsible for full payment of all charges in the absence of authorization.**

_____ _____

Print Name of Patient / Legal Representative *Date*

_____ _____

Signature of Patient / Legal Representative *Description of LR's Authority*

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LUNG ASSOCIATES P.A.

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE SLEEP — ACCREDITED MEMBER CENTER

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ D.O.B.: _____

Social Security Number: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I authorize Lung Associates ☐ Send my records to: ☐ Obtain my records from:

Name of Physician/Facility: _____

Address: _____

Phone #: _____ Fax #: _____

☐ Continued Medical Care ☐ Personal Use ☐ New Patient

For the Purpose of: _____

I understand that my records may contain information about alcohol or drug treatment, mental health, or psychiatric treatment and/or HIV/AIDS information. I do hereby expressly and voluntarily consent to the disclosure of my health information as specified, for the purpose or need as indicated above.

I understand this consent will expire 12 months after the date below, or when the information requested with this consent has been released. A photocopy of this authorization shall have the same effect as the original.

_____ _____

Print Name of Patient / Legal Representative *Date*

_____ _____

Signature of Patient / Legal Representative *Description of LR's Authority*

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CANCELLATION, NO SHOW, & LATE POLICY

Thank you for trusting your medical concerns with Lung Associates. When you schedule an with us, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Additionally, we do not recommend arriving more than 10 minutes prior to your scheduled appointment time, as this does not ensure you receive care sooner than your set appointment. New patients will need to arrive 30 minutes prior to their scheduled appointment.

We understand that unforeseen emergencies occur and if you should experience extenuating circumstances, please contact our Office Manager.

Please Read and Initial Next to Each Indicated Item:

_____ For Established Patients, Cancellations made without the courtesy of 24-Hour notice, Missed Appointment, or No Show will be charged a $50 fee for Office Visits and PFT'S. There is a $150 fee for Sleep Studies.

_____ For New patient, Cancellations made without the courtesy of a 24-Hour notice, Missed Appointment, or a No Show will be charged a $250 fee. Please see the attached page.

_____ Arriving Later than 15 minutes for your appointment, you will be given the option of: Waiting until the end of the day to see a provider if an appointment is available. Reschedule your appointment for a later date and time.

_____ Multiple *NO SHOWS* in any 12-month period may result in termination from our practice.

*****These fees are not covered by insurance and must be paid prior to your next appointment*****

By Signing below, you acknowledge that you have received and that you understand the Cancellation, No Show, and Late Policy.

_____ _____

Print Name of Patient / Legal Representative *Date*

_____ _____

Signature of Patient / Legal Representative *Description of LR's Authority*

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LUNG ASSOCIATES P.A.

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE SLEEP
ACCREDITED MEMBER CENTER

CONSENT FOR PURPOSE OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Lung Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or conduct health care operations of Lung Associates. I understand my diagnosis or treatment of me by Lung Associates may be upon my consent as evidenced by my signature on this document.

I understand I have the right to request restrictions as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of Lung Associates.

Lung Associates is not required to agree to the restrictions that I may request. However, if Lung Associates agrees to a restriction that I request, the restriction is binding of Lung Associates.

I have the right to revoke this consent, in writing, at any time, except to the extent that Lung Associates has acted in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Lung Associates Notice of Privacy Practices prior to signing this document. Lung Associates Notice Of Privacy Practices has been provided to me. The Notice of Privacy described the type of uses and disclosures of protected health information that will occur in my treatment, payment of my bills or in the performance of the heath care operations of Lung Associates. The Notice of Privacy Practices for Lung Associates is also provided in our waiting room. The Notice of Privacy Practices also describes my rights and the

Lung Associates reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy to be sent in the mail or by asking for one at the time of my next appointment.

_____	_____
Print Name of Patient / Legal Representative	*Date*
_____	_____
Signature of Patient / Legal Representative	*Description of LR's Authority*

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LUNG ASSOCIATES P.A.

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE SLEEP — ACCREDITED MEMBER CENTER

HIPAA PRIVACY AUTHORIZATION/MEDICAL INFORMATION RELEASE FORM

We cannot discuss your health information with anyone other than yourself (including spouse) unless you provide us with authorization to do so. Please list below names of the individual/s you authorize our office to discuss care with.

This authorization includes appointment information, complete medical information including treatment plan and/or diagnosis, billing and claim information, and any other pertinent medical information contributed to my health care plan or treatment and care.

Designated Individual/s:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize Lung Associates to disclose/discuss my protected health information described above with the listed individual/s.

_____ _____

Print Name of Patient / Legal Representative *Date*

_____ _____

Signature of Patient / Legal Representative *Description of LR's Authority*

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LUNG P.A. ASSOCIATES

AMERICAN ACADEMY OF SLEEP MEDICINE — WAKE SLEEP — ACCREDITED MEMBER CENTER

WAIVER OF CHAPERONE FORM

It is Lung Associates, PA policy that, for the protection of the patient and the Lung Associates, PA Staff, any patient or provider may request that a second healthcare professional serve as a chaperone during any medical examination.

Your rights as a patient include:

- Lung Associates, PA should accommodate patient preference as to chaperone gender whenever appropriate and feasible.
- If a chaperone of the requested gender is not available, the patient shall be given the opportunity to reschedule the appointment within a reasonable amount of time from the originally scheduled date.
- If a patient refuses to have a chaperone for an examination where one is required or one where the provider has requested a chaperone, Lung Associates may transfer care to nother provider or
- clinic. The provider must document their discussion with the patient regarding Lung Associates requirement and the patient's refusal.
- In a non-emergency situation, the provider may either perform the examination without a chaperone or refer the patient to another qualified provider. The provider must document the referral and the reason for it.

By signing this form, you are waiving the need for a chaperone for office visits, testing, and procedures. At any time, a patient may rescind this waiver and request a chaperone. This waiver will remain in place for 1 year from the date of signature and will be renewed on an annual basis. If you have any questions, please do not hesitate to ask the clinical staff, or ask to speak to a member of management.

_____	_____
Print Name of Patient / Legal Representative	*Date*
_____	_____
Signature of Patient / Legal Representative	*Description of LR's Authority*

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Lung Associates P.A.
Sleep Disorders Clinic P.A.

Welcome to Lung Associates and thank you for choosing our practice. Lung Associates are comprised of highly trained and experienced staff to treat Pulmonary and Sleep conditions. We apply the latest advances in our Pulmonary and Sleep medicine to treat and manage these conditions. It is our goal to treat the patient with a care plan that brings them peace of mind with a knowledge and understanding of their condition and treatment plan. Every patient is considered special and treated with the highest level of care.

I have personally hired the Nurse Practitioners to be Providers at Lung Associates. Each of the Practitioners has solid and impressive backgrounds. Furthermore, we have spent the last few years developing an impressive team and I could not be more confident in their ability to help me in the management of your care. The benefits of seeing the Nurse Practitioners include longer patient encounters which also lead to more opportunities to provide education about your condition, strategies to manage it and ways to prevent further disease or complications.

The entire Lung Associates team values every patient, and every patient deserves the highest quality of care. Many patients have indicated that they have special circumstances, or they are Dr. Rampertaap only. All patients will see both myself and the Nurse Practitioners so that our entire team will know you and be able to knowledgeably care for you both in the office and the hospital.

It is my privilege that you include me in your healthcare plan, and I look forward to my team and I caring for you and your loved ones in the years to come.

With Gratitude,

Moonasar Rampertaap, M.D., F.A.C.P

PLEASE SIGN THE STATEMENT BELOW

I _____(PRINT NAME: Patient/Guardian) have read the contents of this letter and acknowledge that I must see all providers of Lung Associates, PA for the most comprehensive management of my pulmonary health.

Signature: _____ Date: _____

Patient/Guardian

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