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

M.P Rampertaap, MD, FCCP

Board Certified: Internal Medicine, Critical Care Medicine,

Pulmonary Medicine, Sleep Medicine

ACCREDITED MEMBER CENTER

Patient Information / Please Print

First Name: _____ Last: _____ MI: ___ Age: _____

Address: _____ City: _____ ST: ___ Zip: _____

Home #: _____ Work/Cell #: _____ Marital Status: S M W D

Date of Birth (MM/DD/YYYY): ____/____/_____ Social Sec. #: _____

Email: _____

Spouse First name: _____ Last: _____ MI: ___

Work/Cell#: _____ Date of Birth (MM/DD/YYYY): ____/_____/_____

Emergency Contact Name: _____ Phone #: _____

Relationship: _____ Alternate Phone #: _____

If not Permanent Florida Resident, Enter Alternate Address:

Address: _____ City: _____ ST: ___ Zip: _____

Home #: _____ Work/Cell #: _____

Commercial Insurance/Medicare Supplement

Name: _____

Address: _____

Plan ID#: _____ Phone #: _____

1. I understand that if I have no insurance or I am a Canadian resident, all office charges are to be pad at the time of service.
2. I authorize treatment rendered to me by Lung Associates, P.A. Sleep Disorders Clinic
3. I authorize release of medical records services directly to Lung Associates Sleep Disorder Clinic
4. I authorize payment of medical services directly to Lung Associates Sleep Disorders Clinic.
5. Copies of charts will be done for a fee to attorneys and insurance companies. If the fee is denied by the requesting agency, this fee then becomes the responsibility of the patient if they still wish to have records released.
6. Patients who have changed insurance companies or their mailing address, need to make office aware of the change at the time of service or sooner. ***IF THIS IS NOT DONE, THE ENTIRE BALANCE THEN BECOMES THE PATIENTS RESPONSIBILITY.***

Signature: _____ Date: _____

203 3rd Ave E Bradenton, FL 34208 • Office 941-741-8633 Fax 941-741-8632

4002 SR 674, Suite A Sun City Center, FL 33573 • Office 813-634-3306 Fax 813-634-2055

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Name: _____ DOB: _____

Primary Care Physician: _____

Phone: _____ Fax: _____

Pharmacy: _____

Phone: _____ Fax: _____

List all medications you are currently taking:

Medication Name	Dosage	Frequency

Please list allergies or reactions to medications, vaccines, and/or foods: _____

_____

Signature: _____ Date: _____

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No Show/Late Cancellation Policy

We strive to provide excellent medical care to all our patients. To do so effectively and efficiently, we have an appointment cancellation policy that applies to new and existing patients of the practice. We understand that situations arise in which you must cancel your appointment. It is, therefore, requested that if you must cancel your appointment, give our office at least 24-hour's notice for the appointment and 48- hours' notice for testing. This will allow us to offer that time to another patient on our waitlist. To remain consistent with our mission, we have instituted the following policy.

A "No-Show," "No-Call," or missed appointment without proper 24-hour 48-hour notification may be assessed a fee.

You will receive a phone call informing you of your missed appointment with the opportunity to reschedule. Any established patient who fails to show or cancels/reschedules an appointment with no 24-48-hour notice will be charged a $50.00 fee.

This fee is NOT billable to your medical insurance.

As a courtesy, we make reminder calls for appointments one or two days in advance. Please note that if a reminder call or message is not received, the cancellation policy remains in effect.

New Patient & Follow-up appointment: Missed appointment fee of $50
PFT: Missed appointment fee of $50
Sleep Study: Missed appointment fee of $150
Home Sleep Test: Missed appointment fee of $50

Financial Responsibility I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and pay in full for all charges not covered by my insurance company. I authorize my insurance benefits to be paid directly to Florida Sleep Specialist/Discover Health for services rendered. I authorize Florida Sleep Specialists/Discover Health representatives to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim. This signature will act as a lifetime authorization for Medicare. I have read and understood the above Financial Policy and agree to meet all financial obligations.

Printed Name: _____ DOB: _____ Signature: _____

LUNG ASSOCIATES P.A.
SLEEP DISORDERS CLINIC

ACCREDITED MEMBER CENTER

Of Manatee

M P Rampertaap: MD, FACP, FCCP

Board Certified: Internal Medicine, Critical Care Medicine, Pulmonary Medicine and Sleep Medicine

Accredited by the American Academy of Sleep Medicine

Dear Patient,

There is much confusion with respect to which medical insurance plans cover our services and which don't.

In the past we would know that anyone with insurance with a particular carrier would be covered with us, but now many insurance carriers have different plans and we are not on all of them.

We can delay your treatment by waiting to find out in advance whether we are on the provider panel of the plan you have, or alternatively you can agree to pay any amounts that the plan does not pay.

Please sign the below or let us know if you want us to try to verify coverage before providing services. We are fine either way.

If the carrier ends up telling us that we are not in network in your particular plan, then we will still submit the claim to see if they will pay any "out of network" benefit. If so, we will bill you for the difference between what the carrier paid us and the amount of the coinsurance that you are responsible for as indicated by your plan under your out-of-network benefit. If you do not have an out-of-network benefit under your plan then we will bill you for the amount that we customarily charge for the service.

Very truly yours

I agree to pay Dr. Rampertaap as stated above. I understand that many health insurance companies have multiple plans that Dr. Rampertaap may or may not be on the provider panel of the insurance plan that I am on and some services may or may not be covered; I am willing to pay for the uncovered services.

I understand that I could request that services be delayed until it is confirmed that Dr. Rampertaap is on the panel of my particular plan, but have elected to not do so to avoid delay in treatment.

Best regards.

Patient Name: _____ DOB: _____ Date: _____

Lung Associates P.A
Sleep Disorders Clinic, PA of Manatee
Phone: (941) 741-8633 • Fax: (941) 741-8632

M P Rampertaap, M.D., F.A.C.P., F.C.C.P.
Diplomat & Fellow American Board of Internal Medicine
Diplomat & Fellow American Board of Pulmonary Medicine

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: **Dr. Moonasar Rampertaap Phone: 941-741-8633 FAX: 941-741-8632**

Address: **203 3rd Avenue East**

City: **Bradenton** State: **Florida** Zip Code: **34208**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: Continuation of Care

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

LUNG ASSOCIATES P.A.

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*

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

Lung Associates P.A.
EPWORTH SCALE/ SLEEP EVALUATION

PATIENT NAME: _____ **Age:**_____ **DOB:**_____

Height: _____ **Weight:**_____ **BMI:** _____ **Neck C:**_____ **Mallampati:** II III IV

Do you snore? Yes No Don't Know

Is your snoring: slightly louder than breathing7 --- ·As loud as talking7 _Louder than talking,_ Very loud and heard in adJacent rooms, _____

How often do you snore? Nearly every night 3-4 x a week---

Has your snoring ever bothered other people?			Yes	No	
Has anyone noticed that you quit breathing in your sleep?			Yes	No	
Do you wake up gasping for air?			Yes	No	
How often do you feel tired or fatigued after your sleep?	Daily	3-4x/week	1-	1-	never/near
2x/week During your wake time, do you feel tired, fatigued or not wake up to par7				2x/month	never
		Daily	3-4x/week	1-2x/week	never/near
					never
Have you ever nodded off or fallen asleep in a vehicle?			Yes	No	
If yes, how often'		3-4x/week	1-2x/week	1-2x/month	never/near
	Dail		Yes	No	never
y Do you have headaches,		3-4x/week	1-2x/week	1-2x/month	
If yes, how often?	Daily		Yes	No	never/near
Do you have high blood pressure7					never
Do you dream7			Yes	No	
If yes, are these dreams pleasant or scary? _____					
Do you thrash around in your sleep?			Yes	No	
Do you have memory problems,			Yes	No	
Do you have cardiac arrythmias?			Yes	No	
How would you rate your overall sleep quality?	Poor		Fair	Excellent	
Does your sleep quality interfere with your quality	of life,		Yes	No	
Cause Difficulty	Work		Yes	No	
	Family		Yes	No	
	Hobbies		Yes	No	
	Spouse		Yes	No	
	Social Life		Yes	No	
Medication	Sleeping pills		Yes	No	
	Anti-depressants		Yes	No	

0=would never dose I=slight change of dozing 2=possible chance of dozing 3=high chance of dozing

Sitting and Reading:	0		2	3
Watching television	0	1	2	3
Sitting inactive in a public place (ie. Theater)	0		2	3
As a passenger in a car	0		2	
Lying down to rest in the afternoon	0		2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

TOTAL EES:_____

WHO CLASS: III IV ~~NYHA~~ Class: II III ~~IV~~