

SLEEP DISORDERS EVALUATION

When registering, please present proof of insurance, Medicare and/or Medicaid. Payment is expected at the time of service unless special arrangements are made.

PATIENT INFORMATION

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____ Marital Status: _____
Date of Birth: _____ Age: _____ Sex: M F
Driver's License Number: _____ State: _____
Social Security Number: _____
Student: Y N Referred by: _____

PATIENT'S EMPLOYER

Employer: _____
Occupation: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

PATIENT'S SPOUSE/GUARDIAN

Spouse/Guardian: _____
Relationship: _____ Phone: _____
City: _____ State: _____ Zip: _____
Employer: _____ Phone: _____

RESPONSIBLE PARTY *(if other than patient)*

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____ Phone: _____
Social Security Number: _____
Emergency Contact (not living with you): _____
City: _____ State: _____ Zip: _____
Phone: _____

I certify the above information is correct to the best of my knowledge. I also understand that I am financially responsible for all charges whether or not covered by insurance. I authorize the release of any medical or other information necessary to process this claim. I also request payment of claims to be paid to Pulmonary Associates of Brandon.

Signature: _____ Date: _____

4. On the scale below, please estimate the severity of your problem(s).

- Mildly upsetting
- Moderately severe
- Very severe
- Extremely severe
- Totally incapacitating

5. How strongly do you want help with your problem?

- Very much
- Much
- Moderately
- Could do without it

6. How do you describe your sleep problem?

- Difficulty falling asleep
- Wake up during the night
- Wake up in the early morning
- Excessive daytime sleepiness
- Difficulty awakening

7. Do any other members of your family have sleep problems? Please explain.

8. Have you ever consulted with any of the following to help you with a sleep problem or daytime sleepiness?

- | | |
|--|--|
| <input type="checkbox"/> General Practitioner | <input type="checkbox"/> Chiropractor |
| <input type="checkbox"/> Obstetrics/Gynecology | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Nutritionist |
| <input type="checkbox"/> Other Internists | <input type="checkbox"/> Counselor |
| <input type="checkbox"/> Psychiatrist | <input type="checkbox"/> Social Worker |
| <input type="checkbox"/> Other Physician | <input type="checkbox"/> Nurse |
| <input type="checkbox"/> Clinical Psychologist | <input type="checkbox"/> Clergyman |
| <input type="checkbox"/> Other: _____ | |

9. What treatments have you received?

10. Please rate how often you:

N: Never (or NO) R: Rarely O: Occasionally F: Frequently C: Constantly

| | | | | | |
|--|---|---|---|---|---|
| Awaken from sleep short of breath | N | R | O | F | C |
| Awaken at night with heartburn, belching, or cough | N | R | O | F | C |
| Snore | N | R | O | F | C |
| Snore loudly enough that others complain | N | R | O | F | C |
| Have trouble sleeping when you have a cold | N | R | O | F | C |
| Suddenly wake up gasping for breath during the night | N | R | O | F | C |
| Have breathing problems at night (observed by others) | N | R | O | F | C |
| Sweat excessively at night | N | R | O | F | C |
| Notice your heart pounding or beating irregularly during the night | N | R | O | F | C |
| Fall asleep during the day | N | R | O | F | C |
| Fall asleep involuntarily | N | R | O | F | C |
| Fall asleep while driving | N | R | O | F | C |
| Fall asleep during physical effort | N | R | O | F | C |
| Fall asleep when laughing or crying | N | R | O | F | C |
| Experience loss of muscle tone when extremely emotional | N | R | O | F | C |
| Have trouble at school or work because of sleepiness | N | R | O | F | C |
| Feel unable to move (paralyzed) when waking or falling asleep | N | R | O | F | C |
| Experience vivid dreamlike scenes upon awakening or falling asleep | N | R | O | F | C |
| Feel afraid of going to sleep | N | R | O | F | C |
| Have nightmares | N | R | O | F | C |
| Remember your dreams | N | R | O | F | C |
| Have thoughts racing through your mind | N | R | O | F | C |
| Feel sad or depressed | N | R | O | F | C |
| Have anxiety (worry about things) | N | R | O | F | C |
| Have muscular tension | N | R | O | F | C |
| Notice parts of your body jerk | N | R | O | F | C |
| Kick during the night | N | R | O | F | C |
| Experience crawling and aching feelings in your legs | N | R | O | F | C |
| Experience any type of leg pain during the night | N | R | O | F | C |
| Have morning jaw pain | N | R | O | F | C |
| Grind teeth during sleep | N | R | O | F | C |
| Bothered by pain during the day | N | R | O | F | C |
| Awakened by pain during the night | N | R | O | F | C |
| Wake up feeling stiff in the morning | N | R | O | F | C |
| Wake up with sore or achy muscles | N | R | O | F | C |
| Wake up with pain in the neck, spine, or joints | N | R | O | F | C |

11. Is your present situation satisfactory?

Yes No

12. Underline any of the following that apply to you.

- | | |
|---|----------------------------|
| Headaches | Dizziness |
| Palpitations | Stomach trouble |
| Bowel disturbances | Fatigue |
| Nightmares | Take sedatives |
| Feel tense | Feel panicky |
| Depressed | Suicidal ideas |
| Unable to relax | Sexual problems |
| Do not like weekends and vacations | Overambitious |
| Cannot make friends | Memory problems |
| Cannot keep a job | Inferiority feelings |
| Financial problems | Fainting spells |
| No appetite | Insomnia |
| Alcoholism | Tremors |
| Take drugs | Shy with people |
| Cannot make decisions | Home conditions bad |
| Unable to have a good time | Concentration difficulties |
| Take antacids regularly (Tums, Tagamet, etc.) | Others: _____ |

13. Underline any of the following words that apply to you.

- | | | | |
|---------------|-----------------|---------------|----------------------------|
| Worthless | Useless | A "nobody" | "Life is empty" |
| Inadequate | Stupid | Incompetent | Naïve |
| Guilty | Evil | Morally wrong | "Cannot do anything right" |
| Hostile | Full of hate | Anxious | Horrible thoughts |
| Agitated | Cowardly | Unassertive | Panicky |
| Aggressive | Ugly | Deformed | Unattractive |
| Repulsive | Depressed | Lonely | Unloved |
| Misunderstood | Bored | Restless | Confused |
| Unconfident | Full of regrets | Worthwhile | Sympathetic |
| Intelligent | Attractive | Confident | Considerate |
| Others: _____ | | | |

14. Does your sleep problem disturb your sex life? (Provide any information about any significant relationships.)

15. Is your present social life satisfactory? Does your sleep problem require you to cut back on social activity? If so, how?

16. How many hours of sleep do you usually get per night? _____

17. What time do you usually go to bed on WEEKDAYS? _____ WEEKENDS? _____

18. How long does it take for you to fall asleep? _____

19. How many times do you typically wake up at night? _____

20. If you wake up, on the average, how long do you stay awake? _____

21. If you do awaken during the night (after you first fall asleep), which part(s) of your sleep period is it?

- Soon after falling asleep
- Middle of the night
- Early morning

22. What do you usually do when you awaken during the night?

23. What time do you usually awaken on WEEKDAYS? _____ WEEKENDS? _____

24. On average, how long do you stay in bed after waking up in the morning? _____

25. Do you usually (check all that apply)?

- Sleep with someone else in your bed
- Sleep with someone else in your room
- Provide assistance to someone during the night (child, invalid, bed partner, animal)

26. Is your sleep often disturbed by?

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Heat | <input type="checkbox"/> Light |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Bed partner |
| <input type="checkbox"/> Noise | <input type="checkbox"/> Not being in your usual bed |
| <input type="checkbox"/> Other: _____ | |

27. Are your sleep habits on weekends different from the rest of the week?
 No Yes; please describe: _____
28. With whom are you now living (wife, husband, children, parents, etc.; please list ages)?

29. Do you work split shift or rotating (variable) shifts?
 Yes No
30. Do you usually drink coffee or tea within two hours before going to bed?
 Yes No
31. Do you do physical exercise before bedtime?
 Yes No
32. Do you read before falling asleep?
 Yes No
33. Do you watch TV before falling asleep?
 Yes No
34. Do you take naps in the afternoon or evening?
 Yes No
35. Do you feel refreshed after a short (10-15 minute) nap?
 Yes No
36. How do you feel after an average night of sleep?
 Usually drowsy and/or tired; if so, how long?
 1 hour 2 hours 3 hours or longer Most of the time
 Consistently good
37. Do you feel better during?
 Morning Afternoon Evening

38. Do you take any kind of medication?

| <u>Name</u> | <u>Amount</u> | <u>How Often</u> | <u>Reason</u> |
|-------------|---------------|------------------|---------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

39. List your consumption of the following per day.

| | | | |
|-----------|-------|------------------------|-------|
| Coffee | _____ | Alcohol | _____ |
| Tea | _____ | Colas | _____ |
| Chocolate | _____ | Over-the-counter drugs | _____ |
| Nicotine | _____ | Other drugs | _____ |

40. How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to estimate how they would have affected you. Use the following scale to choose the most appropriate number in each situation.

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

| | <u>Chance of Dozing</u> |
|---|-------------------------|
| Sitting and reading | _____ |
| Watching TV | _____ |
| Sitting inactive in public place (i.e., a theater or meeting) | _____ |
| As a passenger in a car for an hour without a break | _____ |
| Lying down to rest in the afternoon when circumstances permit | _____ |
| Sitting and talking with someone | _____ |
| Sitting quietly after a lunch without alcohol | _____ |
| In a car, while stopped for a few minutes in the traffic | _____ |

41. What is your personal interpretation as to why you have your particular sleep/wake problem?

42. Please describe any other information pertinent to your sleep or wakefulness not previously described.

Medical History

Year of last full physical examination: _____

Significant changes in weight in last year (i.e., after quitting smoking, surgery, through diet):

Gained _____ Lost _____

List diagnoses (and dates) that have been given to you:

Mental health (i.e., depression, suicide, alcoholism):

Nervous system (i.e., strokes, seizures, diabetic nerve damage):

Ears, eyes, nose, and throat (i.e., nasal allergies, polyps, tumors):

Heart/circulation (i.e., heart attacks, failure, irregular heartbeats, mitral valve prolapse):

Blood pressure (i.e., high or low blood pressure):

Breathing (i.e., asthma, bronchitis, emphysema):

Stomach (i.e., swallowing difficulties, heartburn, indigestion, hiatal hernia, ulcers):

Bowels (i.e., diarrhea, constipation, cancer):

Urinary or kidney (i.e., infection with frequent nighttime urination or diuretics, stones, cancer):

Sexual (i.e., loss of desire, impotence, penile implant/testosterone shots):

Hormones (i.e., high or low thyroid conditions, prescribed steroids, prednisone/estrogen, for menopause):

Blood (i.e., "low blood" or anemia, thick blood, sickle cell disease, HIV infection):

Chronic pain (i.e., arthritis, broken hip, osteoporosis):

Surgeries (i.e., tonsillectomy, adenoidectomy, nose, jaw, or face surgery, hysterectomy-partial/full):

Here is a quick test that can help determine the quality of your sleep. If you experience any of the following symptoms on a regular basis, check the box beside each which applies to you.

- | | |
|--|---|
| <ul style="list-style-type: none"><input type="checkbox"/> 1. I have been told that I snore loudly.<input type="checkbox"/> 2. I have been told that I stop breathing or gasp for breath while I sleep, although I do not remember this when I wake up.<input type="checkbox"/> 3. I have high blood pressure.<input type="checkbox"/> 4. My friends and family say they have noticed changes in my personality.<input type="checkbox"/> 5. I am gaining weight.<input type="checkbox"/> 6. I sweat excessively during the night.<input type="checkbox"/> 7. I have noticed my heart pounding/beating irregularly during the night.<input type="checkbox"/> 8. I get morning headaches.<input type="checkbox"/> 9. I seem to be losing my sex drive.<input type="checkbox"/> 10. No matter how hard I try to stay awake, I still fall asleep, even after a full night's sleep.<input type="checkbox"/> 11. When I experience strong emotions, such as anger, fear, or surprise, I go limp.<input type="checkbox"/> 12. I have fallen asleep while driving, even after a full night's sleep.<input type="checkbox"/> 13. I experience vivid dreamlike scenes upon or soon after falling asleep.<input type="checkbox"/> 14. I have fallen asleep during physical effort.<input type="checkbox"/> 15. I feel as though I have to cram a full day into every hour to get anything done.<input type="checkbox"/> 16. I have trouble at work or at school because of sleepiness.<input type="checkbox"/> 17. I often feel paralyzed (unable to move) for brief periods when falling asleep or just after awakening. | <ul style="list-style-type: none"><input type="checkbox"/> 18. I have used antacids (Rolaids, Tums, Alka-Seltzer, etc.) almost every week for stomach troubles and wake up with heartburn.<input type="checkbox"/> 19. I have chronic cough.<input type="checkbox"/> 20. I have morning hoarseness.<input type="checkbox"/> 21. I wake up at night coughing or wheezing.<input type="checkbox"/> 22. I have frequent sore throats.<input type="checkbox"/> 23. Even though I slept through the night, I still feel sleepy during the day.<input type="checkbox"/> 24. Other than when I am exercising, I still experience muscle tension, aching, or crawling sensations in my legs.<input type="checkbox"/> 25. I have been told that I kick at night.<input type="checkbox"/> 26. I experience leg pain during the night.<input type="checkbox"/> 27. Sometimes I just cannot keep my legs still at night. I just have to move them.<input type="checkbox"/> 28. I awaken with sore or aching muscles.<input type="checkbox"/> 29. Thoughts race through my mind and this prevents me from sleeping.<input type="checkbox"/> 30. I wake up during the night and cannot go back to sleep.<input type="checkbox"/> 31. I worry about things and have trouble relaxing.<input type="checkbox"/> 32. I wake up earlier in the morning than I would like to.<input type="checkbox"/> 33. I lie awake for a half hour or more before I fall asleep.<input type="checkbox"/> 34. I feel sad and depressed. I feel afraid to go to sleep. |
|--|---|
-

Score yourself:

Questions 1 through 10 – Describe symptoms experienced by people with *SLEEP APNEA*, a potentially life threatening disorder which causes you to stop breathing repeatedly, often several hundred times per night, during your sleep.

Questions 11 through 17 – Describe symptoms experienced by people with *NARCOLEPSY*, a lifelong disorder characterized by uncontrollable sleep attacks during the day.

Questions 18 through 23 – Describe symptoms experienced by people with *GASTROESOPHAGEAL REFLUX*, a disorder caused when stomach acid backs up into the throat during the night.

Questions 24 through 28 – Describe symptoms experienced by people with *NOCTURNAL MYOCLONUS* or *RESTLESS LEGS SYNDROME*, a disorder characterized by pain or crawling sensations in the legs.

Questions 29 through 34 – Describe symptoms experienced by people with *INSOMNIA*, a persistent inability to fall asleep or stay asleep.

REMEMBER, the test you have just completed describes symptoms that are similar to those individuals with sleep disorders. It is intended as a general source of educational information and should not be used for diagnosis or treatment. Your physician can refer you to a comprehensive sleep center where you can be assured that you will get an in-depth evaluation by highly qualified medical personnel.

HOSPITAL ANXIETY AND DEPRESSION SCALE (HAD)

This questionnaire is designed to help your doctor know how you feel. Ignore the numbers printed on the left of the questionnaire. Read each item and underline the reply that comes closest to how you have been feeling in the past week. Do not take too long on your replies. Your immediate reaction to each item will probably be more accurate than an exhaustively considered response.

A I feel tense or "wound up"

- 3 Most of the time
- 2 A lot of the time
- 1 From time to time (occasionally)
- 0 Not at all

D I still enjoy the things I used to enjoy

- 0 Definitely as much
- 1 Not quite so much
- 2 Only a little
- 3 Hardly at all

A I get a sort of frightened feeling as if something awful is about to happen

- 3 Very definitely and quite badly
- 2 Yes, but not too badly
- 1 A little, but it does not worry me
- 0 Not at all

D I can laugh and see the funny side of things

- 0 As much as I always could
- 1 Not quite so much now
- 2 Definitely not so much now
- 3 Not at all

A Worrying thoughts go through my mind

- 3 A great deal of the time
- 2 A lot of the time
- 1 From time to time, but not too often
- 0 Only occasionally

D I feel cheerful

- 3 Not at all
- 2 Not often
- 1 Sometimes
- 0 Most of the time

A I can sit at ease and feel relaxed

- 0 Definitely
- 1 Usually
- 2 Not often
- 3 Not at all

D I feel as if I am slowed down

- 3 Nearly all the time
- 2 Very often
- 1 Sometimes
- 0 Not at all

A I get a sort of frightened feeling like "butterflies" in the stomach

- 0 Not at all
- 1 Occasionally
- 2 Quite often
- 3 Very often

D I have lost interest in my appearance

- 3 Definitely
- 2 I do not take as much care as I should
- 1 I may not take quite as much care
- 0 I take just as much care as ever

A I feel restless as if I have to be on the move

- 3 Very much indeed
- 2 Quite a lot
- 1 Not very much
- 0 Not at all

D I look forward with enjoyment to things

- 0 As much as I ever did
- 1 Rather less than I used to
- 2 Definitely less than I used to
- 3 Hardly at all

A I get sudden feelings of panic

- 3 Very often indeed
- 2 Quite often
- 1 Not very often
- 0 Not at all

D I can enjoy a good book or radio/TV program

- 0 Often
- 1 Sometimes
- 2 Not often
- 3 Very seldom

A total: _____ D total: _____

Name: _____ Date: _____

Please check appropriate space if you have had any of these illnesses:

CHILDHOOD: Rheumatic Fever _____ Mumps _____ Asthma _____
Scarlet Fever _____ Measles _____ Other _____

ADULT: Glaucoma _____ Stroke or Paralysis _____
High Blood Pressure _____ Diabetes _____
Stomach Ulcers _____ Arthritis _____
Hepatitis/Jaundice _____ Gout _____
Cirrhosis of Liver _____ Thyroid Disease _____
Colitis _____ Anemia _____
Diverticulitis _____ Tuberculosis _____
Gallstones _____ Hay Fever _____
Pancreatitis _____ Pneumonia _____
Kidney Stones _____ Pleurisy _____
Gonorrhea/Syphilis _____ Bronchitis _____
Depression _____ Emphysema _____
Nervous Breakdown _____ Heart Disease _____
Epilepsy/Seizures _____ Cancer _____

HOSPITALIZATIONS AND SURGERIES (please list all your hospitalizations and surgeries):

19 _____ Reason _____ Doctor/Hospital _____
19 _____ Reason _____ Doctor/Hospital _____
20 _____ Reason _____ Doctor/Hospital _____
20 _____ Reason _____ Doctor/Hospital _____
20 _____ Reason _____ Doctor/Hospital _____

FAMILY HISTORY: Father Living _____ Age _____ Deceased _____ Age _____
Illnesses _____ Cause of Death _____
Mother Living _____ Age _____ Deceased _____ Age _____
Illnesses _____ Cause of Death _____

List the name, living, age, and illnesses:

BROTHERS: _____ SISTERS: _____

Please check if any of your blood relatives have had any of the following:

Asthma _____ High Blood Pressure _____ Epilepsy _____
Emphysema _____ Heart Disease _____ Cancer _____
Bronchitis _____ Stroke _____ Hay Fever _____
Tuberculosis _____ Arthritis _____ Anemia _____
Diabetes _____ Gout _____ Other: _____

REVIEW OF SYSTEMS (If you have had any of these symptoms within the last 6 months, please put a check by them. If you are unsure, please put a?):

Weight _____ Have you gained or lost over 10 pounds in the past year? _____

SKIN

- _____ Chronic skin irritation
- _____ Lump or growth
- _____ Change in skin color
- _____ Skin cancers

EYES

- _____ Glasses
- _____ Change in vision
- _____ Pain in eyes
- _____ See halo around lights

EARS

- _____ Trouble hearing
- _____ Earaches
- _____ Discharge from ears
- _____ Buzzing or ringing in ears

NOSE AND THROAT

- _____ Frequent sneezing
- _____ Nose continually stuffy or runny
- _____ Frequent sore throats
- _____ Hoarseness

BREAST

- _____ Lump
- _____ Discharge
- _____ Pain

HEART AND LUNG

- _____ Chest pain with activity
- _____ Other chest pain
- _____ Shortness of breath
- _____ Sleep with more than one pillow to help you breathe
- _____ Blood in sputum
- _____ Wheezing
- _____ Unusual heartbeat
- _____ Heart attack
- _____ Swollen ankles

GENERAL

- _____ Loud snoring
- _____ Unusual fatigue
- _____ Unusual weakness
- _____ Swollen lymph glands
- _____ Fever in past month
- _____ Night sweats

ENDOCRINE

- _____ Frequent urination
- _____ Unusual thirst

GENITOURINARY

- _____ Painful urination
- _____ Frequent urination
- _____ Blood in urine
- _____ Discharge from vagina or penis
- _____ Blood or pus in urine
- _____ Difficulty starting urinating

MUSCULOSKELETAL

- _____ Painful joints
- _____ Sore muscles
- _____ Back pain
- _____ Unusual weakness

NEUROPSYCHIATRIC

- _____ Frequent or severe headaches
- _____ Dizziness or fainting
- _____ Depressed
- _____ Convulsions/epilepsy

LUNGS

Shortness of breath:

- _____ at rest
- _____ walking uphill or upstairs
- _____ walking level with others your own age
- _____ walking level at your own pace
- _____ washing or dressing

How far can you walk without stopping? _____

Do you exercise regularly? _____

What type? _____

STOMACH AND LIVER

- _____ Frequent heartburn/indigestion
- _____ Frequent nausea or vomiting
- _____ Stomach pain
- _____ Constipation
- _____ Bleeding ulcers
- _____ Hemorrhoids
- _____ Blood in bowel movements
- _____ Loss of appetite
- _____ Vomiting blood
- _____ Black bowel movements

PULMONARY ASSOCIATES OF BRANDON

Florida Sleep Disorder Center

Richard S. Powell, M.D.
Daniel G. Lorch, M.D.*
Thomas P. Hooker, D.O.
Arthur E. Graves, M.D.
Suketu K. Shah, M.D.*
Barbara E. Quigley, ARNP



Pulmonary Diseases
Sleep Disorders
Critical Care
Internal Medicine

Diplomat: American Board of Pulmonary Disease; Critical Care; Internal Medicine, Sleep Medicine*

ASSIGNMENT OF BENEFITS

In consideration of Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon services rendered or to be rendered, I assign and transfer any interest in any cause of action to Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon any benefits payable to or for my benefit under my medical insurance policy for payment of services rendered. I agree to fulfill all policy provisions such insurance companies may require for payment. I authorize Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon to initiate a complaint to the insurance commissioner for any reason on my behalf.

I authorize Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon to release any medical information pertaining to my diagnosis and to/or treatment, including laboratory test results, medical history, treatment progress, or any other such related information to: (1) representatives of local, state, or federal agencies in accordance with law; (2) my insurance company or its designated representative; and/or (3) any person(s) or entities financially responsible for my care and treatment. I understand this information may be required to be released in order to obtain payment for my medical expenses incurred at Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon.

I understand that if I receive payment from my insurance company for services rendered by Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon, I am obligated to promptly reimburse Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon for the full amount that I receive. If collection action must be taken to reimburse this facility for misappropriated funds owed Pulmonary Associates of Brandon/Florida Sleep Disorder Center at Brandon, I will be held liable for all charges billed to my insurance company as well as any legal fees incurred.

I, THE UNDERSIGNED, PATIENT OR PATIENT REPRESENTATIVE, HAVE READ AND UNDERSTAND THIS INFORMATION.

Patient/Representative

Date

Witness

Date

PRIVACY PRACTICES ACKNOWLEDGEMENT

Pulmonary Associates of Brandon
910 Oakfield Dr. Suite 102
Brandon, FL 33511
(813) 681-4413

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy at our offices.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing signed by you. However, such a revocation shall not affect any disclosures already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

I, _____, acknowledge receipt of the Notice of Privacy Practices from Pulmonary Associates of Brandon.

Signature: _____ Date: ___/___/___

Witness Signature: _____ Date: ___/___/___

PRIVACY PRACTICES ACKNOWLEDGEMENT

Pulmonary Associates of Brandon
910 Oakfield Dr. Suite 102
Brandon, FL 33511
(813) 681-4413

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operation):

II. Please list the family members or significant others, if any, whom we may inform about our medical condition ONLY IN AN EMERGENCY:

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

IV. Please indicate if you want all correspondence from our office to be sent sealed in an envelope marked "CONFIDENTIAL".

_____ YES _____ NO

V. Please print the telephone number where you want to receive all calls about your appointments, lab and x-ray results, or other health care information, if other than your home phone number.

VI. Can confidential messages (i.e.: appointment reminders) be left on your telephone answering machine or voicemail?

_____ YES _____ NO

Patient Name: _____

Patient/Guardian Signature: _____ Date: ___/___/___

PULMONARY ASSOCIATES OF BRANDON

Florida Sleep Disorder Center

Richard S. Powell, M.D.

DANIEL G. LORCH, M.D.*

Thomas P. Hooker, D.O.

ARTHUR E. GRAVES, M.D.

SUKETU K. SHAH, M.D.*

BARBARA A. QUIGLEY, MSN, ARNP-BC



Pulmonary Diseases

SLEEP DISORDERS

Critical Care

INTERNAL MEDICINE

Diplomat: American Board of Pulmonary Disease; Critical Care; Internal Medicine, Sleep Medicine*

Beginning November 15, 2007

We will ask for payment at the time of
service for co-pays, deductibles, and
estimated amounts of personal payment
due after insurance.

910 Oakfield Drive, Suite 102 ▪ Brandon, Florida 33511 ▪ Phone (813) 681-4413 ▪ Fax (813) 681-6429
4051 Upper Creek Drive, Suite 106 ▪ Sun City Center, Florida 33573 ▪ Phone (813) 634-7033 ▪ Fax (813) 634-5797
2111 West Swann Avenue, Suite 101 ▪ Tampa, Florida 33606 ▪ Phone (813) 251-2525 ▪ Fax (813) 250-9533