PULMONARY, CRITICAL CARE, ALLERGY, IMMUNOLOGY, INFECTIOUS DISEASE AND SLEEP MEDICINE ASSOCIATES
Leaders in outcomes oriented, evidence based, compassionate, cost effective care

WELCOME TO OUR PRACTICE

Hello,

We are delighted that you have scheduled an appointment with Pulmonary Medicine, Infectious Disease, and Critical Care Consultants Medical Group. We are honored to participate in your health care.

PMA providers care for some of the most complicated and critically ill patients in the Greater Sacramento Area, both in area hospitals and in the outpatient office environment in three locations. PMA providers are specialists in pulmonary diseases, infectious diseases, sleep medicine, hyperbaric oxygen treatment, palliative care, and critical care medicine. PMA providers are Board Certified.

Our goal is to provide you with exceptional medical care and superior service. To help ensure you have the best possible visit, we offer a few tips:

1. Please completely fill out the attached Demographic and Health History Questionnaire prior to your arrival for your first appointment. If you have completed all the requested paperwork prior to your appointment, **please arrive at least 10 minutes prior to your scheduled appointment time**. If you are unable to complete the required paperwork prior to your appointment, you **must arrive 30 minutes prior** to your scheduled time or your appointment may be rescheduled. Please know that your expected appointment duration is between 2-3 hours. We know that sounds like a long time, but PMA providers would like to ensure that they have as much information about you as needed to provide you with exceptional medical care.

2. Please bring in all prescription and over-the-counter medications you are taking, **and the dates of your current Flu and Pneumonia vaccines**.

3. Write down your questions or issues that you would like to cover with the doctor during your visit so you won't forget to ask and your time will be well spent.

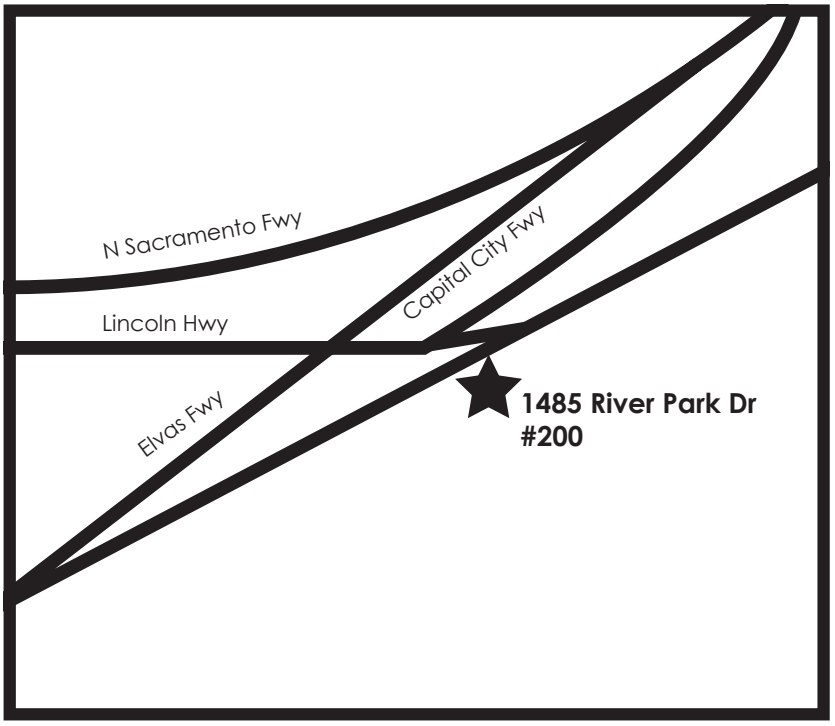
4. Please bring your insurance card(s) and photo identification. We are required to verify the identity and insurance eligibility of all of our patients. We are also required to collect any co-payments and/or deductibles at the time services are provided.

5. Bring cash, check or credit card for your co-payment or deductible.

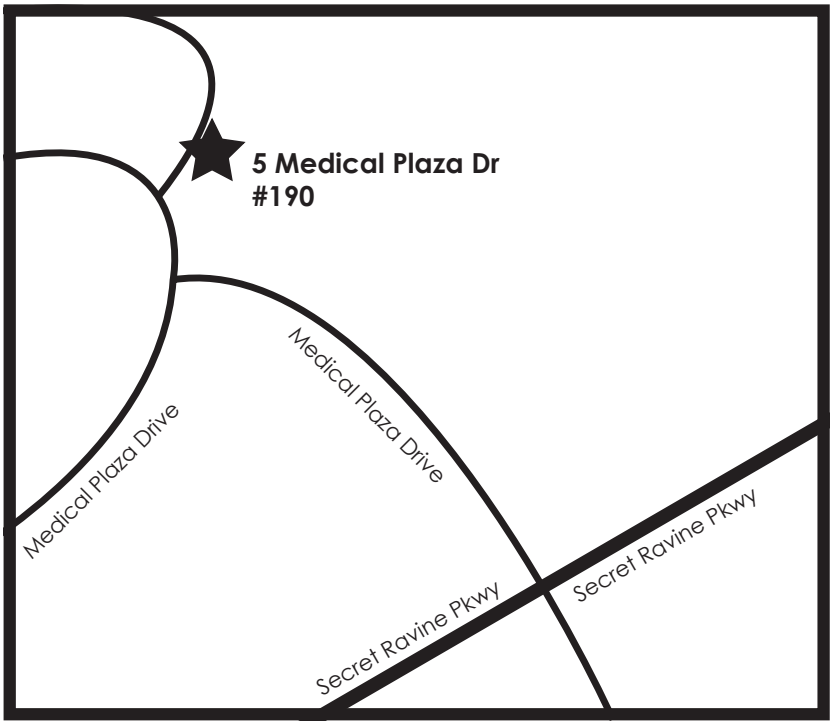
If you are unable to keep your appointment for any reason, please notify us at least 24 hours in advance to avoid a $50 missed appointment fee. We have set aside your appointment time just for you.

Should any questions or concerns arise before your next visit with us, please feel free to contact PMA's Central Scheduling Office by calling (916) 679-3590. We are available Monday through Friday from 8:00 a.m.-4:30 p.m and closed for lunch from 12:00 p.m. -1:00 p.m.

Directions



Sacramento Office
1485 River Park Dr., Suite 200
Sacramento, CA 95815



Roseville Office
5 Medical Plaza Dr., Suite 190
Roseville, CA 95661

POS Reorder # 1807359

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REGISTRATION FORM

Today's Date _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Social Security Number _____

Street Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Sex: ❑ Male ❑ Female Pregnant: ❑ Yes ❑ No Marital Status _____

Race: _____ Ethnicity: _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address _____ Preferred Method of Contact _____

Referring Doctor _____ Primary Doctor _____

Preferred Pharmacy _____ Preferred Diagnostic Lab _____

Preferred Imaging Facility _____

RESPONSIBLE PARTY / GUARANTOR

❑ **Same as patient**

Last Name _____ First Name _____ Relation to Patient _____

Home Phone _____ Date of Birth _____ Email _____

Street Address _____ City _____ State _____ Zip Code _____

Spouse or Parent (if patient is a minor)

Last Name _____ First Name _____ Relation to Patient _____

Date of Birth _____ Sex: ❑ Male ❑ Female Social Security Number _____

Home Phone _____ Cell Phone _____ Email _____

INSURANCE

PRIMARY INSURANCE

Insurance Company Name _____ Billing Address _____ Billing Phone _____

Group Number _____ Policy or ID Number _____ Effective Date _____

SECONDARY INSURANCE

Insurance Company Name _____ Billing Address _____ Billing Phone _____

Group Number _____ Policy or ID Number _____ Effective Date _____

EMERGENCY CONTACT

In addition to being my emergency contact, I authorize PMA to communicate with the individual listed below regarding any medical and/or financial issues.

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

I HEREBY AUTHORIZE MEDICAL TREATMENT FOR THE ABOVE INDIVIDUAL BY PULMONARY MEDICINE, INFECTIOUS DISEASE AND CRITICAL CARE CONSULTANTS. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE ABOVE NAMED PROVIDER, REALIZING I AM RESPONSIBLE TO PAY NON-COVERED SERVICES AND I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO INSURANCE CARRIERS.

Signature of Patient _____ Date _____

Signature of Insured, Parent or Legal Agent _____ Date _____

Thank you for choosing PMA to participate in your medical care. We are committed to providing the best possible medical care to our patients while also minimizing administrative costs. This financial policy has been established with these objectives in mind, and to prevent any misunderstanding or disagreement concerning payment for professional services.

All Patients are financially responsible for services provided by Pulmonary Medicine Associates

_____ Initials PMA requires that you provide a copy of your current insurance card and photo ID at every visit.

_____ Initials PMA participates with numerous insurance plans. For patients who are covered by one of these insurance plans, our billing office will submit a claim for our services, directly to your insurance.

_____ Initials As a requirement of both PMA and your insurance company, Co-payments are due at the time of service.

_____ Initials Payment of Co-Insurance or any charges not covered by your plan is required at the time of service.

_____ Initials Payment is required in full at the time of service from uninsured patients, unless arrangements have been made with the Business Office in advance.

_____ Initials Payment for services can be made with cash, check or credit card.

_____ Initials It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice prior to the visit. Visits may be rescheduled due to lack of referral or authorization.

_____ Initials PMA charges a missed appointment fee of $50 if you do not come to your appointment for any reason, unless you cancel the appointment at least 24 hours in advance. Insurance does not cover this administrative fee. You will receive a bill.

_____ Initials Any account over 90 days old will be turned over to a collection agency unless arrangements have been made with the Business Office, and any payment plan is up-to-date.

_____ Initials Our staff members are happy to answer insurance questions relating to how a claim was filed, or regarding any additional information the payer might need to process the claim. However, specific coverage issues can only be addressed by the insurance company member services department. You can find this phone number on your insurance card.

_____ Initials **Designation of certain relatives, close friends and other caregivers as my personal representative:** I agree that the practice may disclose my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, Pulmonary Medicine Associates will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____ Phone #:_____

Print Name:_____ Phone #:_____

Pulmonary Medicine Associates firmly believes that a good physician-patient relationship is based upon mutual understanding and good communication. All questions and communication about financial arrangements should be directed to the central billing office (916) 482-7623, option 1.
We are happy to help you.

ACKNOWLEDGMENT:

- I acknowledge that I have received access to the "Notice of Privacy Practices" for PMA. I have read and understand the "HIPAA & Release of Medical Information Policy".
- I hereby authorize PMA to release any information requested by the insurance company or companies or respective representatives and act as my agent to secure payment from any and all services rendered.
- I understand that I am financially responsible to the physician for any and all charges incurred by myself and/or dependents.
- I further acknowledge and understand that I accept the terms outlined in each of the policies.
- I understand that no warranty or guarantee has been made to me relative to result in care or medical outcome.

X_____ _____

Patient or Guardian Signature Date

HEALTH HISTORY QUESTIONNAIRE

We are delighted that you have scheduled an appointment with a Pulmonary Medicine Associates Medical Group provider. To help ensure that you receive the very best care and service, we would like to know more about you and your health history. Please take the time to answer all of the questions on the following pages. We look forward to seeing you at your scheduled appointment – Be sure to bring this completed form with you.

Name: _____ Birthdate: _____

Primary Care Physician:_____ Referring Provider: _____

Specialists Involved In Your Care:

_____

_____

_____

_____

1. Please describe your current medical problem (reason for your visit):

_____

_____

_____

_____

_____

2. Medication(s) you are allergic to with <u>type of reaction and severity</u> for each:
(Ex: Advil, Itching, Mild)

_____

_____

_____

_____

_____

3. Current Prescription and Over-the-Counter Medications (please list strength, dosage and frequency):
(Ex: Lisinopril 10 mg 1 tablet daily)

_____

_____

_____

_____

_____

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HEALTH / SOCIAL HISTORY

PATIENT'S VACCINES

TdaP (Tetanus, Diphtheria, Pertussis) **Last Date** _____

MMR (Measles, Mumps, Rubella) ❑ Yes ❑ No

H. Flu **Last Date** _____

Pneumonia Shot (Pneumovax) **Last Date** _____ ❑ I have not had this shot

Pneumonia Shot (Prevnar13) **Last Date** _____ ❑ I have not had this shot

Current Season Flu Shot **Last Date** _____ ❑ Decline/Refuse Shot ❑ I have not had this shot

PATIENT'S FAMILY MEDICAL HISTORY (please check all that apply)

❑ I don't know my family's medical history

	Mother	Father	Brother	Sister
Autoimmune Disease	❑	❑	❑	❑
Food Allergies	❑	❑	❑	❑
Hay Fever	❑	❑	❑	❑
Hives	❑	❑	❑	❑
Recurrent Infections	❑	❑	❑	❑
Eczema	❑	❑	❑	❑
Angioedema	❑	❑	❑	❑

PATIENT'S SOCIAL HISTORY:

Smoking Status (choose one)

❑ Never Smoker

❑ Former Smoker **Quit Date:** _____ How much did you smoke? _____

❑ Current Every Day Smoker How much do you smoke? _____

❑ Current Some Day Smoker How much do you smoke? _____

❑ Smoker - Current Status Unknown

❑ Unknown If Ever Smoked

Total Years of Tobacco Use? _____

Smokeless Tobacco use? (choose one) ❑ Never used smokeless tobacco ❑ Former smokeless tobacco user ❑ Current snuff user ❑ Currently chew tobacco ❑ Currently uses moist powdered tobacco

E-cigarette/Vape use? (choose one) ❑ Never used ❑ Former user ❑ Current user

Is there someone in the house who smokes? ❑ Yes ❑ No Who? _____

Present job type of work: _____

Have you ever been exposed to fumes/chemicals/dust? ❑ Yes ❑ No

Have you ever been exposed to radiation/x-ray? ❑ Yes ❑ No

Have you even been exposed to asbestos or known toxic materials? ❑ Yes ❑ No

Are you married? ❑ Yes ❑ No

Do you have children? ❑ Yes ❑ No

Where were you born? _____

Have you lived in different geographic regions for over one year? ❑ Yes ❑ No

If YES, Where? _____

What is your level of education? _____

What are your major activities and hobbies? _____

Do you have any household pets? ❑ Yes ❑ No

PATIENT'S SOCIAL HISTORY (Continued):

Do you drink coffee or caffeinated beverages? ❑ Yes ❑ No If YES, how many cups per day? _____

Do you exercise regularly? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No

Do you live in a house, apartment or trailer?_____

Where is the home located (check all that apply)

❑ Rural ❑ City ❑ Near factories or industries ❑ Near a river/stream/ocean

How old is the home? _____ How long have you lived there? _____

Has there been any water leakage or damage in your home? _____

Do you have HEPA filters? ❑ Yes ❑ No

Do you have a fireplace? ❑ Yes ❑ No

Do you have a wood burning stove? ❑ Yes ❑ No

Do you have carpet in your home? ❑ Yes ❑ No

Do you have a feather pillow and/or comforters? ❑ Yes ❑ No

Do you have a pillow and mattress dust-proof encasements? ❑ Yes ❑ No

PATIENT'S SURGICAL HISTORY: (please check all that apply)

❑ Abdominal (Belly)
❑ Cancer
❑ Cardiovascular (Heart or Blood Vessels)
❑ Orthopedic (Bones or Joints)
❑ Pulmonary (Lungs)

PATIENT'S PAST MEDICAL HISTORY: (please check all that apply)

❑ Anemia or Blood Disorder
❑ Asthma
❑ Blood Clot
❑ Bronchitis/COPD/Emphysema
❑ Cancer
❑ Diabetes
❑ Hay Fever or Allergies
❑ Heart Trouble
❑ High Blood Pressure
❑ Kidney Disease
❑ Liver Disease
❑ Musculoskeletal Disease
❑ Stroke
❑ Sleep Apnea
❑ Tuberculosis
❑ Hospitalizations
❑ Any Other Chronic Illness

Please check if you have had any of the following conditions:

Constitutional
❑ Fever
❑ Weight Change

Eyes
❑ Itching
❑ Epiphora (watery eyes)
❑ Scleral injection (red eyes)

Head
❑ Trauma

Ears
❑ Ear "Popping"
❑ Itching of the ears

Nose
❑ Sinus Pressure
❑ Nasal Congestion
❑ Sneezing
❑ Nasal itching

Throat
❑ Itching throat
❑ Post-nasal drip (PND)
❑ Voice Change

Respiratory
❑ Wheezing
❑ Cough
❑ Shortness of Breath
❑ Chest tightness
❑ Exercise intolerance
❑ Nocturnal awakenings

Gastrointestinal
❑ Nausea
❑ Vomiting
❑ Constipation
❑ Diarrhea
❑ Belching (eructation)
❑ Abdominal pain
❑ Flatulence
❑ Bloating
❑ Constant feeling of need to pass stool (tenesmus)
❑ Frothy, floating, foul smelling stool (steatorrhea)

Psychiatric
❑ Irritability
❑ Mood swings
❑ Hallucinations

Cardiovascular
❑ Irregular heartbeat
❑ High blood pressure (hypertension)
❑ Heart murmurs

Skin
❑ Rash
❑ Hives
❑ Itching (pruritus)
❑ Eczema
❑ Psoriasis

Hematologic/Lymphatic
❑ Swollen Glands
❑ Easy Bruising

❑ Aspirin/NSAIDs cause wheezing/shortness of breath/nasal congestion
❑ Ever been intubated for asthma?

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PULMONARY, CRITICAL CARE, ALLERGY, IMMUNOLOGY, INFECTIOUS DISEASE AND SLEEP MEDICINE ASSOCIATES

ALLERGY, ASTHMA AND IMMUNOLOGY

ALLERGY SKIN TESTING PREPARATION INSTRUCTIONS

During your visit, allergy skin tests may be applied to help determine your suspected allergy (food, insect, or environmental allergies). This type of test is quickly performed and is very well tolerated by even small children. However, in order to be able to perform a skin test, you must stop your antihistamines a certain amount of time before your test date. This includes:

Medications to be stopped at least 7 days prior to your appointment:

- Desloratadine (Clarinex)
- Tricyclics (doxepin, amitriptyline)
- Loratadine (Claritin, Claritin D, Alavert)
- Herbs (e.g. tumeric, green tea)

Medications to be stopped at least 5 days prior to your appointment:

- Cetirizine (Zyrtec, Zyrtec D)
- Fexofenadine (Allegra, Allegra D)
- Dexchlorpheniramine (Polaramine)
- Doxylamine (Bendectin, Nyquil)
- Levocetirizine (Xyzal)
- Meclizine (Antivert, Dramamine)

Medications to be stopped at least 2 days prior to your appointment:

- Brompheniramine (Actifed, Atrohist, Dimetapp, Drixoral)
- Chlopheniramine (Chlortrimeton, Deconamine, Kronofed A, Novafed A, Rynatan)
- Clemastine (Tavist, Antihist)
- Cyproheptadine (Periactin)
- Promethazine (Phenergan)
- Diphenhydramine (Allernix, Benadryl, Nytol)
- Hydroxyzine (Atarax, Vistaril)

Note: Antihistamines are found in many over the counter medications, including Tylenol PM, Actifed Cold and Allergy, Alka-Seltzer Plus Cold with Cough Formula, motion sickness medications, sleep aids, and many others. Make sure you read check the ingredients carefully.

Nose sprays and eye drops to stop at least 2 days prior to your appointment:

- Azelastine (Astelin, Astepro, Dymista, Optivar)
- Bepotastine (Bepreve)
- Ketotifen (Zaditor, Alaway)
- Olapatadine (Pataday, Patanase)
- Pheniramine (Visine A, Naphcon A)

Antacids to stop at least 2 days prior to appointment:

- Cimitidine (Tagamet)
- Famotidine (Pepcid)
- Nizatidine (Axid)
- Ranitidine (Zantac)

There is **no need** to stop steroid nasal sprays such as Flonase (fluticasone), Nasonex, Nasacort (triamcinolone), Rhinocort, and Veramyst as these medications **will not affect the skin test**.

DO NOT STOP YOUR ASTHMA MEDICATIONS!

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. You have the right to obtain a paper copy of this Notice upon request.

Patient Health Information
Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information. Your information may be stored electronically and if so is subject to electronic disclosure.

How We Use and Disclose Your Patient Health Information
Treatment: We will use and disclose our health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your treatment team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, and to family members who are helping with your care.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment or disclose your information to payors to determine whether you are enrolled or eligible for benefits. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, arranging for legal services and to assess the care and outcomes of your case and others like it.

Special Uses and Disclosures
Following a procedure, we will disclose your discharge instructions and information related to your care to the individual who is driving you home from the center or who is otherwise identified as assisting in you post-procedure care. We may also disclose relevant health information to a family member, friend or others involved in your care or payment for your care and disclose information to those assisting in disaster relief efforts.

Other Uses and Disclosures
We may be required or permitted to use or disclose the information even without your permission as described below:
Required by Law: We may be required by law to disclose your information, such as to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.
Research: We may use or disclose information for approved medical research.
Business Associates: We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
Public Health Activities: We may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.
Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.
Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.
Law Enforcement Purposes: We may disclose information needed or requested by law enforcement officials or to report a crime on our premises.
Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.
Serious Threat or Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Military and Special Government Functions: If you are a member of the armed forces, we may release information required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.
Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.
Messages: We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information unless you have signed an authorization.

Individual Rights
You have the following rights with regard to your health information. Please contact the Contact Person listed below to obtain the appropriate form for exercising these rights
❏ You may request restrictions on certain uses and disclosures. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid in full, out-of-pocket for the item or service covered by the request and when the uses or disclosures are not required by law.
❏ You may ask us to communicate with you confidentially for example, sending notices to a special address or not using postcards to remind you of appointments.
❏ In most cases, you have the right to look at or get a copy of your health information. There may be a small charge for the copies.
❏ You have the right to request that we amend your information.
❏ You may request a list of disclosures of information about you for reasons other than treatment, payment, or health care operations and except for other exceptions.
❏ You have the right to obtain a paper copy of the current version of this Notice upon request, even if you have previously agreed to receive ii electronically.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this Notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the Notice currently in effect. We are required to notify affected individuals in the event of a breach involving unsecured protected health information.

Changes in Privacy Practices
We may change our policies at any time and make the new terms effective for all health information we hold. The effective date of this Notice is listed at the bottom of the page. If we change our Notice, we will post the new Notice in the waiting area. For more information about our privacy practices, contact the person listed below.

Complaints
If you are concerned that we have violated your privacy rights, you may contact the person listed below. You also may send a written complaint to the U.S. Department of Health and Human Services. The person listed below will provide you with the appropriate address upon request. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact:

1300 Ethan Way, Suite 600
Sacramento, CA 95825
Telephone: 916-482-7623
Fax: 916-488-7432

POS Reorder # 1807363