**PULMONARY, CRITICAL CARE, INFECTIOUS DISEASE AND SLEEP MEDICINE ASSOCIATES**
**www.pmamed.com**
**PMA Portal: https://1119.portal.athenahealth.com**

# WELCOME TO OUR PRACTICE

We are delighted that you have scheduled an appointment with Pulmonary Medicine Associates.

**Your Appointment has been scheduled**

Date: _____

Time: _____

Provider: _____

**At the following Location:**

☐ **5 Medical Plaza Dr., Suite 190, Roseville, CA 95661**

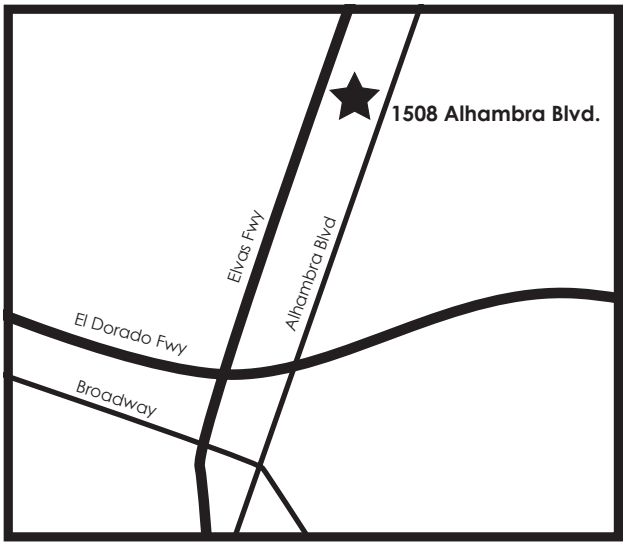
☐ **1508 Alhambra Blvd., Suite 200, Sacramento, CA 95816**

**Please arrive at least 30 minutes before your scheduled appointment time.**

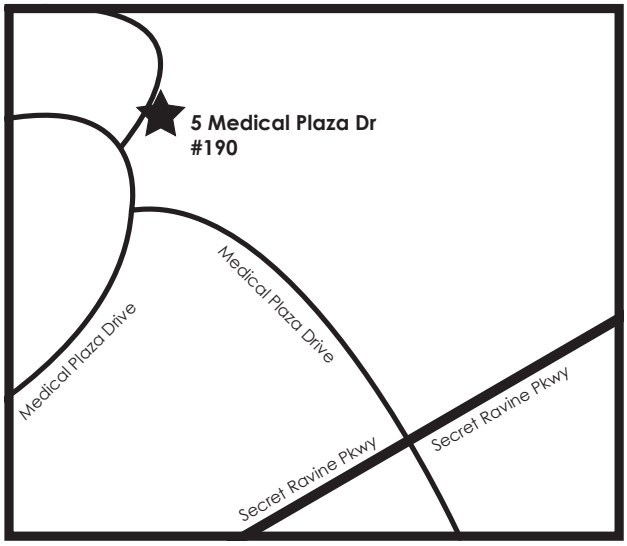
Our goal is to deliver exceptional medical care and superior service to you. To help ensure you have the best possible visit, we offer a few tips:

1. **Please completely fill out the attached Demographic and Health History Questionnaire and bring it to your scheduled appointment.** If you are unable to complete the required paperwork prior to your appointment, please arrive at least 60 minutes before your scheduled time; otherwise, your appointment may be rescheduled.
2. Please bring in all prescription and over-the-counter medications you are taking, **and the dates of your current Flu, Pneumonia, and COVID vaccines.**
3. 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.
4. Bring cash, check, or credit card for your co-payment or deductible.
5. Write down your questions or issues that you would like to discuss with the provider during your visit, so you won't forget to ask, and your time will be well spent.
6. 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 reserved your appointment time specifically for you.
7. Should any questions or concerns arise before your next visit with us, please feel free to contact our Roseville office at 916-786-7498 or our Sacramento office at 916-325-1040.

# Directions




**Alhambra Office**
1508 Alhambra Blvd.
Sacramento, CA 95816




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

# Benefits of the Patient Portal

- View your visit summary
- View your test results on your time
- Message your care team directly anytime, anywhere
- View account balances, statements and pay bills online

- **Q: Is my information secure?**
- **A:** Yes. Safeguarding your information is a priority for us. To ensure the security of your personal information, we use industry-standard encryption to prevent unauthorized access to your data.

- **Q: How do I register for the Patient Portal?**
- **A:** When you come in for your appointment, ask our registration staff to get you registered. You must have a personal email address to get started. We will send you a special email that will take you through the registration process.
- **A:** You can also register for an account by calling one of our offices.

- **Q: How do I access the Patient Portal?**
- **A:** PMA website: https://1119.portal.athenahealth.com and enter your email and password.

Version 2025.2
**POS** Reorder # 1806327

# 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 ☐ Other Marital Status _____

Race: _____ Ethnicity: _____

Preferred Phone _____ Alt Phone _____ Agree to Text Reminder?: ☐ Yes

Patient's Email Address _____ Agree to Portal Access and Emails?: ☐ Yes

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 _____

**This financial policy** has been established with the following objectives in mind, and to prevent any misunderstanding or disagreement regarding 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 (a $10 fee will be charged for any checks returned by your bank as unprocessed).

_____ 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.

*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.*

**HIPAA PRIVACY, PERSONAL REPRESENTATIVES, AND PATIENT PORTAL ACCESS:**
Pulmonary Medicine Associates follows all federal HIPAA regulations to protect the privacy and security of your health information.

You may designate individual(s) below as your Personal Representative(s), giving us permission to discuss your care or billing with them. Only information directly related to their involvement will be shared.

Providing an email address is optional. If listed, that person may be granted access to view your medical history through the patient portal. Portal access can be revoked at any time, provided written notice is given.

PRINT Name(s), Relationship, Phone Number, and (optional) Email for Portal Access:

_____

_____

**ACKNOWLEDGMENT:**
- I acknowledge that I have received access to the "Notice of Privacy Practices" for PMA.
- 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.
- I agree to provide legal documentation identifying any individual who has the legal right to act on my behalf or behalf of the patient (e.g., custody, conservatorship, healthcare power of attorney).
- The Open Payments Database is a federal tool to search for payments made by drug and device companies to physicians and teaching hospitals. It is available at https://openpaymentsdata.cms.gov. A printed copy is available upon request at the front desk.

**X** _____ _____
Patient or Guardian Signature Date

# HEALTH HISTORY QUESTIONNAIRE

**We are pleased that you've scheduled an appointment with a Pulmonary Medicine Associates Medical Group provider. To ensure you receive the best care and service, we'd like to learn more about you and your health history. Please take the time to answer all questions on the following pages. We look forward to seeing you at your appointment – be sure to bring this completed form with you.**

Name: _____ Birthdate: _____

Referring Provider: _____

Other 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)**

_____

_____

_____

_____

_____

# EPWORTH SLEEPINESS SCALE

Name: _____ Date: _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you haven't done some of these activities recently, think about how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = Would never doze
1 = Slight chance of dozing
2 = Moderate chance of dozing
3 = High chance of dozing

It is important that you circle a number (0 to 3) on each of the questions.

| **Situation** | **Chance of Dozing** | | | |
|---|---|---|---|---|
| Sitting and reading | 0 | 1 | 2 | 3 |
| Watching TV | 0 | 1 | 2 | 3 |
| Sitting inactive in a public place (e.g. a theatre or a meeting) | 0 | 1 | 2 | 3 |
| As a passenger in a car for an hour without a break | 0 | 1 | 2 | 3 |
| Lying down to rest in the afternoon when circumstances permit | 0 | 1 | 2 | 3 |
| Sitting and talking to someone | 0 | 1 | 2 | 3 |
| Sitting quietly after a lunch (when you've had no alcohol) | 0 | 1 | 2 | 3 |
| In a car, while stopped in traffic | 0 | 1 | 2 | 3 |

Total: _____

# STOP-BANG SLEEP APNEA

****Patient: Please fill out and answer Yes or No to each question**

**STOP**

| | | |
|---|---|---|
| Do you **SNORE** loudly (louder than talking or enough to be heard through closed doors)? | YES | NO |
| Do you often feel **TIRED**, fatigued, or sleepy during daytime? | YES | NO |
| Has anyone **OBSERVED** you stop breathing during your sleep? | YES | NO |
| Do you have or are you being treated for high blood **PRESSURE**? | YES | NO |

**Clinic Staff Only:**
**BANG**

| | | |
|---|---|---|
| **B**MI more than 35kg/m2? | YES | NO |
| **A**GE over 50 years old? | YES | NO |
| **N**eck circumference > 16 inches (40 CM)? | YES | NO |
| **G**ender: Male? | YES | NO |

Total Score: _____

| | |
|---|---|
| High risk of OSA: | Yes 5-8 |
| Intermediate risk of OSA: | Yes 3-4 |
| Low risk of OSA: | Yes 0-2 |

Version 2023.2
**POS** Reorder # 2122509

# HEALTH / SOCIAL HISTORY

**YOUR VACCINES (please provide most recent vaccination date for each)**

| | | | |
|---|---|---|---|
| Pneumonia Shot (Pneumovax) | **Date** _____ | ☐ I have not had this shot | |
| Pneumonia Shot (Prevnar13) | **Date** _____ | ☐ I have not had this shot | |
| Current Season Flu Shot | **Date** _____ | ☐ Decline/Refuse Shot | ☐ I have not had this shot |
| COVID Vaccine | **Date** _____ | ☐ Decline/Refuse Shot | ☐ I have not had this shot |

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

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

| | **Mother** | **Father** | **Brother** | **Sister** |
|---|---|---|---|---|
| Cancer | ☐ | ☐ | ☐ | ☐ |
| Lung Disease | ☐ | ☐ | ☐ | ☐ |
| Heart/Vascular Disease | ☐ | ☐ | ☐ | ☐ |
| Rheumatoid Disease | ☐ | ☐ | ☐ | ☐ |

**YOUR 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

Present State of Health: _____

Occupation: _____

Present Job Concerns for Health: _____

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

Are you married? ❑ Yes ❑ No

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

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

**YOUR SURGICAL HISTORY: (please check all that apply)**

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

**YOUR 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:**

**Sleep Habits**

☐ Daytime Sleepiness
☐ Snoring

**Constitutional**

☐ Fever/Chills/Sweats
☐ Weight Change
☐ Weakness/Fatigue

**Head**

☐ Trauma to Head/Headache

**Eyes**

☐ Discharge
☐ Vision Change

**Ears**

☐ Hearing Loss
☐ Ear Discharge
☐ Ear Pain

**Nose**

☐ Sinus Problems/Nosebleed

**Mouth/Throat**

☐ Sore Throat/Thrush
☐ Difficulty/Pain with Swallowing
☐ Voice Change

**Cardiovascular**

☐ Chest or Arm Pain on Exertion
☐ Shortness of Breath when Walking or Lying Down
☐ Palpitations
☐ Leg Edema (Swelling)

**Respiratory**

☐ Cough
☐ Sputum Production
☐ Coughing up Blood
☐ Wheezing
☐ Shortness of Breath
☐ Pleurisy (Sharp Pain in Chest Wall when inhaling and exhaling)

**Gastrointestinal**

☐ Abdominal Pain
☐ Vomiting
☐ Nausea
☐ Dark Tarry Stools or Blood in Stools
☐ Vomiting Blood
☐ Heartburn

**Genitourinary**

☐ Increased Urinary Frequency
☐ Hematuria (Blood in Urine)

**Musculoskeletal**

☐ Muscle Aches or Weakness
☐ Joint Pain or Swelling

**Skin/Integumentary**

☐ Rash
☐ Itching
☐ Dry Skin
☐ Lesions

**Neurologic**

☐ Loss of Consciousness
☐ Seizures
☐ Dizziness

**Psychiatric**

☐ Depression
☐ Anxiety

**Endocrinology**

☐ Diabetes
☐ Thyroid Disease

**Hematologic/Lymphatic**

☐ Swollen Glands
☐ Easy Bruising

# 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 you 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 it 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 pate. 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**

Version 2023.2
**POS** Reorder # 1806331