PACIFIC
PULMONARY MEDICAL GROUP
Pulmonary • Critical Care • Sleep

Riverside Location:
4234 Riverwalk Pkwy, Ste 230, Riverside, CA 92505
Ph: 951.781.3672 Fax: 951.781.0365

Irvine Location:
16305 Sand Canyon Ave, Ste 225, Irvine, CA 92618
Ph: 949.679.6874 Fax: 949.242.2772

AMERICAN ACADEMY OF SLEEP MEDICINE
WAKE
SLEEP
ACCREDITED
MEMBER CENTER

Hello,

We are delighted that you have scheduled an appointment with Pacific Pulmonary Medical Group (PPMG). We are honored to participate in your health care.

PPMG providers care for some of the most complicated and critically ill patients in Riverside and Orange County Area, both in area hospitals and in the outpatient office environment in 5 locations. PPMG providers are specialists in pulmonary diseases, infectious diseases, sleep medicine, pulmonary hypertension, lung cancer, and critical care medicine. PPMG 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 30 minutes prior to your scheduled appointment time. If you are unable to complete the required paperwork prior to your appointment, you must arrive 60 minutes prior to your scheduled time or your appointment may be rescheduled. We know that sounds like a long time, but PPMG providers would like to ensure that they have as much information about you as needed to provide you with exceptional medicalcare.

2. Please bring in all current medications or a complete list of all prescription and over-the-counter medications you are taking, along with all dose and frequency information.

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 wellspent.

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 $250 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 PPMG's Central Scheduling Office by calling (951) 781-3672 for our Riverside Office and (949) 696-6874 for our Irvine Office. We are available Monday through Friday from 8:00 a.m.-5:00 p.m.

PATIENT DEMOGRAPHICS

Last Name | First Name | Middle | Social Security No.

Mailing Address: Street | Apt. | City | State | Zip

Date of Birth | ☐ Male ☐ Female (Sex) | ☐ Yes ☐ No (Pregnant) | Marital Status

Home Phone | Work Phone | Cell Phone

E-mail Address | ☐ Home ☐ Work ☐ Cell ☐ E-mail (Preferred Method of Contact)

Referring Doctor (Last Name, First Name) | Primary Doctor – (Last Name, First Name)

Preferred Pharmacy (name and address):

Preferred Diagnostic Lab (name and address):

Preferred Imaging Facility (name and address):

Responsible Party/Guarantor

☐ Same as patient

Last Name | First Name | Middle | Relationship to Patient

Home Phone | Date of Birth | E-mail address

Mailing Address: Street | Apt. | City | State | Zip

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 PPMG 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

THE FEDERAL GOVERNMENT REQUIRES PPMG TO ASK ABOUT OUR PATIENT'S RACE AND ETHNICITY:

Ethnicity

Are you Hispanic or Latino:
- ☐ Yes
- ☐ No
- ☐ Decline to Respond

Race

Select all that apply:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline to Respond

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HEALTH HISTORY QUESTIONNAIRE

We are delighted that you have scheduled an appointment with a Pacific Pulmonary 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

Name: _____ Date of Birth: _____

Referring Provider: _____

Other Specialists Involved in Your Care: _____

_____

_____

1. **Please describe you the reason for your visit:**

2. **Medication(s) you are allergic to with <u>type of reaction and severity</u> foreach:**
   (E.g. Advil, Itching, Mild)

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

Past Medical History

Please check the box next to any conditions you have ever had:

- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Blood Clot (e.g. DVT, PE)
- ☐ Cancer
- ☐ Claustrophobia
- ☐ Congestive heart failure
- ☐ COPD
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ GERD
- ☐ Head Trauma
- ☐ Heart Disease
- ☐ High blood pressure (hypertension)
- ☐ Hospitalizations
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Nasal/ Sinus problems
- ☐ Panic Attacks
- ☐ Seizures
- ☐ Sinus disease
- ☐ Sleep Apnea
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other (specify): _____

Past Surgical History

Please list any surgeries you have ever had and the year:

Family History

Please check the box under any conditions your family members have ever had:

	Mother	Father	Sibling	Other
Cancer	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
Autoimmune disease	☐	☐	☐	☐
Other (specify)				

Social History

Smoking Status (Choose One)

☐ Never Smoker		
☐ Former Smoker	Quit Date:	What year did you start smoking:
☐ Current Every Day Smoker		On average, how much do/did you smoke daily:
☐ Current Occasional Smoker		

Other recreational drugs (check if ever used):

☐ Chewing tobacco	☐ Alcohol	Drinks/week: _____
☐ Vaping	☐ Marijuana	
☐ Cocaine	☐ Heroin	
☐ Amphetamines	☐ Other	Specify: _____

Exposures (check if ever exposed):

☐ Asbestos ☐ Silica Dust
☐ Beryllium ☐ Coal-mining

Pets:

☐ Dog ☐ Cat
☐ Bird ☐ Other, Specify: _____

Occupation (Current and Prior): _____

Married: ☐ Yes ☐ No

How frequently do you exercise: ☐ Daily ☐ Weekly ☐ Occasionally ☐ Rarely/Never

Where have you traveled in the past year: _____

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Sleep Screening Questionnaire

Name: _____ **Date of Birth:** __/__/__ **Height:** _____ **Weight:** _____ **Age** ____ **Neck Size:** ____ **in.**

Life and Work Habits:

1.) Are you a shift worker? For how long?: _____

_____

2.) What is your primary sleep complaint(s) and how long have you been experiencing it:

_____

3.) Do you drink caffeinated beverages? □ Yes □ No If yes what kind and how many?

Coffee/Tea:_____/day ____/week – Cola:____/day ____/week

4.) Do you drink Alcoholic beverages? □ Yes □ No If yes what kind and how many?

Beer/Wine/Liquor/mixed drinks: _____/day _____/week

Sleep-related Problems:

1.) Do you have trouble relaxing and feeling ready to go to sleep?	□ Yes □ No
2.) Do you hear, see or feel things that might not be real as you are falling asleep or waking up? (For example, hearing voices or feeling that someone is in the room)	□ Yes □ No
3.) Do you have trouble initiating sleep?	□ Yes □ No
4.) Do you wake up during sleep and have trouble falling back asleep?	□ Yes □ No
5.) Do you frequently check the clock?	□ Yes □ No
6.) Do you have difficulty sleeping due to discomfort in legs or arms?	□ Yes □ No
7.) Have you ever walked or talked in your sleep?	□ Yes □ No
8.) Do you have nightmares?	□ Yes □ No
9.) Do you have a history of wetting the bed?	□ Yes □ No
If yes, when?	□ Child □ Adult
10.) Do you grind your teeth?	□ Yes □ No
If yes do you use an oral appliance to prevent this?	□ Yes □ No
11.) Have you ever thrashed, thrown covers off or fallen out of bed?	□ Yes □ No
12.) Have you ever hit or kicked your bed partner or injured yourself during sleep?	□ Yes □ No
13.) Have you ever awaken screaming?	□ Yes □ No
14.) Do you snore or have you been told that you snore?	□ Yes □ No
15.) Have you ever experienced muscle weakness with strong emotions? (For example, you feel your body, knees, and/or legs weak when experiencing anger, fear, laughter, etc.)	□ Yes □ No
16.) Do you usually feel sleepy anytime during the daytime?	□ Yes □ No
17.) Do you usually need a nap during the day?	□ Yes □ No
18.) Do you wake up with headaches?	□ Yes □ No
19.) Have you ever awaken confused or disoriented?	□ Yes □ No
20.) Have you ever awaken and feel like you cannot move?	□ Yes □ No
21.) Do you feel tired when you wake up?	□ Yes □ No
22.) Has anyone ever said you stop breathing while you are asleep?	□ Yes □ No

Sleep Hygiene:

1.) Do you perform any of the following in bed prior to sleep? (Please check all that apply)

□ None □ Read □ Have arguments □ Eat

□ Watch TV □ Worry □ Write □ Use phone/Play games

2.) What time do you normally start to fall asleep? _____ AM/PM

(Whether it be on the couch, recliner, bed, etc.)

3.) What time do you normally wake up? _____AM/PM

4.) How long does it take you to fall asleep? _____ HOURS _____ MINUTES

5.) How many hours on average do you sleep per night? _____ HOURS _____MINUTES

Sleep Disturbances:			
My sleep is frequently disturbed by (Please check all that apply):			
□ None	□ Need to urinate		□ Nausea
□ Sinus/cold problems	□ Indigestion	□ Asthma	□ Thirst
□ Leg Discomfort	□ Pain	□ Cough	□ Noise
□ Choking or gasping for air	□ Hunger	□ Children	□ Stress
□ Frightening dreams	□ Bed partner	□ Headaches	□ Shortness of breath
Please list any other symptoms that disturb your sleep that are not listed above: _____ _____			

Epworth Sleepiness Scale

Name: _____ Date: _____

How likely are you to doze off or fall asleep in the situations described below, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not 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 – No chance of dozing
1 – Slight chance of dozing
2 – Moderate chance of dozing
3 – High chance of dozing

Please circle a number (0 to 3) for each of the following questions:

Situation	**Score**			
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (e.g. a theater 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 Score:				

REFERRAL COPY

Berlin Questionnaire

1. Complete the following:

height _____ age _____

weight _____ male/female _____

category 1

2. Do you snore?

- ☐ yes
- ☐ no
- ☐ don't know

If you snore:

3. Your snoring is?

- ☐ slightly louder than breathing
- ☐ as loud as talking
- ☐ louder than talking
- ☐ very loud. Can be heard in adjacent rooms.

4. How often do you snore?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

5. Has your snoring ever bothered other people?

- ☐ yes
- ☐ no

6. Has anyone noticed that you quit breathing during your sleep?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

category 2

7. How often do you feel tired or fatigued after your sleep?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

8. During your waketime, do you feel tired, fatigued or not up to par?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

9. Have you ever nodded off or fallen asleep while driving a vehicle?

- ☐ yes
- ☐ no

If yes, how often does it occur?

- ☐ nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ never or nearly never

category 3

10. Do you have high blood pressure?

- ☐ yes
- ☐ no
- ☐ don't know

BMI = _____

Scoring Questions:

Any answer within black box outline is a positive response.

Scoring Categories:

Category 1 is positive with 2 or more positive responses to questions 2-6 ☐

Category 2 is positive with 2 or more positive responses to questions 7-9 ☐

Category 3 is positive with 1 positive response and/or a BMI >30 ☐

Final Result:

Two or more positive categories indicates a high likelihood of sleep disordered breathing.

Name _____

Address _____

_____

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Thank you for choosing ***Pacific Pulmonary Medical Group (PPMG)*** as your healthcare provider. The medical services you seek imply an obligation on your part to ensure payment in full is made for services received. This Patient Financial Responsibility Statement ("Statement") will assist you in understanding that financial responsibility. Feel free to ask if you have any questions. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this Statement with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By your acknowledgement of this Statement and/or by receipt of medical services from Medical Associates Clinic, P.C. ("Medical Associates"), you agree:

1. PPMG will attempt to verify in advance that the patient's insurance company will pay for specific medical procedures. Occasionally, even though coverage was verified before the medical services were provided, the insurance company denies the claim. *If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible in addition to whatever amounts the insurance company does not pay.*
2. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility indicated by your insurance carrier or our FINANCIAL POLICIES, which are not otherwise covered by supplemental insurance.
3. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a primary care physician (PCP) before receiving services at Pacific Pulmonary Medical Group, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at PPMG are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at PPMG; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.
4. If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit same to PPMG until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize PPMG to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a financially responsible party, and any remaining balance will be returned to the payor.

CONTRACTUAL AGREEMENT TO PAY MEDICAL EXPENSES

I understand that I am personally responsible for all medical expenses incurred at Pacific Pulmonary Medical Group for medical care and treatment. I agree to pay all medical expenses within 30 days of the date that I am billed for those expenses, unless other arrangements have been made with PPMG. If I do have insurance, I authorize release of my medical information to my insurance company that I authorize payment of all medical benefits by my insurance company to Pacific Pulmonary Medical Group.

Signature: _____ Date: _____

Printed Name: _____

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Appointment & Cancellation Policy

1. **By Appointment Only**
   Pacific Pulmonary Medical Group sees patients by appointment only. We make every effort to provide prompt medical care to all our patients. If you arrive to our clinic as a walk-in, please understand if you will be seen, it will be according to the availability of the provider. **Initials:**_____

2. **24-Hour Confirmation**
   Patients are required to confirm their appointments *no later than 24 hours prior to their appointment*. If you fail to confirm the appoint, we reserve the right to apply a fee of $50. **Initials:**_____

   When appointments are not confirmed within 24 hours, *Pacific Pulmonary Medical Group* reserves the right to cancel the appointment and give it to the next patient on the waiting list. It will be your responsibility to call our office to reschedule the appointment. **Initials:**_____

3. **Late Arrival**
   We make every effort to maintain appointment time commitments and we request that you extend the same courtesy to us. If you are running late, please call our office to notify us and/or reschedule if needed. We understand special circumstances can arise which may cause you to run a few minutes behind. On occasion we are able to work-in late arrivals into the schedule, however, this is at the discretion of the provider. **Initials:**_____

   If you are more than 15 minutes late to your appointment without prior notification, we reserve the right to cancel the appointment and apply *the cancellation fee of $50.00*. **Initials:**_____

4. **Missed Appointments (No-Shows)**
   If you are unable to make your appointment, we ask that you notify our clinic at least 24 hours in advance. Failure to cancel an appointment that you do not attend will be considered a missed appointment or no show. **Initials:**_____

   Repeat cancellations and no-shows jeopardize your health and the quality of care you receive. If you accumulate three no-shows, we will direct you to your Primary Care Physician and/or Referring Physician to re-evaluate your care. *Pacific Pulmonary Medical Group* reserves the right to discharge patients with excessive missed appointments from our clinic. **Initials:**_____

   If you miss your appointment or cancel after 9:00am on the day of your appointment, *Pacific Pulmonary Medical Group* reserves the right to *bill you $50.00* for each no-show or late cancellation. **Initials:**_____

We value you as our patient and know your time is valuable. We are always seeking ways to improve our ability to welcome new patients as well as maintain the relationship of our current patients. At times it may seem that you are waiting awhile or that patients arriving after you are seen first. Please understand that patients are not called back in the order they arrive at our clinic. This is due to simultaneous appointment schedules, which are specific to multiple treatment services and providers in our clinic.

Thank you for understanding the importance of keeping your appointment.

I have read and understand the Patient Appointment & Cancellation Policy of the practice and I agree to the terms. I also understand that such terms may be amended periodically by the practice

Signature: _____ Date: _____

Printed Name: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H)_____ **Phone: W)** _____

Address: _____ **City/State/Zip:** _____

Please Note: Copy Fee May Be Charged For Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ **Facility Phone:** _____

Facility Address:_____ **Facility Fax:**_____

City, ST, Zip: _____

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:

_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other_____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____ ☐ **Please mail records.**

Fax:_____ **Phone:**_____ ☐ **Please fax records.**

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.**

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.) **Date**

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative

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I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

_____

Signed:_____ Date: _____

Print Name:_____ Telephone: _____

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: _____

_____

_____

☐ Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

Me gustaría recibir una copia del Aviso de Prácticas de Privacidad modificada por e-mail a:

_____

Firmado:_____ Fecha:_____

Imprimir Nombre:_____ Teléfono:_____

Si no está firmada por el paciente, por favor indique la relación:

☐ El padre o tutor del paciente menor de edad

☐ Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: _____

_____

_____