



Pulmonary • Critical Care • Sleep

Riverside Location:

4234 Riverwalk Pkwy, Ste 230, Riverside, CA 92505

Ph: 951.781.3672 Fax: 951.781.0365

Irvine Location:

4 Hughes, Ste 100, Irvine, CA 92618

Ph: 949.679.6874 Fax: 949.242.2772



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 medical care.
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 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 \$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 NUMBER	
MAILING ADDRESS: STREET		APT.	CITY	STATE	ZIP CODE
DATE OF BIRTH	HOME PHONE		CELL PHONE	WORK PHONE	
SEX: M <input type="checkbox"/> F <input type="checkbox"/>	PREGNANT? YES <input type="checkbox"/> NO <input type="checkbox"/>		MARITAL STATUS	E-MAIL ADDRESS	

REFERRING DOCTOR (LAST, FIRST)	PRIMARY DOCTOR (LAST, FIRST)
PREFERRED PHARMACY (Name and Address):	

PREFERRED DIAGNOSTIC LAB (Name and Address):	

PREFERRED IMAGING FACILITY (Name and Address):	

SAME AS PATIENT

RESPONSIBLE PARTY / GUARANTOR

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	CELL PHONE
WORK 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
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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 ALASKAN NATIVE
 ASIAN
 BLACK OR AFRICAN AMERICAN
 NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
 WHITE
 DECLINE TO RESPOND

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 the reason for your visit:

2. Medication(s) you are allergic to with type of reaction and severity for each:
(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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Nasal / Sinus Problems |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Blood Clot (e.g. DVT, PE) | <input type="checkbox"/> Head Trauma | <input type="checkbox"/> Sinus Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Claustrophobia | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Congestive Heart Failure | (Hypertension) | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hospitalizations | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other (specify): |
| | <input type="checkbox"/> Liver Disease | |

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify)				

SOCIAL HISTORY

Smoking Status (Choose One)

<input type="checkbox"/> Never Smoker <input type="checkbox"/> Former Smoker <input type="checkbox"/> Current Every Day Smoker <input type="checkbox"/> Current Occasional Smoker	Quit Date: _____	What year did you start smoking?: _____ On average, how much do/ did you smoke daily?: _____
--	------------------	---

Other recreational drugs (check if ever used)

<input type="checkbox"/> Chewing Tobacco <input type="checkbox"/> Vaping <input type="checkbox"/> Cocaine <input type="checkbox"/> Amphetamines	<input type="checkbox"/> Alcohol <input type="checkbox"/> Marijuana <input type="checkbox"/> Heroin <input type="checkbox"/> Other	Drinks / Week: _____ Specify: _____
--	---	--

Exposures (check if ever exposed)

<input type="checkbox"/> Asbestos <input type="checkbox"/> Beryllium	<input type="checkbox"/> Silica Dust <input type="checkbox"/> Coal-mining	Pets: <input type="checkbox"/> Dog <input type="checkbox"/> Bird	<input type="checkbox"/> Cat <input type="checkbox"/> Other Specify: _____
---	--	---	---

Occupation (Current and Prior): _____

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

Where have you traveled in the past year? _____

Name: _____ Date of Birth: ____ / ____ / ____ Height: _____ Weight: _____ Age: _____

SLEEP SCREENING QUESTIONNAIRE

LIFE AND WORK HABITS

Are you a shift worker? Yes No

If yes, for how long: _____

What are your primary sleep complaints, and for how long have you experienced them?: _____

Do you drink caffeinated beverages? Yes No If yes, what kind and how many?
Coffee / Tea: _____ /day _____ /week Cola: _____ /day _____ /week

Do you drink alcoholic beverages? Yes No If yes, what kind and how many?
Beer / Wine / Liquor / Mixed Drinks: _____ /day _____ /week

SLEEP-RELATED PROBLEMS

- | | | |
|---|--|---|
| Do you have trouble relaxing and feeling ready to go to sleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you hear, see or feel things that might be real as you are falling asleep or waking up?
<i>(e.g. hearing voices or feeling that someone is in the room?)</i> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have trouble initiating sleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you wake up during sleep and have trouble falling back asleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you frequently check the clock? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have difficulty sleeping due to discomfort in legs or arms? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever walked or talked in your sleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have nightmares? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you have a history of wetting the bed?
If yes, when? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Child <input type="checkbox"/> Adult |
| Do you grind your teeth?
If yes, do you use an oral appliance to prevent this? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever thrashed, thrown covers off, or fallen out of bed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever hit or kicked your bed partner or injured yourself during sleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever awakened screaming? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you snore or have you been told that you snore? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever experienced muscle weakness with strong emotions?
<i>(e.g. you feel your body, knees, and/or legs go weak when experiencing anger, fear, laughter, etc.)</i> | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you usually feel sleepy any time during daytime hours? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you usually need a nap during the day? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you wake up with headaches? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever awakened confused or disoriented? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you ever awakened and feel like you cannot move? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Do you feel tired when you wake up? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Has anyone ever said that you stop breathing while you are asleep? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

SLEEP HYGIENE

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

- | | | | |
|-----------------------------------|--------------------------------|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Read | <input type="checkbox"/> Have arguments | <input type="checkbox"/> Eat |
| <input type="checkbox"/> Watch TV | <input type="checkbox"/> Worry | <input type="checkbox"/> Write | <input type="checkbox"/> Use phone / Play games |

What time do you normally start to fall asleep? _____ AM/PM (Whether it be on the couch, recliner, bed, etc.)

What time do you normally wake up? _____ AM/PM

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

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):

- | | | | |
|---|--|--|---------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Need to urinate | <input type="checkbox"/> Asthma | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Sinus / cold problems | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Cough | <input type="checkbox"/> Thirst |
| <input type="checkbox"/> Leg discomfort | <input type="checkbox"/> Pain | <input type="checkbox"/> Children | <input type="checkbox"/> Noise |
| <input type="checkbox"/> Choking or gasping for air | <input type="checkbox"/> Hunger | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Frightening dreams | <input type="checkbox"/> Bed partner | <input type="checkbox"/> 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			
	0	1	2	3
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:				

BERLIN QUESTIONNAIRE

1. Height: _____ Weight _____ Age _____ Sex: _____

CATEGORY 1

2. Do you snore?
<input type="checkbox"/> Yes
<input type="checkbox"/> No
<input type="checkbox"/> Don't know
<i>If you snore:</i>
3. Your snoring is
<input type="checkbox"/> Slightly louder than breathing
<input type="checkbox"/> As loud as talking
<input type="checkbox"/> Louder than talking
<input type="checkbox"/> Very loud. Can be heard in adjacent rooms.
4. How often do you snore?
<input type="checkbox"/> Nearly every day
<input type="checkbox"/> 3-4 times a week
<input type="checkbox"/> 1-2 times a week
<input type="checkbox"/> 1-2 times a month
<input type="checkbox"/> Never or nearly never
5. Has your snoring ever bothered other people?
<input type="checkbox"/> Yes
<input type="checkbox"/> No
6. Has anyone noticed that you quit breathing during your sleep?
<input type="checkbox"/> Nearly every day
<input type="checkbox"/> 3-4 times a week
<input type="checkbox"/> 1-2 times a week
<input type="checkbox"/> 1-2 times a month
<input type="checkbox"/> Nearly or nearly never

Scoring Questions:

Any answer within black box outline is 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

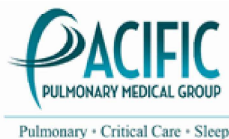
Final Result:

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

CATEGORY 2

7. How often do you feel tired or fatigued after you sleep?
<input type="checkbox"/> Nearly every day
<input type="checkbox"/> 3-4 times a week
<input type="checkbox"/> 1-2 times a week
<input type="checkbox"/> 1-2 times a month
<input type="checkbox"/> Never or nearly never
8. During your waketime, do you feel tired, fatigued, or not up to par?
<input type="checkbox"/> Nearly every day
<input type="checkbox"/> 3-4 times a week
<input type="checkbox"/> 1-2 times a week
<input type="checkbox"/> 1-2 times a month
<input type="checkbox"/> Never or nearly never
9. Have you ever nodded off or fallen asleep while driving a vehicle?
<input type="checkbox"/> Yes
<input type="checkbox"/> No
If yes, how often does it occur?
<input type="checkbox"/> Nearly every day
<input type="checkbox"/> 3-4 times a week
<input type="checkbox"/> 1-2 times a week
<input type="checkbox"/> 1-2 times a month
<input type="checkbox"/> Nearly or nearly never
10. Do you have high blood pressure?
<input type="checkbox"/> Yes
<input type="checkbox"/> No
<input type="checkbox"/> Don't know
BMI = <input style="width: 100px;" type="text"/>

CATEGORY 3



Phone: 951-373-5814
Fax: 951-781-0365



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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: _____

Fax: _____ Phone: _____

- Please mail records.
- 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:

Print Name: _____ **Telephone:** _____

Signed: _____ **Date:** _____

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 practices 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 gustaria recibir una copia del Aviso de Prácticias de Privacidad modificada por e-mail a:

Imprimir Nombre: _____ **Teléfono:** _____

Firmado: _____ **Fecha:** _____

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

- El padres o guardián del paciente menor de edad
- Guardián o curador de un paciente incompetente

Nombre y dirección del paciente: _____
