Pulmonary and Sleep Center of New England

Mohammad Khamiees M.D.

3353 Mendon Rd Suite 3 Cumberland, RI 02864

Phone: 401-405-0899 Fax: 401-405-0890

Patient Name: _____

You have an appointment on: _____at: _____am/pm

Welcome to our practice! Please fill forms enclosed and bring with you the day of your office visit along with a picture ID and insurance card(s). If you have HMO Insurance please contact your Primary Care Physician for a referral to see Dr. Khamiees. So that we may better serve you, please bring any recent radiology results, lab results, and a medication list. If you are unable to keep your appointment, please kindly give us 24 hours' notice.

We reserve the right to charge you directly a fee of $50.00 for any appointments cancelled without a 24 hours notice. There may be an automatic $50.00 fee for no show. This will be billed to you directly not your insurance company.

Sincerely,

Pulmonary and Sleep Center of New England

Patient Signature: _____ Date: _____

Staff Signature: _____ Date: _____

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PATIENT REGISTRATION

Welcome to our office! We are committed to providing the best, most comprehensive care possible. Please assist us by providing the following information. All information is confidential and is released only with your consent.

Patient Name	Today's Date	Date of Birth	Sex	Age
Social Security Number	Primary Insurance Carrier		Member/Subscriber ID	
Email Address	Would you like to receive an invitation to our Patient Portal?			
Home Address	City	State	Zip	
Mailing Address (If Different)	City	State	Zip	
Home Phone	Cell Phone	Work Phone	Preferred Method of Contact? ☐ Home ☐ Cell ☐ Work	
Occupation	Employer's Name			
Employer's Address	City	State	Zip	
Primary Care Physician Name:	Telephone Number :			
Whom May We Thank For Referring You To Our Practice?				
Pharmacy:	Pharmacy City/State:		Pharmacy Phone:	

NOTIFY IN CASE OF EMERGENCY

Name	Relationship		
Address	City	State	Zip
Home Telephone Number	Work Telephone Number		
Nearest Relative (Not Living With You)			
Home Telephone Number	Work Telephone Number		

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR FEES

Name	Telephone Number		
Address	City	State	Zip

Pulmonary and Sleep Center of New England

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Patient History

Patient Name: (Print) _____

Today's Date: _____ Date of Birth: _____ Marital Status: _____

Briefly state reason for today's visit: _____

List Known Allergies: _____

Do you smoke Cigarettes? Yes _____ No _____ If yes how many per day? _____

Medical History: Please check below if any applies to you

☐ High Blood Pressure	☐ Chest Pain/Tightness	☐ Diabetes	☐ Peptic Ulcer
☐ Heart Attack	☐ Heart Murmur	☐ Stroke	☐ Hepatitis
☐ Shortness of Breath	☐ Tuberculosis	☐ Arthritis	☐ Thyroid problem
☐ Kidney Stones	☐ Diverticulitis	☐ Abdominal Bleeding	☐ Lung Problem
☐ Asthma	☐ Emphysema	☐ Daytime Sleepiness	☐ Cancer
☐ Bleeding Problems	☐ Alcoholism	☐ Psychiatric History	☐ Drug Abuse

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Have you ever had surgery? Yes ____ No ____ If yes where and when: _____

Are you on oxygen at home? Yes ____ No ____ If yes how may liters: ____

Have you ever had a blood transfusion? Yes ____ No____ If yes when: _____

Other Medical Problems? _____

Family History:

Father: _____

Mother: _____

Exercise Tolerance (Walking): Number flight of stairs? _____ Number of blocks? _____

Medications you are currently taking: (May provide a separate list)

_____

Are you presently taking?

Aspirin: Yes _____ No _____ Plavix: Yes _____ No _____ Coumadin: Yes _____ No _____

Have you had?

Flu Shot: Yes _____ No _____ Pneumonia Shot: Yes ____ No ____ TB Testing: Yes ____ No ____

Patient Signature: _____

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Authorization for use or Disclosure of Medical Record Information

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Home Phone: _____

City: _____ State: _____ Zip: _____ Cell Phone: _____

RELEASE INFORMATION TO

I hereby authorize Pulmonary and Sleep Center of New England to: ○ Release To: ○ Obtain From:

☐ Mail Copies To: ☐ Hold for Patient Pick-up ☐ Discuss Medical Information With:

Name/Facility: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ Fax: _____

PURPOSE OF REQUEST: ○ Personal ○ Continuing Care ○ Insurance ○ Legal ○ Other

○ Transfer out of Practice / Reason? _____

INFORMATION TO BE RELEASED

☐ 2 year abstract (includes 5 years of diagnostics) ☐ Test results (sleep study, PFT)

☐ Radiology results ☐ Office Notes

☐ Other (Specify):_____

Note: You will be invoiced at the allowable RI Statute rate. RI Statute Copy Fee: $15.00 clerical fee, plus $.76 per page for the first 50 pages.

THIS AUTHORIZATION IS VALID FOR ONE YEAR UNLESS YOU SPECIFY OTHERWISE. YOU MAY REVOKE THIS AUTHORIZATION AT ANY TIME.

_____ _____

Patient Signature Date

_____ _____

Legally Recognized Representative Signature Date

_____ _____

Signature of Witness Date

Pulmonary and Sleep Center of New England

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Consent for Release of Information and Assignment of Benefits:

I hereby authorize my health care provider to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all payment activities. I consent to assign all payments for services directly to this practice.

Financial Policy:

We appreciate you choosing us for your healthcare. We will adhere to the following financial policy in order to consistently deliver high quality care and services. The patient/responsible party assumes responsibility to ensure that the financial obligation is fulfilled for the health care services received.

- I understand that I am responsible for all co-payments, deductibles, and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulations.
- I understand that if I have an insurance co-payment, I am expected to make payment when checking in for my appointment.
- I understand that my contract with my insurance entity may or may not cover some services. All insurance policies are not the same. Pulmonary and Sleep Center of New England is not responsible or able to know every policy available. It is my responsibility to verify applicable coverage prior to receiving the services. If I seek care outside of my contract terms, I am aware that I may be responsible for all charges that are incurred.
- I understand that it is my responsibility to report any changes in insurance coverage and contact information to Pulmonary and Sleep Center of New England as soon as changes go into effect. I am aware that I may be responsible for all charges that are incurred as a result of failure to report any changes in my coverage to my healthcare provider.

_____ _____

Today's Date **Signature of Patient/Responsible Party**

_____ _____

Today's Date **Authorized Facility Signature**

The signature on file (SOF) is valid from this date. A photocopy of this authorization may act as an original.

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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.

Purpose of this Notice

In the normal course of doing business, this office gathers and retains personal health information about our patients for the purpose of providing medical care, billing, and health plan-related issues. Our physician(s) and staff respect the privacy of your personal information and understand the importance of keeping this information confidential and secure. This **Notice** describes how this office protects the confidentiality of the personal health information we receive.

What is "Personal Health Information"?

"Personal Health Information" is private, protected information that identifies who you are and relates to your past, present, or future physical or mental health or condition, the provision of health care given to you, or past, present, or future payment(s) for the provision of health care given to you. Personal Health Information does not include information about you that is publicly available, or that is available or reported in summary form but does not identify who you are.

Types of Uses and Disclosures of Personal Information

Federal law allows this office to use and disclose your personal information in order to provide health care services to you as well as to bill and collect payments for the health care services provided to you by participating physicians. Federal law also allows this office, in conjunction with its business partners, to use and disclose your personal information as necessary in connection with usual and customary health care operations. For example, this office may use your personal healthcare information in order to obtain authorized referrals to specialists, to review the quality of care provided to you and receive payment from your insurance provider for services given. Your personal healthcare information may also be used by these entities in connection with any grievance or appeal that you file, either with us or with your health plan (your health insurance company). Certain governmental oversight agencies may also request access to your personal information in order to monitor the activities of certain physicians or providers, or to monitor your health plan or insurance company.

This office and/or your health plan may use your personal health information in evaluating physician compliance with any applicable disease management programs or medical care guidelines. Required rules of privacy are observed.

This office is also allowed by law to use and disclose your personal information without your consent or authorization for the following purposes:

- When required by law, such as court-ordered subpoenas
- To comply with State Workers' Compensation laws;
- For public health activities, such as reports about communicable diseases or work-related health issues (privacy of identity is utilized);
- In reports about child abuse, domestic violence, or neglect;
- For health oversight activities, such as reports to governmental agencies that are responsible for licensing physicians or other health care providers;
- In connection with court proceedings or proceedings before administrative agencies;
- For tissue or organ donation;
- To notify or assist in notifying a family member, or another person responsible for your care, about your medical condition or in the event of an emergency or of your death;
- Marketing purposes, i.e. as a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointments to remind you of your appointment time. If you are not home, we may leave a reminder message on your answering machine or with the person answering the phone;
- Change of ownership, in the event that this practice is sold or merged with another organization, your information/record will become the property of the new owner;
- To avert a serious threat to the health or safety of a person or of the public;
- For national security and intelligence activities, including the protection of the President.

Access to Personal Information

As a matter of federal and state law, you have the right to review and/or receive a copy of the personal information received, created and retained (i.e. medical records) by this office. If you request to inspect or receive a copy of your health information held by this office, time to inspect and/or a copy will be provided. This office may reserve the right to charge a reasonable administrative fee, in addition to a per page copy fee for copying your personal information as allowed by applicable law. This office has up to five working days to comply with a request for inspection and/or 15 days after receipt to comply with a copy request.

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NOTICE OF PRIVACY PRACTICES (Cont.)

Right to Request Restrictions on Disclosures of Personal Health Information
You may request restrictions on the use and disclosure of your personal health information by this office. This office has the right to accept or reject your request for restrictions. All requests for restrictions must be made in writing. All requests for restrictions will be made part of your medical record. After receipt of your request, and within 30 days of receipt, this office will notify you in writing of its decision to accept or reject the request. Acceptance of restrictions will be in effect until any written notice to the contrary. If you should decide to terminate with this office your personal health information will be used in accordance with applicable State and Federal law, with the most restrictive rule being in effect in the event of any contradiction.

Right to Receive this Notice
You have the right to request and receive a copy of this Notice in written form. A copy will be provided to you at no charge.

Right to Confidential Communications
You have the right to request that your personal health information be sent to you in a confidential manner. For example, you may request that this office sends your personal information by alternate means or to an alternate address, such as by telephone to a different telephone number or to an office address rather than your home address.

Right to Complain
Complaints about your privacy rights, or how this practice handles your health information should be directed to our Privacy Officer by calling 401-490-2130

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____
Patient's Name (print)

_____ _____
Patient's Signature Date

_____ _____
Authorized Facility Signature Date

Per the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

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Epworth Sleepiness Scale

Name:_____ DOB:____/____/____

Scale:

0= **No** chance of dozing
1= **Slight** chance of dozing
2= **Moderate** chance of dozing
3= **High** chance of dozing

Instructions: For each scenario, circle one number from 0-3 based on the scale above that best fits your chance of dozing for each situation.

Situation	Chance of Dozing			
-Sitting and reading	0	1	2	3
-Watching TV	0	1	2	3
-Sitting Inactive in a public place (i.e.-in a theater or a meeting)	0	1	2	3
-As a passenger in a car for 1 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 lunch without alcohol	0	1	2	3
-In a car, while stopped for a few minutes in traffic	0	1	2	3

Total Epworth Score=_____

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Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours' notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours' notice, we are unable to offer that slot to other patients. Office appointments which are cancelled with less than 24 hours notification may be subject to a $**50.00** cancellation fee. Overnight Sleep Study or Pulmonary Function Testing cancellations require 2 business days advance notice. Without notification they may be subject to a **$200.00** cancellation fee. Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered as **NO SHOW**. Patients who No-Show two (2) or more times in a 12 month period, *may* be dismissed from the practice thus they will be denied any future appointments. ***The Cancellation and No Show fees are the sole responsibility of the patient *not the insurance company* and must be paid in full before the patient's next appointment.***

We understand that special unavoidable circumstances may cause you to cancel within 24 hours. If this type of situation is to arise, upon submittal of proof of emergency, these fees may be waived but only with management approval. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department.

Please sign that you have read and understand this Cancellation and No show Policy.

_____ _____

Patient Name (Please Print) **Date of birth**

_____ _____

Signature of Patient or Representative **Date**