Lung Center
Pulmonary, Sleep & Critical Care Specialists

P: (256) 265 - 5864
F: (256) 265 - 5865

Dear Patient,

We would like to take this opportunity to thank you for choosing the Huntsville Hospital Lung Center for your medical care and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services. Our website (huntsvillehospital.org/hhlung) will help answer most questions about our office. We want you to know about our office services and what to expect at the time of your first visit.

We prefer that you mail, fax, or drop off the completed new patient forms prior to your appointment. If unable to do so, please bring the completed forms with you to your appointment.

We ask that all new patients arrive 30 minutes prior to your appointment time, so you can be seen by the provider as close to your scheduled time as possible. Please be sure to remember to bring the following items to your appointment:

- Identification card
- Insurance card
- Medication bottles
- Co-payment and/or deductible
- If you are currently on CPAP, please bring your SD card

If you are unable to keep your appointment for any reason or if you are going to be 15 minutes or more late, please call our office as soon as possible. We will be happy to reschedule a more convenient time for you.

Appointment Details
Provider:_____
Date and Time: _____

Huntsville

☐ 420 Lowell Dr SE
Suite 500
Huntsville, 35801

☐ 725 Madison St SE
Huntsville, AL 35801

Madison

☐ 1041 Balch Rd
Suite 175
Madison, AL 35758

☐ 8371 Hwy 72 W
Suite 204
Madison, AL 35758

Decatur

☐ 1874 Beltline Rd W
Suite 100
Decatur, AL 35601

If you have any questions prior to your visit, please don't hesitated to give us a call at (256) 265 – 5864.
We look forward to seeing you soon.

Sincerely,

Sam Brunson
Director, Huntsville Hospital Lung Center

HH Lung Center
Pulmonary, Sleep & Critical Care Specialists

Phone: (256) 265-5864
Fax: (256) 265-5868
huntsvillehospital.org/hhlung

Patient Information

Name:_____DOB:_____Today's Date: _____
Address:_____City:_____State:_____Zip:_____
Home Phone:_____Cell Phone:_____Work Phone: _____
SSN:_____Sex: ☐Male ☐Female
Occupation:_____Employer: _____
Employer's Address:_____Employer's Phone: _____

Spouse's Name:_____Spouse's DOB:_____Spouse's SSN: _____
Spouse's Occupation:_____Spouse's Employer: _____
Spouse's Employer's Address:_____Spouse's Employer's Phone: _____

In case of emergency, notify:_____Relationship: _____
City:_____State:_____Phone: _____

If patient is a minor, list person(s) other than emergency contact above who has permission to bring child to office for treatment:
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____
Name:_____Relationship:_____Phone:_____

Insurance *(provide patient information unless patient is a minor, then provide guarantor's information)*

Primary
Insurance Name: _____ Relationship to patient: _____
Subscriber's Name: _____ Co-pay amount: _____
Subscriber's ID/Contract Policy #: _____ Group #: _____
Subscriber's SSN: _____ Subscriber's DOB: _____
Subscriber's Employer: _____ Employer's Phone: _____

Secondary
Insurance Name: _____ Relationship to patient: _____
Subscriber's Name: _____ Co-pay amount: _____
Subscriber's ID/Contract Policy #: _____ Group #: _____
Subscriber's SSN: _____ Subscriber's DOB: _____
Subscriber's Employer: _____ Employer's Phone: _____

Person responsible for this account:_____Phone: _____

I agree payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Physician Care to release information to insurance carriers and for insurance carriers to release information to HH Physician Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physician all payments for medical services rendered to myself or my dependents if assignment applies.

_____ _____ _____
Signature Date Time

Lung Center
Pulmonary, Sleep & Critical Care Specialists

Phone: (256) 265-5864
Fax: (256) 265-5865
huntsvillehospital.org/hhlung

Pulmonary History and Symptom Form

General Information

Appointment Date:_____ Appointment with:_____
Name:_____ DOB:_____ Age:_____
Sex: ☐Male ☐Female
Referring Physician:_____ Family Physician: _____
Pharmacy: _____
Do you have an Advanced Directive (Living Will)? ☐Yes ☐No

Your Visit

What brings you to our office today?_____
How long have you had this problem? _____
Are there any factors that make this better or worse? _____

List any tests done for this problem already:
1. _____
2. _____
3. _____

Medications

List current medications with dosages including over-the-counter or herbal:
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Drug Allergies

List any drug allergies/reactions:
1. _____ 2. _____ 3. _____

Diseases / Illness History

List any illnesses or diseases that you are being treated for or have been treated in the past:
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Surgery and Operation History

List any surgeries or operations you have had:
1. _____ 3. _____
2. _____ 4. _____

Pulmonary History

Have you had problems with (please circle):
1. ☐Yes ☐No Shortness of breath If yes, how long? _____
2. ☐Yes ☐No Cough
3. ☐Yes ☐No Coughing phlegm
4. ☐Yes ☐No Coughing blood
5. ☐Yes ☐No Coughing/choking after eating
6. ☐Yes ☐No Cough at night
7. ☐Yes ☐No Wheezing
8. ☐Yes ☐No Runny nose
9. ☐Yes ☐No Itchy eyes
10. ☐Yes ☐No Sinusitis
11. ☐Yes ☐No Post nasal drip If yes, does it occur year round? Yes / No
12. ☐Yes ☐No Heartburn

☐Yes ☐No Do you feel like these issues affect your life?

Social History

For Office Use Only:				
Wt:	BP:	Neck Circ:	Pulse:	Pulse ox:
Allergies				Ht:

Marital Status: ☐Single ☐Engaged ☐Married ☐Separated ☐Divorced ☐Widowed
Work: ☐Part Time ☐Full Time ☐Retired ☐Disabled Occupation: _____ ☐Day Shift ☐Night Shift
Children: ☐Yes ☐No How many? _____
Religious Affiliation: _____

Risk Factors

Tobacco use: ☐Yes ☐No
Type: ☐Cigarettes ☐Cigars ☐Snuff ☐Vapor If yes, how many years?:_____Amount per day:_____
If you do not currently smoke, but did in the past, when did you quit smoking?_____
How long did you smoke before quitting?_____
Alcohol use: ☐Yes ☐No If yes, how many drinks per day?_____
Caffeine use: ☐Yes ☐No
Recreational drug use: ☐Yes ☐No
Are you exposed to chickens, pigeons, or pet birds? ☐Yes ☐No

Family History

	Age	Serious Health Problems	Cause of Death
Father			
Mother			
Brother			
Sister			

Medical Problems (Please mark any that are applicable)

General
☐ Weight Loss
If yes,_____lbs. since when_____
☐ Fever
☐ Chills
☐ Night Sweats

Skin/Breasts
☐ Bruising
☐ Rash/Itching
☐ Lumps
☐ Color Change

Hematology/Lymphatic
☐ Anemia
☐ Bleeding
☐ Enlarged Nodes

Musculoskeletal
☐ Arthritis
☐ Weakness
☐ Fracture

Endocrine
☐ Thyroid
☐ Diabetes

Sleep
☐ Snoring
☐ Daytime Drowsiness
☐ Morning Headaches
☐ Waking at Night Choking
☐ Waking at Night Short of Breath

Eyes
☐ Vision Loss
☐ Trauma
☐ Color Blind
☐ Glasses/Contacts
☐ Cataracts

ENT
☐ Deafness
☐ Dizziness
☐ Mouth Sore
☐ Throat Sore
☐ Nose Bleed
☐ Hoarseness
☐ Tooth Problems

Cardiovascular
☐ Angina
☐ Chest Pain
☐ Rheumatic Fever
☐ Palpitations
☐ Heart Attack
☐ Hypertension

Gastrointestinal
☐ Trouble Swallowing
☐ Vomiting
☐ Diarrhea
☐ Cough after you eat

Genitourinary
☐ Kidney Stones
☐ Increased Urine
☐ Hysterectomy/Tubal
☐ Hormones
☐ Birth Control Pills
☐ Incontinence
☐ Prostate
☐ Menstrual Irregularity

Neurological
☐ Stroke
☐ Seizure
☐ Paralysis

Psychiatric
☐ Bad Nerves
☐ Depression
☐ Hallucination
☐ Sleep Disturbance

Pain
☐ Pain Level: /10
☐ Pain Location: _____
☐ Pain Intensity: _____
☐ Pain Description:_____
_____

Health System

Race and Ethnicity Form

Name:_____DOB:_____

This classification provides a minimum standard for maintaining, collecting and presenting date on race and ethnicity for all Federal reporting purposes. This is not to be used as determinants of eligibility for participation in any Federal Program.

Race (select one or more):

☐ White (not of Hispanic origin): All persons having origins in any of the original peoples of Europe, North Africa, or Middle East.

☐ Black (not of Hispanic origin): All persons having origins in any of the Black racial groups of Africa.

☐ Hispanic: All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

☐ Asian or Pacific Islander: All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.

☐ American Indian or Alaskan Native: All persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

☐ Declined

Ethnicity (select one):

☐ Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be in addition to "Hispanic or Latino."

☐ Non-Hispanic or Latino

☐ Declined

Preferred Language: _____

Signature:_____Date:_____

Health System

Patient Agreement and Acknowledgment

REGADM

REGADM

Patient Name:_____
MRN:_____
Date of Birth_____

or use patient label

□ Yes □ No **FACILITY DIRECTORY**: While in our facility, if someone asks for you by name, may we acknowledge that you are here?

□ Yes □ No **PATIENT'S RIGHTS**: I have been provided a copy of Huntsville Hospital Health System's Patient's Rights and Notice of Privacy Practices.

ADVANCE DIRECTIVES: □ NA (patient 18 and younger)
Does patient have an Alabama living will or a durable power of attorney for health care?
□ Yes; Advance Directive with patient, copy made and attached to clinical chart.
□ Yes; Advance Directive not with patient. Patient's family/significant other notified to bring Advance Directive to hospital.
□ No, information offered to patient or authorized representative.
□ Advance Directive from another State (indicate name of state)_____, copy attached to clinical chart and offered patient an Alabama Advance Directive.
□ NA (If receiving services in any Physicians Network Hospital-Based Clinics or The Heart Center, Inc.)

□ Yes □ No **ASSIGNMENT OF INSURANCE RESPONSIBILITY**: I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to Huntsville Hospital and any physician rendering services. If the check must be made out to me, I understand the check must be sent to this address: Huntsville Hospital, 101 Sivley Road, Huntsville, AL 35801. If appeal efforts are necessary I authorize Huntsville Hospital Health System and its designee to appeal this claim on my behalf with my insurance company and/or my insurance company designee.

□ Yes □ No **STATEMENT OF FINANCIAL RESPONSIBILITY:** I understand Huntsville Hospital Health System (HHHS) and any physician rendering services must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect or secure, including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise is the financial responsibility of the patient or guardian. Patients who are considered a legal adult are financially responsible for all services rendered. I have been offered a copy of HHHS Patient Financial Responsibility statement.

□ Yes □ No **MEDICARE/TRICARE RIGHTS (IP only)**: applies □ Yes □ No
I have received a copy of the Medicare or Tricare Message (Rights). I understand that this does not waive my right to request a review by a Peer Review Organization. When a review is requested, I understand that I am not liable for any payment until the Peer Review Organization has made its final decision.

□ Yes □ No **PATIENT TREATMENT:** I understand that I may receive care or treatment from doctors who are not employees or agents of Huntsville Hospital Health System, but instead are independent practitioners. These independent doctors include, but may not be limited to, doctors who read x-rays (radiologists), doctors who test specimens removed from me (pathologists), and doctors who give anesthesia (anesthesiologists).

□ Yes □ No **CONSENT FOR MEDICAL/EMERGENCY TREATMENT**: I hereby consent to and authorize HHHS to render usual and customary medical/emergency treatment, including diagnostic and radiological procedures, minor surgical procedures and administration of local anesthetics as necessary, and other general medical/emergency treatment and hospital care considered advisable or necessary by the physician.

□ Yes □ No **FINANCIAL ASSISTANCE**: I understand that financial assistance may be available for individual patients who are uninsured or who otherwise meet financial aid criteria. The hospital's overall ability to remain financially stable and provide essential health care services to all members of our community is dependent upon the financial resources available to cover services provided to patients. My assistance in providing such information is necessary to determine possible financial aid available to me. If I am uninsured and need financial assistance, I may contact a Financial Counselor and make a request to see if I qualify.

□ Yes □ No **CELL PHONE COMMUNICATION CONSENT:** By providing any telephone number via any oral or written method at any time to HHHS or by contacting us or our contractors or agents, from any phone number and/or email address, you authorize HHHS, our clients, agents, and/or contractors to use any or all information, including cellular telephone numbers, for the purpose of contacting you regarding this account and any prior or subsequent accounts. This authorization is also expressly conveyed to any contractor, agent, third-party, individual or others authorized by HHHS or its providers to assist with the resolution or collection of any indebtedness to any party for any reason. You acknowledge this contact may occur via automated dialing and messaging equipment; text messages; leaving of messages on answering machine/voice mail or similar devices or methods; and includes leaving messages with individuals. You acknowledge and understand this authorization is not a condition of receiving healthcare treatment or services. This authorization shall remain in effect until individually withdrawn by you in writing to HHHS and/or any others to which authorization has been extended.

□ Yes □ No **PHOTOGRAPHY CONSENT:** I authorize photography for purposes of clinical treatment and staff education. I understand that any images or photographs will be used solely for these purposes and that I have the right to revoke this authorization or to refuse to be photographed at any time. I understand that only hospital authorized or issued equipment will be used to take photographs, and that my privacy and confidentiality will be maintained in the use of these images.

I certify that all information given to Huntsville Hospital Health System on this contract is true and accurate. I have had the opportunity to ask questions that have been answered to my satisfaction. I have read this contract, understand its contents, and I have willingly signed this document.

X _____ _____ _____

Signature of Patient or Legally Authorized Representative | Date/ Time | Witness/Employee Signature

_____ _____

Authorized Representative's Relationship to Patient | Employee ID #

I wish to submit my restrictions in writing to Huntsville Hospital Health System (HHHS), and I understand that HHHS may not agree with my restrictions. _____

Signature Not Obtained

First Attempt: Date _____ Time _____ Reason: (check one) □ Emergency Situation □ Communication Barrier

_____ _____

Signature of Employee attempting to obtain signature | Witness

Second Attempt: Date_____ Time_____ Reason: (check one) □ Emergency Situation □ Communication Barrier

_____ _____

Signature of Employee attempting to obtain signature | Witness

HUNTSVILLE HOSPITAL HEALTH SYSTEM
101 SIVLEY ROAD • HUNTSVILLE, AL 35801 • 256-265-1000

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ SS Number (Optional)_____

Date of Birth _____ Address _____

Phone Number (____)_____Date of Service_____ Patient Number

I authorize the use or disclosure of the above named individual's health information as described below:

1. Huntsville Hospital is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ Facesheet	☐ Physician Orders	☐ Laboratory Results	Records Release Format
☐ Discharge Summary	☐ Outpatient Record	☐ Imaging Results	☐ e-delivery (Healthport Connect)
☐ History and Physical	☐ Emergency Dept. Record	☐ Bill / Claim Form	☐ CD
☐ Operative Note	☐ EKG Report	☐ Itemized Statement	☐ Paper
☐ Pathology Report	☐ EBC Application	☐ Other_____	
☐ Consultation Report	☐ Autopsy Report		
☐ Progress Notes			

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, 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.

4. This information may be disclosed to, and used by, the following individual or organization:

   Name:_____

   Address: _____

5. For the purpose of _____

6. I understand that I have a right to 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 Medical Record 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.

7. Unless otherwise revoked, the 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 in six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

    or

    I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
    Treatment Enrollment in the health plan Eligibility for benefits

SIGNATURE		DATE	TIME
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS	DATE	TIME