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

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Sleep History and Symptom Form (New Patients)

Name:_____DOB:_____
Referring Physician:_____Primary Physician: _____
What brings you to our office today?_____

Your main sleep complaints:

☐Snoring ☐Daytime sleepiness ☐Insomnia ☐Leg jerks ☐Interruptions in breathing ☐Nightmares
How long have your complaints bothered you? ☐<12 months ☐1-2 years ☐>2 years
Have you had a previous sleep study? ☐Yes ☐No
If Yes, when:_____Where:_____What was recommended? _____

Sleep Schedule:

Total sleep time in 24hrs_____
1. During the week, what time do you normally go to bed?_____AM/PM awaken_____AM/PM
2. During the weekend, what time do you normally go to bed_____AM/PM awaken_____AM/PM
3. How long does it take you to get to sleep?_____min/hours
4. Approximately how many times do you awaken during your sleep cycle? _____
   How long to get back to sleep? _____
5. What are the usual reasons that awaken you?

☐ Urination ☐ Heat ☐ Heartburn ☐ Light ☐ Pain ☐ Shortness of breath
☐ Noise ☐ Cold ☐ Body Jerks ☐ Child ☐ Partner ☐ Other_____

6. ☐Yes ☐No Do you work night shifts? — Circadian / Sleep Screening
7. ☐Yes ☐No Sleep separately from your bed partner?
8. ☐Yes ☐No Does your bed partner or you leave the bedroom b/c of your sleep problem?
9. ☐Yes ☐No Do you awaken feeling tired and not refreshed?
10. ☐Yes ☐No Take naps on arrival home from work?
11. ☐Yes ☐No Are short naps refreshing?
12. ☐Yes ☐No Do you fall asleep while driving?
13. ☐Yes ☐No Have trouble at work or school because of sleepiness?
14. ☐Yes ☐No Snore loud enough for others to complain? — Apnea Screening
15. ☐Yes ☐No Are you told you stop breathing while sleeping?
16. ☐Yes ☐No Awakened short of breath or choking?
17. ☐Yes ☐No Awakened with heart burn belching or coughing?
18. ☐Yes ☐No Awakened with chest pain or chest heaviness?
19. ☐Yes ☐No Awakened with heart racing or pounding?
20. ☐Yes ☐No Do you wake up with morning headache?
21. ☐Yes ☐No Have poor memory?
22. ☐Yes ☐No Have trouble concentrating?
23. ☐Yes ☐No Has your sexual relationship been affected because of your being tired or sleepy?
24. ☐Yes ☐No Do you feel the uncontrollable urge to sleep while sad, happy or mad? — Narcolepsy Screening
25. ☐Yes ☐No Feel your knees buckle arms weak, or jaw drop when mad happy or sad?
26. ☐Yes ☐No Experience vivid dream-like scenes upon awakening or falling sleep?
27. ☐Yes ☐No Feel unable to move (paralyzed) when waking from or falling asleep?
28. ☐Yes ☐No Do you have leg cramps at bedtime? — PLM Screening
29. ☐Yes ☐No Experience crawling and aching feeling in arms or legs which makes you want to move them?
30. ☐Yes ☐No Been told your legs move throughout the night?

Questions continue on next page.

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

31. ☐Yes ☐No Awaken suddenly with a jerk soon after falling asleep?
32. ☐Yes ☐No Do you remember your dreams? Parasomnia Screening
33. ☐Yes ☐No Have nightmares?
34. ☐Yes ☐No Been told you act out your dreams (talk or move)?
35. ☐Yes ☐No Been told you sleepwalk?
36. ☐Yes ☐No Been told you awaken from sleep confused / inconsolable?
37. ☐Yes ☐No Are you unable to fall asleep in 15 minutes or less? Insomnia Screening
38. ☐Yes ☐No Wake up several times during the night and cannot get back to sleep?
39. ☐Yes ☐No Have thoughts racing through your mind while trying to sleep?
40. ☐Yes ☐No Do you watch the clock while trying to fall asleep?
41. ☐Yes ☐No Do you grind teeth during sleep? Bruxism Screening

Review of Symptoms: Please check all that apply to you at this time.

Sleep
☐ Daytime sleepiness
☐ Dry mouth
☐ Snore
☐ Sore throat
☐ Apnea
☐ Daytime naps
☐ Insomnia

General
☐ Night sweats
☐ Weight gain
☐ Fatigue
☐ Weight loss
☐ Hot flashes

Eyes / ENT
☐ Sinus trouble
☐ Difficulty hearing
☐ Difficulty seeing
☐ Sneezing / watery eyes
☐ Nose bleed

Cardiovascular
☐ Chest pain
☐ Shortness of breath
☐ Rapid/skipped heartbeats
☐ Ankle swelling

Urinary
☐ Frequent urination
☐ Nighttime urination
☐ Urinary incontinence

Musculoskeletal
☐ Muscle pain
☐ Joint pain
☐ Back pain
☐ Leg jerks
☐ Leg pain with walking

Gastrointestinal
☐ Nausea / vomiting
☐ Heart burn
☐ Irritable bowel
☐ Difficulty swallowing

Psychological
☐ Depression
☐ Anxiety
☐ Hallucinations

Pulmonary
☐ Chronic cough
☐ Coughing blood
☐ Shortness of breath
☐ Sputum production
☐ Wheezing
☐ Use of Oxygen

Neurological
☐ Memory loss
☐ Dizziness
☐ Difficulty walking
☐ Difficulty talking
☐ Tremors
☐ Numbness/tingling
☐ One-sided weakness
☐ Morning headaches

Social History: Please check all that apply to you.

Alcohol use: ☐Current ☐Past ☐Beer ☐Liquor ☐Night cap How much? _____
Smoke tobacco: ☐Current ☐Past Packs per day? _____
Chew tobacco: ☐Current ☐Past How much? _____
Illicit drug use: ☐Current ☐Past What drug? _____
Caffeine: ☐Current ☐Past How many cups per day? _____
Marital Status: ☐Single ☐Engaged ☐Married ☐Separated ☐Divorced ☐Widowed
Children: ☐Yes ☐No How many? _____
Occupation:_____Hours of work/week:_____☐Day Shift ☐Night Shift
Do you drive or operate commercial vehicles: ☐Yes ☐No
Other: Do you have an advanced directive? ☐Yes ☐No

Gynecological History: For women only

Are you currently pregnant? ☐Yes ☐No
Are you currently breastfeeding? ☐Yes ☐No

Past Medical History: Please check any of the following conditions that apply to you or your family.

	Yourself	Parents	Children	Sibling	
Sleep Apnea					
Narcolepsy					
Hypersomnia					
Congestive Heart Failure					
Restless Legs					
Diabetes					
Asthma/COPD					
Fibromyalgia					
Acid Reflux					
Heart Arrhythmia					
High Blood Pressure					

Traumatic Brain Injury					
Migraine Headache					
Psychiatric Problem					
Parkinson's					
Seizures / Epilepsy					
Stroke					
Other					

Past Surgeries: What surgeries have you had in the past? (Please mark if applicable and include date of surgery)

☐ Hysterectomy____/___/___ ☐ Brain surgery ___/___/___ ☐ Heart surgery____/___/___
☐ Nose surgery ___/___/___ ☐ Throat surgery____/___/___ ☐ Tonsillectomy____/___/___
☐ Bariatric surgery___/___/___ ☐Other:_____/___/___

Current medications: Please indicate any vitamins, herbs, and over the counter medications.

1._____ 4._____ 7._____ 10._____
2._____ 5._____ 8._____ 11._____
3._____ 6._____ 9._____ 12._____

Allergies: Please indicate any vitamins, herbs, and over the counter medications.

1._____ 3._____ 5._____ 7._____
2._____ 4._____ 6._____ 8._____

Epworth Sleepiness Scale:

How likely are you to doze off asleep in the following situations?

	(0) None	(1) Low	(2) Moderate	(3) High
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (ex: theater, meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting down talking with someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes with traffic				
			Epworth Total	**___/ 24**

Functional Outcome of Sleep Questionnaire:

When the words "sleepy" or "tired" are used, it means the feeling that you can't keep your eyes open, your head is droopy, that you want to "nod off" or that you feel the urge to take a nap. Select only one answer for each question.

Do you have difficulty with:	(1) Extreme	(2) Moderate	(3) Little	(4) No
Concentrating on the things you do because you are sleepy or tired?				
Remembering things, because you are sleepy or tired?				
Finishing a meal because you become sleepy or tired?				
Working on a hobby (for example sewing, collecting, gardening) because you are sleepy or tired?				
Doing work around the house (for example, cleaning house, doing laundry, taking out the trash, repair work) because you are sleepy or tired?				
Operating a motor vehicle for short distances (less than 100 miles) because you become sleepy or tired?				
Operating a motor vehicle for long distances (greater than 100 miles) because you become sleepy or tired?				
Getting things done because you or too sleepy or tried to drive or take public transportation?				
Taking care of financial affairs and doing paperwork (for example writing checks, paying bills, keeping financial records, filling out tax forms, etc.) because you are sleepy or tired ?				
Performing employed or volunteer work because you are sleepy or tired?				
			FOSQ-10 Score	**___/ 40**

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