

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 hesitate to give us a call at (256) 265 – 5864. We look forward to seeing you soon.

Sincerely,



Sam Brunson
Director, Huntsville Hospital Lung Center

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

Pediatric Sleep History and Symptom Form (New Patients)

Name: _____ Gender: Male Female Age: _____ DOB: _____

Referring Physician: _____ Primary Physician: _____

What brings your child to our office today? _____

Child's Main Sleep Complaints: Parent's Main Sleep Complaint (about child's sleep)

- | | |
|---|---|
| <input type="checkbox"/> Daytime sleepiness | <input type="checkbox"/> Daytime sleepiness |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Interruptions in breathing | <input type="checkbox"/> Interruptions in breathing |
| <input type="checkbox"/> Leg jerks | <input type="checkbox"/> Leg jerks |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

How long have the complaints bothered your child? Last 3 months 6-12 months 1-2 years >2 years

How would you rate the severity of your child's complaint? Mild Moderate Severe

Has your child had a previous sleep study? Yes No

If "Yes", when: _____ Where: _____ Physician: _____

What was recommended? _____

Sleep Schedule:

Total sleep time in 24hrs _____

1. During the week, what time does your child normally go to bed? _____ AM/PM awaken _____ AM/PM

2. During the weekend, what time does your child normally go to bed _____ AM/PM awaken _____ AM/PM

3. How long does it take your child to get to sleep? _____ mins/hours

4. Approximately how many times does your child awaken during their sleep cycle? _____

How long to get back to sleep? _____

5. What are the usual reasons that awaken your child?

- | | | | | | |
|------------------------------------|-------------------------------|-------------------------------------|----------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Urination | <input type="checkbox"/> Heat | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Light | <input type="checkbox"/> Pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Noise | <input type="checkbox"/> Cold | <input type="checkbox"/> Body Jerks | <input type="checkbox"/> Sibling | <input type="checkbox"/> Other _____ | |

6. Yes No Does your child sleep through the night?

7. Yes No Does your child sleep in parents' bed/bedroom?

8. Yes No Does anyone leave the bedroom because of your child's sleep problem?

9. Yes No Does your child awaken feeling tired and not refreshed?

10. Yes No Does your child take naps on arrival home from school/work?

11. Yes No Are short naps refreshing for your child?

12. Yes No Does your child fall asleep while driving or riding in a car?

13. Yes No Does your child have trouble at school or work because of sleepiness?

14. Yes No Does your child snore loud enough for others to complain?

15. Yes No Does your child stop breathing while sleeping?

16. Yes No Does your child ever awaken short of breath or choking?

17. Yes No Does your child ever awaken with heart burn, belching, or coughing?

18. Yes No Does your child ever awaken with chest pain or chest heaviness?

19. Yes No Does your child ever awaken with heart racing or pounding?

20. Yes No Does your child ever wake up with morning headache?

21. Yes No Does your child have a poor memory?

22. Yes No Does your child have trouble concentrating?

23. Yes No Has your child's family relationship been affected because they are tired or sleepy?

24. Yes No Does your child feel the uncontrollable urge to sleep while mad, happy, or sad?

Questions continue on next page.

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

25. Yes No Does your child feel their knees buckle, arms weaken, or jaw drop when mad, happy, or sad?

26. Yes No Does your child experience vivid dream-like scenes upon awakening or falling asleep?
27. Yes No Does your child ever feel unable to move (paralyzed) when waking from or falling asleep?
28. Yes No Does your child have leg cramps at bedtime?
29. Yes No Does your child experience a crawling and aching feeling in their arms or legs which makes them want to move them?
30. Yes No Do your child's legs move throughout the night?
31. Yes No Does your child awaken suddenly with a jerk soon after falling asleep?
32. Yes No Does your child remember their dreams?
33. Yes No Does your child have nightmares?
34. Yes No Does your child act out their dreams (talk or move)?
35. Yes No Does your child sleepwalk?
36. Yes No Does your child awaken from sleep confused/inconsolable?
37. Yes No Does your child awaken from sleep panicked/anxious?
38. Yes No Is your child unable to fall asleep in 15 minutes or less?
39. Yes No Does your child wake up several times during the night and cannot get back to sleep?
40. Yes No Does your child wake up 1 to 2 hours early in the morning?
41. Yes No Does your child have thoughts racing through their mind while trying to sleep?
42. Yes No Does your child watch the clock while trying to fall asleep?
43. Yes No Does your child wake up with sore, achy muscles?
44. Yes No Does your child wake up feeling depressed or sad?
45. Yes No Does your child clench their teeth during sleep?
46. Yes No Does your child grind their teeth during sleep?
47. Yes No Does your child have morning jaw pain?

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

Sleep

- Daytime sleepiness
- Dry mouth
- Snore
- Sore throat
- Apnea
- Daytime naps
- Insomnia

General

- Night sweats
- Weight gain
- Fatigue
- Weight loss

Eyes / ENT

- Sinus trouble
- Difficulty hearing
- Difficulty seeing
- Nose bleed

Cardiovascular

- Chest pain
- Shortness of breath
- Rapid/skipped heartbeats

Urinary

- Nighttime urination
- Urinary incontinence

Musculoskeletal

- Muscle pain
- Joint pain
- Back pain
- Leg jerks

Gastrointestinal

- Heart burn
- Irritable bowel
- Difficulty swallowing

Psychological

- Depression
- Anxiety
- Hallucinations

Pulmonary

- Chronic cough
- Shortness of breath
- Wheezing
- Use of Oxygen

Neurological

- Memory loss
- Dizziness
- Difficulty walking
- Difficulty talking
- Tremors
- Numbness/tingling
- Morning headaches

Birth History:

Did the child's mother receive regular prenatal care while pregnant? Yes No

Were there any complications during pregnancy with this child? Yes No

If yes, explain: _____

Were there any complications post-delivery with this child? Yes No

If yes, explain: _____

Birth Weight: _____ #Weeks of Gestation: _____ Length of labor: _____ APGAR score: _____ @ 5 mins

Type of Delivery? SVD (vaginal) C-section

Any birth defects/trauma? Yes No If yes, please explain: _____

Jaundice? Yes No Prolonged neonatal stay? Yes No If yes, please explain: _____

Other: _____

Social History:

Number of siblings: _____

Does your child have their own room? Yes No

Does your child sleep in their own bed? Yes No

Are there any pets in the house? Yes No If yes, do the pets sleep with the child? Yes No
 Is there any smoking in the house (2nd hand tobacco smoke)? Current Past Never
 Home family status: Married Separated Divorced Joint Custody Civil Union Foster Care
 Does your child have special needs? _____

To the best of your knowledge, does your child use any of the following:

Alcohol use: Current Past How much? _____
 Illicit drug use: Current Past What drug? _____
 Nicotine abuse: Current Past Type/Packs per day? _____
 Caffeine: Current Past How many cups/glasses/cans per day? _____

Past Medical History: Please check any of the following conditions that apply to your child or your child's family:

	Child	Father	Mother	Sibling	Grandfather	Grandmother	Description
Acid Reflux							
Arthritis Pain							
Asthma							
Cancer							
Depression							
Diabetes							
Emphysema/COPD							
Heart Arrhythmia							
High Blood Pressure							
High Cholesterol							
Narcolepsy							
Migraine Headache							
Psychiatric Problem							
Restless Legs							
Seizures / Epilepsy							
Sleep Apnea							
Tuberculosis							
Thyroid Disease							
Other							

Do you wish your child to be on life support? Yes No

Do you have someone to make health decisions for you for your child in case you were incapacitated? Yes No

If yes, please list the names of who can make health decisions for your child: _____

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

Abdominal surgery ___/___/___ Ear Tubes ___/___/___ Heart surgery ___/___/___
 Appendectomy ___/___/___ Circumcision ___/___/___ Gallbladder ___/___/___
 Hernia ___/___/___ Brain/Head ___/___/___ Tonsillectomy ___/___/___
 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 list any medication, food, or chemicals which your child is allergic to or has a major side effect to.

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

Epworth Sleepiness Scale:

How likely is your child to fall 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



Race and Ethnicity Form

Name: _____ DOB: _____

This classification provides a minimum standard for maintaining, collecting and presenting data 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: _____

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



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:

- Huntsville Hospital is authorized to make the disclosure.
- The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

<input type="checkbox"/> Facesheet	<input type="checkbox"/> Physician Orders	<input type="checkbox"/> Laboratory Results	Records Release Format
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Outpatient Record	<input type="checkbox"/> Imaging Results	<input type="checkbox"/> e-delivery (Healthport Connect)
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Emergency Dept. Record	<input type="checkbox"/> Bill / Claim Form	<input type="checkbox"/> CD
<input type="checkbox"/> Operative Note	<input type="checkbox"/> EKG Report	<input type="checkbox"/> Itemized Statement	<input type="checkbox"/> Paper
<input type="checkbox"/> Pathology Report	<input type="checkbox"/> EBC Application	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Consultation Report	<input type="checkbox"/> Autopsy Report		
<input type="checkbox"/> Progress Notes			
- 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.
- This information may be disclosed to, and used by, the following individual or organization:
 Name: _____
 Address: _____
- For the purpose of _____
- 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.
- 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.
- 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.
- 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.
- 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