MARTIN C JOHNSON MD
KAMRAN FIROOZI MD
FAYEZ BADER MD

Dear Patient,

Your New Patient Evaluation has been scheduled for: _____

We would like to welcome you as a new patient and thank you for choosing Salem Pulmonary Associates, P.C. and Sleep Center for your health care needs. We are a specialty medical practice providing care for patients with pulmonary and sleep related disorders. It is our goal to provide you with the highest level of care and wish to make your appointments here an informative and rewarding experience.

We encourage you to make a list of any questions you may have. During your initial evaluation we will review your medical history, perform a physical exam and will ask more detailed questions regarding your symptoms, sleep history, sleep patterns and level of fatigue. Many patients find it helpful if their bed partner joins them during the exam. Your bed partner may be able to offer insight into your breathing patterns and behaviors at night. This process allows us to better understand your sleep disorder and based upon your answers, we will decide if additional diagnostic testing is needed.

To assist us in making your first visit more efficient, please fill out each of the forms attached. We also ask that you bring the following to your appointment:

1. *Current medication/allergy list*
2. *Picture I.D. (State issued drivers license, state issued I.D., military I.D.)*
3. *Current Insurance card*

Please arrive 15 minutes prior to your scheduled appointment time with your completed forms and other requested information.
Failure to complete paperwork prior to your appointment may result in rescheduling.

*Please feel free contact us at **(503)588-3945** if you have any questions.*

Thank You,

Salem Pulmonary Associates, P.C. and Sleep Center

801 Mission St SE Salem, Or 97302-6222
503-588-3945 503-588-0256 FAX

SALEM PULMONARY ASSOCIATES, PC AND SLEEP CENTER
801 MISSION ST SE
SALEM, OR 97302-6222
503-588-3945 503-588-0256 FAX

PATIENT INFORMATION

Name: _____ DOB: _____
Last *First* *M.I.*

Home Address: _____
Street *City/State* *Zip*

Home Phone: (____)_____ Work: (____)_____ Cell: (____)_____

May we leave a message at your home? YES NO At your place of employment? YES NO

Email Address: _____ SSN: _____

Marital Status: Single Married Divorced Separated Widowed

Race: _____ Language: _____ Ethnicity: _____

Employer: _____ Occupation: _____

Employer Address: _____
Street *City/State* *Zip*

Primary Care Physician: _____ Referring Physician: _____

SPOUSE/PARENT INFORMATION/OTHER RESPONSIBLE PERSON

Name: _____ DOB: _____
Last *First* *M.I.* Relationship: _____

Home Address: _____
Street *City/State* *Zip*

Home Phone: (____)_____ Work: (____)_____ Cell: (____)_____

Email Address: _____ SSN: _____

METHOD OF PAYMENT: CASH CHECK CREDIT CARD INSURANCE OTHER

Primary Insurance Co: _____ Policy #: _____ Group #: _____

Secondary Insurance Co: _____ Policy #: _____ Group #: _____

Is this office visit due to a work injury: _____

Signature: _____ Date: _____

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Form 2A-1

Disclosure of PHI and Treatment, Payment, and Health Care Operations

Under the HIPPA Privacy Rule, Salem Pulmonary Associates, PC may disclose protected health information (PHI) for treatment, payment, or health care operations without permission from an individual under the following circumstances:

1. **For our treatment, payment, or health care operations (TPO)**
2. **For treatment activities of another health care provider**
3. **For the payment activities of another covered entity or health care provider, as long as the recipient of the PHI is that covered entity or health care provider**
4. **For purposes of health care operations, between covered entities participation in an organized health care arrangement (OHCA)**

The terms, treatment, payment, and health care operations, as well as health care provider and covered entity have specific meanings that must be understood before disclosure. Please read Form 2B-1 (Spa Office) for more information regarding your rights. Please see our Privacy Officer for an explanation of these terms.

I understand that during the course of normal business, Salem Pulmonary Associates, P.C. and Sleep Center may need to electronically transmit (fax) my medical records. I hereby authorize such transmission and absolve Salem Pulmonary Associates, P.C. and Sleep Center, its physicians, and its employees of any liability relating to such transmission of records.

If you have any questions regarding the permissibility of the disclosure or use of the information, please contact our Privacy Officer: Mark Harrison (503)588-3945.

ACCEPT: _____ **DO NOT ACCEPT: _____**

_____ **_____**
Signature of Individual Authorizing Release of Information **Printed Name**

_____/_____/_____ **_____**
Date of Birth **Date**

I hereby authorize the use and/or disclosure on my PHI with the person or person's listed below: I give permission for them to receive and have access to my PHI. I understand that this authorization is voluntary and is not part of my treatment.

Name: _____ **Relationship: _____**

Name: _____ _____ **Relationship: _____**

Name: _____ _____ **Relationship: _____**

- **You may revoke this authorization at any time by providing written notice to: Salem Pulmonary Associates, P.C. and Sleep Center 801 Mission St SE, Salem, Or 97302-6222.**
- **Your revocation will not affect any actions already taken in reliance on this authorization.**
- **You are entitled to receive a copy of this authorization upon request**

SALEM PULMONARY ASSOCIATES, PC AND SLEEP CENTER
801 MISSION ST SE
SALEM, OR 97302-6222
503-588-3945 503-588-0256 FAX

Salem Pulmonary Associates, P.C. and Sleep Centers goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy, allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions please do not hesitate to ask a member of our staff.

1. Upon arrival, please present your current insurance card(s) at every visit. Please inform us of any changes in your personal information.
2. It is your responsibility to understand your insurance plan and if a written referral or authorization is required to see a specialist, if preauthorization is required prior to a procedure and what services are covered. Please be aware that if you choose to be seen before you have received a valid authorization your insurance may not pay for the visit. The Business Office cannot guarantee payment for services or coverage of services from your health plan. Patients are ultimately responsible for understanding their coverage limitation and benefits.
3. According to your insurance plan, you are responsible for any and all co-payments, deductible and co-insurances at time of service. Co-payments are the amount your policy requires us to collect with each visit. Please be prepared to pay at the time of your visit. The co-insurance is the percentage of the bill that is your responsibility according to the contract with your insurance company. The deductible is the total amount your policy requires you to pay before they pay a claim on your behalf. We will be collecting a portion or all of your owing co-insurance or deductible at the time of your office visit. We accept cash, check, Visa, Mastercard and American Express.
4. Patients without insurance or seeing a provider out of network will be required to make a deposit at the time of the visit at the following rates: New patient office visit- $100 deposit, Established patient office visit-$100 deposit, Sleep Study procedures-$100 deposit.
5. Patient balances are billed immediately upon receipt of your insurance plans explanation of benefits. Your remittance is due 10 business days from receipt of your bill.
6. If previous arrangements have not been made with our finance office, any account balance over 90 days will be turned over to a collection agency.
7. A $25 fee will be assessed for all appointments cancelled without a 24 hr notice.
8. A $35 fee will be assesses for not showing up for your scheduled appointments.
9. **Patients who accumulate a total of 3 No Show/Same Day cancellations within a 12 month period, will automatically be TERMINATED from SPA as a patient. Exceptions will be made dependent on circumstances.**
10. **If you have not been seen in over one (1) year, Salem Pulmonary Associates, P.C. and Sleep Center WILL NOT REFILL ANY PRESCRIPTIONS UNTIL YOU ARE SEEN.**

I acknowledge that I am financially responsible for all charges whether or not they are covered by my insurance. I understand and agree that health insurance policies are an arrangement between an insurance carrier and myself and that my doctor and/or his staff are not the administrators of the policy. I authorize payment of my medical benefits to Salem Pulmonary Associates, P.C. and Sleep Center and my doctor for medical services rendered. A photocopy of the signature is as valid as the original.
If it becomes necessary to effect collections for any amount owed on this or subsequent visits, the undersigned agrees to pay for all the costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment. Any check returned to Salem Pulmonary Associates, P.C. and Sleep Center due to non-sufficient funds will be charged a fee of $25.00.
I have read and understand the above Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

_____ _____
Patient Name (Please Print) Date

_____
Patient, Parent or Guardian Signature

Salem Pulmonary Associates, PC & Sleep Center

801 Mission Street SE
Salem, OR 97302
Phone: 503-588-3945
Fax: 503-588-0256

New Patient Sleep Medicine Questionnaire

Name: _____ Primary Care Physician: _____
Date of Visit: _____ Referring Physician: _____
Age: _____ Height: _____
Occupation: _____ Weight: _____

The purpose of this questionnaire is to get adequate information of the nature of your sleep problem. Please complete and be as thoroughly as you can.

What are your problems: (Check all that apply)

[ ] Snoring [ ] Trouble breathing while asleep [ ] Hold breath while asleep

[ ] Gasp or Choke [ ] Problem falling asleep [ ] Hard to stay asleep

[ ] Tired & fatigue [ ] Sleepy during the day [ ] Moving a lot while asleep

[ ] Legs move [ ] Acting out dreams [ ] Partner asked to seek help

Other: _____

Sleep History:

How long have you had these problems? [ ] > 1 year [ ] 6-12 months [ ] 1-6 months [ ] 1 month

How these problems affected:

Quality of life	[ ] None	[ ] Occasionally	[ ] A lot
Social life	[ ] None	[ ] Occasionally	[ ] A lot
Work performance	[ ] None	[ ] Occasionally	[ ] A lot
Relationship with partner	[ ] None	[ ] Occasionally	[ ] A lot

Have you ever had a sleep evaluation: [ ] Yes [ ] No

If yes: specify. Where? _____ When: _____

Have you ever received any treatment(s) for a sleep problem: [ ] Yes [ ] No

If yes: specify. _____

Are you using any sleep medicine or sleep aids: [ ] Yes [ ] No

If yes: list the medications: _____

_____

How often *you or others* have noted that you?

Snore:	[ ] None	[ ] Occasionally	[ ] A lot
Snore so loudly that others complain:	[ ] None	[ ] Occasionally	[ ] A lot
Awaken from sleep feeling short of breath, gasping or choking:	[ ] None	[ ] Occasionally	[ ] A lot
Stop breathing while you sleep:	[ ] None	[ ] Occasionally	[ ] A lot
Have headaches in the morning:	[ ] None	[ ] Occasionally	[ ] A lot
Have a dry month or sore throat upon awakening:	[ ] None	[ ] Occasionally	[ ] A lot
Sweat profusely at night:	[ ] None	[ ] Occasionally	[ ] A lot
Have heart palpitation at night:	[ ] None	[ ] Occasionally	[ ] A lot
Have nightmares or night terrors:	[ ] None	[ ] Occasionally	[ ] A lot
Act out dreams:	[ ] None	[ ] Occasionally	[ ] A lot
Walk in your sleep:	[ ] None	[ ] Occasionally	[ ] A lot
Do anything else unusual while “asleep”:	[ ] None	[ ] Occasionally	[ ] A lot
Feel unable to move or paralyzed when waking up/ falling asleep:	[ ] None	[ ] Occasionally	[ ] A lot
Have vivid dreams while waking up or falling asleep:	[ ] None	[ ] Occasionally	[ ] A lot
Have constant rhythmic movement, twitching or jerking of legs:	[ ] None	[ ] Occasionally	[ ] A lot
Feel restless, agitated or uncomfortable at bedtime	[ ] None	[ ] Occasionally	[ ] A lot
Do you feel an urge to move your legs?	[ ] Yes	[ ] No	
Does it happen only in the evening?	[ ] Yes	[ ] No	
Does it happen only when relaxed?	[ ] Yes	[ ] No	
Does it get better with moving or walking?	[ ] Yes	[ ] No	
Does it disturb sleep or falling asleep?	[ ] Yes	[ ] No	
How often do these happen?	[ ] Daily	[ ] Few days per week	
Awaken feeling tired or unrefreshed?	[ ] None	[ ] Occasionally	[ ] A lot
Feel tired or exhausted during the day?	[ ] None	[ ] Occasionally	[ ] A lot
Get sleepy while driving:	[ ] None	[ ] Occasionally	[ ] A lot
Had a car accident or came close to from falling asleep while driving	[ ] None	[ ] Occasionally	[ ] A lot
Have trouble at work or school because of sleepiness:	[ ] None	[ ] Occasionally	[ ] A lot
Feel irritable:	[ ] None	[ ] Occasionally	[ ] A lot
Have memory problems:	[ ] None	[ ] Occasionally	[ ] A lot
Fall asleep involuntarily or suddenly or in awkward situations:	[ ] None	[ ] Occasionally	[ ] A lot
Experience sudden weakness, buckling of knees or facial heaviness when laughing, scared, angry or crying:	[ ] None	[ ] Occasionally	[ ] A lot

Sleep Habits:

At what time do you usually go to bed? On workdays? _____ On non-workdays? _____

When do you wake up? On workdays? _____ On non-workdays? _____

When do you get out of bed? On workdays? _____ On non-workdays? _____

How long does it take to fall asleep? _____

How often do you wake up at night? _____ times

Why do you wake up at night? [ ] Pain [ ] Trouble breathing [ ] Go to the bathroom

[ ] Leg movement and discomfort [ ] Other: _____

How long does it take to fall back asleep? _____

Do you feel refreshed upon awakening? [ ] Yes [ ] No

How many hours of sleep do you estimate you have every night? _____ hours

Do you take a nap during the day? [ ] Yes [ ] No

If yes: how many hours do you nap? _____ hours

Do you sleep: [ ] Alone [ ] With partner

Do you feel depressed or sad? [ ] Yes [ ] No

Do you anxious before bedtime? [ ] Yes [ ] No

Do you worry a lot around bedtime? [ ] Yes [ ] No

Do you watch TV before bed time? [ ] Yes [ ] No

Do you read before bed time? [ ] Yes [ ] No

Do you work on computer before bedtime? [ ] Yes [ ] No

Do you drink caffeinated products: [ ] Yes [ ] No

If yes: specify [ ] Coffee [ ] Tea [ ] Soft drink

When? [ ] Morning [ ] Afternoon [ ] Evening [ ] Bedtime

Do you drink alcohol? [ ] Yes [ ] No

If yes: What type? _____ How much? _____

Past Medical History:

[ ] Heart Disease	[ ] Heart Attack	[ ] Heart Failure	[ ] Irregular heartbeat
[ ] Angina	[ ] High blood pressure	[ ] Stroke	[ ] High cholesterol
[ ] Blood vessel problems	[ ] Reflux disease	[ ] Stomach ulcer	[ ] Liver problem
[ ] Hiatal hernia	[ ] Asthma	[ ] COPD	[ ] Emphysema
[ ] Allergy	[ ] Diabetes	[ ] Thyroid problem	[ ] Anemia
[ ] Fatigue	[ ] Headache	[ ] Seizure	[ ] Neuropathy
[ ] Tremor	[ ] Joint pain/arthritis	[ ] Fibromyalgia	[ ] Depression
[ ] Anxiety	[ ] Panic attacks	[ ] Other: _____	

Past Surgical History: List all types of surgeries you've had

Type of surgery	Year	Type of surgery	Year
---	---	---	---
---	---	---	---
---	---	---	---

Social History:

Marital Status: [ ] S [ ] M [ ] D

Occupation: _____

Smoking: [ ] Yes [ ] No If yes: How many? _____pack(s) per day for _____years.

Family History: Do any of your family members have any of the following conditions? Check all that apply and list relationship

Condition	Relationship	Condition	Relationship
[ ] Narcolepsy	_____	[ ] Sleep Walking	_____
[ ] Obstructive sleep apnea	_____ _____	[ ] Restless leg syndrome	_____
[ ] Snoring	_____ _____	[ ] Insomnia	_____
[ ] Acting out dreams	_____ _____	[ ] Hypertension	_____
[ ] Heart problem	_____ _____	[ ] Diabetes	_____
[ ] Stroke	_____	[ ] Fatigue	_____

Medications: list all your medications with doses and frequency

Medication	Dose & frequency	Medication	Dose & frequency
---	---	---	---
---	---	---	---
---	---	---	---
---	---	---	---

Allergies: list all drug allergies.

Medication	Reaction	Medication	Reaction
---	---	---	---
---	---	---	---
---	---	---	---

Review of systems: **Check all that apply**

Constitutional

[ ] Weight gain if any, how much: _____ lb [ ] Weight loss if any, how much: _____ lb

[ ] Night Sweat [ ] Fever [ ] Chills [ ] Fatigue [ ] Change in appetite

Head, Ears, Eyes, Throat

[ ] Vision changes [ ] Hearing loss [ ] Headache [ ] Nose congestion [ ] Runny nose

[ ] Post nasal drip [ ] Rhinitis [ ] Sore throat [ ] Neck swelling [ ] Oral thrush

[ ] Nose bleed

Heart

[ ] Chest pain [ ] Rapid heart rate [ ] Irregular heart beat [ ] Leg swelling

Lung

[ ] Shortness of breath [ ] Cough and sputum [ ] Trouble breathing/ lying flat [ ] Coughing up blood

Gastrointestinal

[ ] Abdominal pain [ ] Nausea /vomiting [ ] Heartburn [ ] Diarrhea [ ] Constipation

[ ] Indigestion [ ] Bloating [ ] Vomiting blood [ ] Blood in stools [ ] Problems swallowing

Genital and urinary

[ ] Blood in urine [ ] Voiding often [ ] Burning with urine [ ] Kidney stone [ ] Erectile dysfunction

Musculoskeletal

[ ] Joint pain or swelling [ ] Back pain [ ] Leg cramps [ ] Muscle pain or weakness

Skin

[ ] Skin rash [ ] Skin cancer [ ] Sensitive skin

Hematology

[ ] Bleeding tendency [ ] Anemia [ ] Blood clots in legs [ ] Blood clots in lung

Blood vessels

[ ] Leg pain with walking [ ] Blocked or narrowed arteries

Neurology

[ ] Headache [ ] Paralysis [ ] Passing out [ ] Balance problem [ ] Dizziness

[ ] Trouble walking [ ] Forgetful [ ] Tremors [ ] Numbness

Endocrine

[ ] Heat intolerance [ ] Cold intolerance [ ] Excessive thirst [ ] Hot flashes

Psychiatry

[ ] Hallucinations [ ] Nightmares [ ] Depressed [ ] Nervous or tense

---

For Doctor Use:

Rest of review of system is otherwise negative

Reviewed questionnaire with patient

Signature: _____ Date: _____

Salem Pulmonary Associates, PC & Sleep Center

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FAYEZ BADER MD

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations? Circle the number that applies the most

0 - would never doze

1 - Slight chance of dozing

2- Moderate chance of dozing

3- High chance of dozing

Sittings and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (theater or meeting)	0	1	2	3
As a passenger in a car	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch	0	1	2	3
In a car, stopped in traffic	0	1	2	3

Total: _____

Salem Pulmonary Associates, PC & Sleep Center

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FAYEZ BADER MD

Patient Sleep Questionnaire (STOP BANG)

Please answer the following questions to find out if you are at risk for Obstructive Sleep Apnea (OSA)

STOP

S (snore)	Have you been told that you snore?	Yes / No
T (tired)	Are you often tired during the day?	Yes / No
O (obstruction)	Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	Yes / No
P (pressure)	Do you have high blood pressure or on medication to control high blood pressure?	Yes / No

If you answered yes to two (2) or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea

To find out if are at moderate to severe risk of OSA, complete the BANG questions below:

BANG

B (BMI)	Is your body mass index greater than 28?	Yes / No
A (age)	Are you 50 years old or older?	Yes / No
N (neck)	Are you a male with a neck circumference greater than 17 inches or a female with a neck circumference greater than 16 inches?	Yes / No
G (gender)	Are you a male?	Yes / No

The more questions you answer yes to on the BANG portion, the greater your risk of having moderate to severe Obstructive Sleep Apnea.

Salem Pulmonary Associates, PC & Sleep Center

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Bed Partners Questionnaire:

Let your partner fill this part out if possible

Have you seen your partner have the following behaviors or problem?

Snoring	[ ] Yes	[ ] No	Stops breathing while sleeping	[ ] Yes	[ ] No
Grinding teeth	[ ] Yes	[ ] No	Sleep talks	[ ] Yes	[ ] No
Sleep walks	[ ] Yes	[ ] No	Acting out on dreams	[ ] Yes	[ ] No
Gasping for air	[ ] Yes	[ ] No	Twitch or moves arms/leg	[ ] Yes	[ ] No
Falls asleep while talking	[ ] Yes	[ ] No	Falls asleep while driving	[ ] Yes	[ ] No
Tired all the time	[ ] Yes	[ ] No	Wakes up tired	[ ] Yes	[ ] No

Other events that are important: _____

_____

_____

_____

For Doctor Use:

Reviewed questionnaire

Physician Signature: _____ Date:_____