

Dear Patient,

Your New Patient Evaluation has been scheduled for:	
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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

### 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: <i>Last</i>	First		M.I.	DOB:	
Home Address:					
Street		City,	/State		Zip
Home Phone: ()		Work: ()		Cell: ()	
May we leave a messa	age at your home?	YES NO	At yo	our place of employment?	YES NO
Email Address:			SSN:		
Marital Status: Single	Married	Divorced	Separated	Widowed	
Race:	Langı	uage:		Ethnicity:	
Employer:			Occu	pation:	
Employer Address:					
Street		City,	'State		Zip
Primary Care Physician: SPOUSE/PARENT INFORMA				sician:	
Name:	First		<i>M.I.</i> Rela	DOB:ationship:	
Last	First		<i>M.I.</i> Rela		
Last Home Address: Street	First	City,	M.I. Reli /State	ationship:	
Last  Home Address:  Street  Home Phone: ()	First	<i>City,</i> Work: ()	/State	ationship:	Zip
Last  Home Address:  Street  Home Phone: ()  Email Address:	First	<i>City,</i> Work: ()	/State	ationship:Cell: ()_	Zip
Last  Home Address:  Street  Home Phone: ()  Email Address:  METHOD OF PAYMENT:	CASH	City, Work: () CHECK	/State SSN: CREDIT CAR	Cell: ()	Zip OTHER
Last  Home Address:  Street  Home Phone: ()  Email Address:  METHOD OF PAYMENT:  Primary Insurance Co:	CASH	City, Work: ()  CHECK Police	SSN: CREDIT CAR	Cell: () PD INSURANCE Group #:	Zip
Home Address:  Street  Home Phone: ()  Email Address:  METHOD OF PAYMENT:  Primary Insurance Co:  Secondary Insurance Co:	CASH	City, Work: ()  CHECK  Police Police	SSN:  CREDIT CAR  Ey #:  Ey #:	Cell: ()  Cell: ()  Group #:  Group #:	Zip
Last  Home Address:  Street  Home Phone: ()  Email Address:  METHOD OF PAYMENT:  Primary Insurance Co:	CASH	City, Work: ()  CHECK  Police Police	SSN:  CREDIT CAR  Ey #:  Ey #:	Cell: ()  Cell: ()  Group #:  Group #:	Zip

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

#### 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
I hereby authorize the use and/or disclosure on my PHI with the receive and have access to my PHI. I understand that this author	e person or person's listed below: I give permission for them to prization 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.

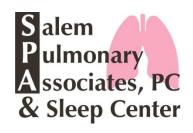
- 1. Upon arrival, please present your current insurance card(s) at every visit. Please inform us of any changes in your personal information.
- 2. It is your responsibility to understand your insurance plan and if a written referral or authorization is required to see a specialist, if preauthorization 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		



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

Fax: 503-588-0256

## **New Patient Sleep Medicine Questionnaire**

		Primary Care Physician: Referring Physician: Height: Weight:		
The purpose of this questionnaire		on of the nature of your s ly as you can.	sleep problem. Please comple	ete and be as
What are your problems: (	Check all that apply)			
[ ] Snoring	[ ] Trouble breat	thing while asleep	[ ] Hold breath while a	asleep
[ ] Gasp or Choke	[ ] Problem falli	ng asleep	[ ] Hard to stay asleep	
[ ] Tired & fatigue	[ ] Sleepy during	g the day	[ ] Moving a lot while	asleep
[ ] Legs move	[ ] Acting out dr	reams	[ ] Partner asked to see	ek help
Other:				
Sleep History:				
How long have you had these pro	oblems? [ ] > 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	[]Alot
	Work performance	[ ] None	[ ] Occasionally	[]Alot
	Relationship with partner	r [] None	[ ] Occasionally	[]Alot
Have you ever had a sleep evalua	ition:	[ ] Yes	[ ] No	
If yes: specify. Where	e?	Wh	nen:	
Have you ever received any treat	ment(s) for a sleep problem	: [ ] Yes	[ ] No	
If yes: specify.				
Are you using any sleep medicine	e or sleep aids:	[ ] Yes	[ ] No	
If yes: list the medicatio	ns:			

How often you or others have noted that you? Snore:	[ ] None	[ ] Occasionally	[]Alot
		•	
Snore so loudly that others complain:	[ ] None	[ ] Occasionally	[]Alot
Awaken from sleep feeling short of breath, gasping or choking:	[ ] None	[ ] Occasionally	[]Alot
Stop breathing while you sleep:	[ ] None	[ ] Occasionally	[]Alot
Have headaches in the morning:	[ ] None	[ ] Occasionally	[]Alot
Have a dry month or sore throat upon awakening:	[ ] None	[ ] Occasionally	[]Alot
Sweat profusely at night:	[ ] None	[ ] Occasionally	[]Alot
Have heart palpitation at night:	[ ] None	[ ] Occasionally	[]Alot
Have nightmares or night terrors:	[ ] None	[ ] Occasionally	[]Alot
Act out dreams:	[ ] None	[ ] Occasionally	[]Alot
Walk in your sleep:	[ ] None	[ ] Occasionally	[]Alot
Do anything else unusual while "asleep":	[ ] None	[ ] Occasionally	[]Alot
Feel unable to move or paralyzed when waking up/ falling asleep:	[ ] None	[ ] Occasionally	[]Alot
Have vivid dreams while waking up or falling asleep:	[ ] None	[ ] Occasionally	[]Alot
Have constant rhythmic movement, twitching or jerking of legs:	[ ] None	[ ] Occasionally	[]Alot
Feel restless, agitated or uncomfortable at bedtime	[ ] None	[ ] Occasionally	[]Alot
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	[]Alot
Feel tired or exhausted during the day?	[ ] None	[ ] Occasionally	[]Alot
Get sleepy while driving:	[ ] None	[ ] Occasionally	[]Alot
Had a car accident or came close to from falling asleep while driving	[ ] None	[ ] Occasionally	[]Alot
Have trouble at work or school because of sleepiness:	[ ] None	[ ] Occasionally	[]Alot
Feel irritable:	[ ] None	[ ] Occasionally	[]Alot
Have memory problems:	[ ] None	[ ] Occasionally	[]Alot
Fall asleep involuntarily or suddenly or in awkward situations:	[ ] None	[ ] Occasionally	[]Alot
Experience sudden weakness, buckling of knees or facial heaviness when laughing, scared, angry or crying:	[ ] None	[ ] Occasionally	[]Alot

### **Sleep Habits:**

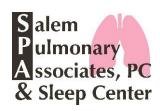
At what time do you usuall	ly go to bed?	On workdays? _	On no	on-workday	s?		
When do you wake up?		On workdays? _	On no	on-workday	s?		
When do you get out of be	d?	On workdays? _	On no	on-workday	s?		
How long does it take to fa	ıll asleep?						
How often do you wake up	at night?	times					
Why do you wake up at nig	ght?	[ ] Pain	[ ] Trouble bro	eathing	[ ] Go to the bath	nroom	
		[ ] Leg moveme	nt and discomfor	t	[ ] Other:		
How long does it take to fa	ıll back asleep?						
Do you feel refreshed upor	n awakening?	[ ] Yes	[ ] No				
How many hours of sleep of	do you estimate yo	ou have every night	? hour	s			
Do you take a nap during the	he day?	[ ] Yes	[ ] No				
If yes: how many	hours do you nap	? hours					
Do you sleep:		[ ] Alone	[ ] With partne	er			
Do you feel depressed or sa	ad?	[ ] Yes	[ ] No				
Do you anxious before bed	time?	[]Yes	[ ] No				
Do you worry a lot around	bedtime?	[ ] Yes	[ ] No				
Do you watch TV before be	ed time?	[ ] Yes	[ ] No				
Do you read before bed tim	ne?	[ ] Yes	[ ] No				
Do you work on computer	before bedtime?	[ ] Yes	[ ] No				
Do you drink caffeinated pr	roducts:	[ ] Yes	[ ] No				
If yes: specify	[ ] Coffee	[ ] Tea	[ ] Soft drink				
When?	[ ] Morning	[ ] Afternoon	[ ] Evening	[] Bedt	time		
Do you drink alcohol?		[ ] Yes	[ ] No				
If ves:	What type?		How much?				

Past Medical	l History	<u>:</u>				
[ ] Heart Disease	e	[ ] Heart At	tack	[ ] Heart Failu	re	[ ] Irregular heartbeat
[ ] Angina		[ ] High blo	od pressure	[ ] Stroke		[ ] High cholesterol
[ ] Blood vessel	problems	[ ] Reflux d	isease	[ ] Stomach uld	cer	[ ] Liver problem
[ ] Hiatal hernia		[ ] Asthma		[]COPD		[ ] Emphysema
[ ] Allergy		[ ] Diabetes		[ ] Thyroid pro	blem	[ ] Anemia
[] Fatigue		[ ] Headach	e	[ ] Seizure		[ ] Neuropathy
[ ] Tremor		[ ] Joint pai	n/arthritis	[] Fibromyalg	ia	[ ] Depression
[ ] Anxiety		[ ] Panic att	acks	[ ] Other:		
Past Surgica	l History	: List all types of s	urgeries you	u've had		
Type of surgery		Ye	ear	Type of surgery		Year
<b>Social Histor</b>						
Marital Status:	[ ]S	[ ] M	[ ]D			
Occupation:						
Smoking:	[]Yes	[ ] No	•	How many?		-
	ory: Do an		bers have any	of the following condition		ly and list relationship
Condition		Relationship		Condition	Relationship	
[ ] Narcolepsy				[ ] Sleep Walking		
	sleep apnea		<del></del>	[ ] Restless leg syndrome	e	
[ ] Snoring		<del></del>		[ ] Insomnia		<del> </del>
[ ] Acting out dr				[ ] Hypertension		<del></del>
[ ] Heart problem	m			[ ] Diabetes		<del></del>
[] Stroke				[] Fatigue		<del></del>
	: list all you	ır medications with do	ses and freque			
Medication		Dose & frequency		Medication	Dose & frequence	ey .
Allergies: list	all drug al	lergies.				
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 [ ] Trouble breathing/ [ ] Coughing up blood [ ] Cough and sputum lying flat 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 cancer [ ] Sensitive skin [ ] Skin rash Hematology [ ] Bleeding tendency [ ] Anemia [ ] Blood clots in legs [ ] Blood clots in lung **Blood vessels** [ ] Blocked or narrowed arteries [ ] Leg pain with walking Neurology [] Headache [ ] Paralysis [ ] Balance problem [ ] Dizziness [ ] Passing out [ ] 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

Date: \_

Signature:



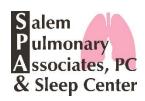
# The Epworth Sleepiness Scale

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		



# **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

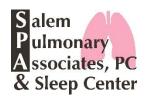
If you answered yes to two (2) or more questions on the STOP portion you are at risk for Obstructive Sleep Apnea

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

## **BANG**

<b>B</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
${f G}$ (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.



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

# **Bed Partners Questionnaire:**

Let your partner fill this part out if possible

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 impor	tant:				
For Doctor Use:					
Reviewed questionnaire					
Physician Signature:			Date:		