Millennium Physicians
Respiratory & Sleep Disorder Specialists

NO-SHOW/CANCELLATION POLICY

Respiratory & Sleep Disorders Specialists is implementing a 'no-show' policy. A patient will be considered a 'no-show' if an appointment is missed or canceled with less than 24 hours notice. When this occurs, our facility loses the opportunity to care for other patients who wish to be seen. If 24 hours notice is not received, a fee of $35.00 may be charged to your account. This fee is not covered by insurance and is therefore the sole responsibility of the patient.

I, _____ understand and acknowledge that Respiratory & Sleep Disorders Specialists has a policy to charge me a $35.00 fee if I fail to show up for a scheduled appointment. I agree to pay this fee if necessary.

Signature:_____ **Date:**_____

SLEEP STUDY NO-SHOW/CANCELLATION POLICY

In the event that your physician orders a sleep study, please be aware of the following policy:

In order to better serve all patients, please be advised that cancellations or rescheduling of sleep studies must be done 24 hours prior to your scheduled appointment, or by Friday morning if scheduled for a Saturday or Sunday night. In the event you do not cancel or reschedule within the allotted time period, you could be charged a fee of $200.00, (or a $35.00 fee for an HST), which is the cost of paying the sleep lab technician and being unable to utilize that night for other sleep studies. If you are charged the no-show fee, payment will be expected prior to rescheduling appointment. If you have any additional questions or concerns please have them addressed with the Sleep Center Manager prior to allotted time for cancellations or reschedules.

To cancel or reschedule your sleep study, call 281-296-8788 ext. 7519.

Thank you, Lash Wright

Sleep Center Manager, lawright@mphcc.com

Patient Signature: _____ **Date:**_____

Witness Signature: _____ **Date:** _____

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PATIENT INFORMATION

Section 1- Demographic Information

Patient Name: _____ **DOB:** _____/_____/_____

SSN: _____-_____-_____ **M**___ **F**___ **Web Portal: Y**___ **N**___ **E-Mail Address:**_____

Home#:_____ **Cell#:**_____ **Work#:**_____

Address:_____

- **Marital Status**: ____**Married** ____**Single** ____**Widow** ____**Divorced**
- **Employment Status**: ____**Full** _____**Part** ____**Temp** ____**Retired** ____**N/A**
- **Student Status**: ____**Full** _____**Part** ____**N/A**

Section 2- Referring Physician, PCP & Pharmacy

Name of physician who referred you to our office:_____

Name of PCP:_____ **Phone#**:_____

Pharmacy Name:_____ **Phone#:**_____

Section 3: Emergency Contact

Name:_____ **Relationship:**_____ **Contact#:**_____

Section 4: Insurance Information

	Primary	Secondary	Tertiary
Insurance			
Name of Policy Holder			
SSN of Policy Holder			
Relation to Patient			
Employer			
Policy #			
Group #			
Plan #			

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above & assign directly to RSDS all my insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the use of this signature of all insurance submissions. I have received, read, & understand all documents given to me in regards to HIPPAA rights as a patient. If patient is a minor, I consent to evaluation and treatment.

Signature:_____ **Date:**_____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Millennium RSDS
DBA: Millennium Physicians Association, PLLC

With my consent, **Millennium RSDS** may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to our Notice of Privacy Information Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Information Practices prior to signing this consent. We reserve the right to revise its Notice of Privacy Information Practices at any time. A revised Notice of Privacy practices may be obtained by forwarding a written request to Privacy Officer at **Millennium RSDS.**

With my consent**,** we may mail to my home or other designated location and leave a message on voice mail or in-person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent**,** we may mail to my home or other designated location any items that assist the practice on carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that **Millennium RSDS** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Millennium RSDS**'s use and disclosure of my PHI to carry out my TPO. I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent**,** we may decline to provide treatment to me.

Print Name:_____

Signature:_____ **Date:**_____

ACKNOWLEDGEMENT OF RECEIPT, NOTICE OF PRIVACY INFORMATION PRACTICES

Section A:

I, _____, acknowledge and agree that I have received a copy of the Notice of Privacy Practices for **Millennium RSDS**.

Signature:_____ **Date**:_____

Patient Legal Representative:_____ **Relation to Patient**:_____

Section B:

Millennium RSDS made to following good faith efforts to obtain the above referenced individuals written acknowledgment of receipt of Notice of Privacy Practices:

[Identify the efforts that were made to obtain the individuals written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained]

Date/Comment _____

_____

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ACCESS OF MEDICAL RECORDS

In general, the HIPPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

___ Cell Phone: _____

___ Work Phone: _____

___ Home Phone: _____

___ By Mail (Home Address): _____

Print Name:_____

Signature:_____ **Date:**_____

The privacy rule also allows for a patient to be able to call for certain people to have access to their records, per patient's written allowance. Please list below the family members and/or significant others that are allowed this access to your medical records.

Name	Relationship to Patient	Contact Phone Number

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PULMONARY HISTORY

Patient name:_____ **Date of Birth:** _____/_____/_____

Referring Doctor:_____ **Phone #**_____

1. Why are you here to see a pulmonary doctor? _____

_____

_____

2. Check off any lung or breathing problems/symptoms:

___ Unable to catch your breath
___ Shortness of breath
___ Swollen legs
___ High blood pressure
___ Heart murmur
___ Unable to sleep lying flat or with one pillow
___ Sudden onset of difficulty breathing
___ Leg cramps when you walk
___ Dizziness
___ Wheezing
___ Heart failure
___ Chest pains or pressure
___ Blue lips or fingernails
___ Coughing up blood
___ Night sweats

3. Have you ever had:

___ A pulmonary stress test
___ An electrocardiogram
___ A pulmonary function or spirometry test
___ A bronchoscopy or bronchial/lung biopsy
___ Lung surgery, including complete or partial removal
___ Blood clots
___ Pneumonia
___ Heart surgery
___ Lung cancer
___ Exposure to tuberculosis or had TB

4. Are you being treated now or have been treated for any illnesses? Please list them:

_____

_____

5. Have you ever had any operations or injuries? What year?

_____

6. Check if any close family members have any of the following:

___ Heart problems
___ High blood pressure
___ Diabetes
___ Other, explain:_____
___ Cancer
___ Heartburn
___ Sleep apnea

7. Who do you live with? _____

8. Occupation? _____

9. What are your leisure activities? _____

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PULMONARY HISTORY CONT'D

10. Check if you have:

___ Worked around toxic chemicals or substances
___ Lived with someone who smokes
___ Other: _____
___ Asbestos exposure
___ Asthma
___ Ever smoked

11. Do you exercise (including walking)? _____Yes _____No

12. Do you have a close family member that had lung cancer, tuberculosis, or emphysema? ____Yes ____No
If yes, who?_____

13. Please tell us anything else about your lungs. _____
_____

14. Health habits:

Do you smoke? _____ Yes _____No
For how many years?_____
How many packs per day?_____
If you no longer smoke, when did you quit?_____
How many years did you smoke?_____
How much alcohol do you drink?_____

Do you use recreational drugs? _____Yes _____No
List them:
_____
_____
_____

15. Are you allergic to any medications? _____ Yes _____ No
List all medications to which you are allergic reactions:

Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____
Medication:_____ Reaction:_____

16. Do you have hay fever? _____Yes _____No

What is your reaction? _____

17. Have you had the following vaccinations and when (dates)?

_____ Influenza (flu shot) Annually
_____ Pneumococcal (pneumonia) vaccine

18. Please list all your current medications: Names, dose or strength & how many times a day.

- _____
- _____
- _____
- _____
- _____
- _____
- _____

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PULMONARY HISTORY CONT'D

Please check all that apply:

Allergic/Immunologic

___ Post-nasal drip
___ Itchy/watery eyes
___ Rash or hives
___ Runny nose/sneezing

Ear/Nose/Mouth/Throat

___ Hearing loss
___ Earache or drainage
___ Sinus problems or rhinitis
___ Nose bleeds
___ Bleeding gums
___ Sore Throat
___ Hoarseness
___ Swollen glands in neck

Gastrointestinal

___ Black/tarry stools
___ Blood in stool
___ Nausea or vomiting
___ Abdominal pain
___ Heart burn or reflux
___ Loss of appetite
___ Change in bowel movements
___ Diarrhea or constipation

History of Skin Reaction to:

___ Penicillin
___ Iodine
___ Other:_____

Psychiatric

___ Insomnia
___ Depression
___ Memory loss or confusion
___ Nervousness/anxiety

Cardiovascular

___ Chest pain or angina
___ Pain in legs with walking
___ Swelling of feet, ankles, hands
___ Palpitations
___ Shortness of breath with exertion
___ Shortness of breath when lying flat

Endocrine/lymphatic

___ Increased thirsty or urination
___ Glandular/hormonal imbalance
___ Heat or cold intolerance
___ Enlarged glands or lymph nodes

Genitourinary

___ Increased or decreased urination
___ Painful urination
___ Blood in urine
___ Kidney stones
___ Incontinence
___ Testicular pain
___ Vaginal discharge

Musculoskeletal

___ Joint pain
___ Stiffness or swelling
___ Weakness of muscles or joints
___ Back pain
___ Cold extremities
___ Difficulty walking
___ Muscle pain or cramps
___ Feel need to move/jerk/stretch legs
___ Involuntary leg jerks at night

Respiratory

___ Frequent pneumonias or chest infections
___ Pain with deep breathing
___ Cough
___ Shortness of breath
___ Wheezing or asthma
___ Spitting up blood

Constitutional

___ Poor General health
___ Unintended weight loss
___ Fever or chills
___ Night sweats
___ Fatigue
___ Daytime sleepiness
___ Loud snoring
___ Insomnia

Eyes

___ Itchy/watery eyes
___ Eye disease or injury
___ Blurred/double vision
___ Glaucoma

Hematologic

___ History of transfusions
___ Easy bruising or bleeding
___ Anemia
___ Phlebitis

Neurologic

___ Head injury
___ Headaches
___ Dizziness/lightheaded
___ Passing out spells
___ Numbness or tingling
___ Tremors
___ Paralysis
___ Seizures
___ Stroke

Skin/Breast/Hair

___ Rash or itching
___ Change in skin color
___ Change in hair or nails
___ Breast pain
___ Breast lump
___ Breast discharge

Signature:_____ **Date:**_____

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SLEEP QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____/_____/_____

Height:_____ Weight:_____ Bed Partner?: _____ Yes _____ No

Marital Status: _____ Married _____ Single _____ Widow _____ Divorced

1. Main sleep complaints, check all that apply:

__ Loud or disturbing snoring
__ I've been told I stop breathing when I sleep
__ I am tired and sleepy during the day
__ I wake up gasping for air
__ I fall asleep unintentionally
__ I can't fall asleep or stay asleep
__ My limbs jerk or kick at night
__ I have unwanted behavior during sleep. Explain:_____
__ Other:_____

2. How long have you had a sleep problem? _____

3. Have you ever had a sleep study? If so, when? _____

4. CPAP of BIPAP therapy? If yes, what is the current pressure and mask type?
_____

5. Have you gained or lost weight recently? How much? _____

6. What time do you usually:
Go to bed? Weekday: _____ Weekend: _____
Wake up? Weekday: _____ Weekend: _____

7. Do you take naps during the day? _____Yes _____No If yes, how many and how long? _____

8. Do you work rotating shifts? _____**Yes** _____**No**

9. Do you have trouble falling asleep? _____**Yes** _____**No**

10. Do you have trouble staying asleep? _____**Yes** _____**No**

11. Do you have trouble falling back to sleep once awakened? _____**Yes** _____**No**

12. Do you lie in bed with racing/repetitive thoughts? _____**Yes** _____**No**

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13. Do you take medications to help you fall asleep? _____ Yes _____ No
14. Do you take stimulants during the day to help you stay awake? _____ Yes _____ No
15. Do you suffer from pain that interferes with your sleep? _____ Yes _____ No
16. Have you ever been told that you snore? _____ Yes _____ No
17. Have you ever been told that you stop breathing in your sleep? _____ Yes _____ No
18. Do you wake yourself from snoring, or from choking/gasping for air? _____ Yes _____ No
19. Do you suffer from indigestion/heartburn/reflux disease? _____ Yes _____ No
20. Do you ever awaken suddenly feeling short of breath? _____ Yes _____ No
21. Do you wake up with a dry mouth or sore throat? _____ Yes _____ No
22. Do you suffer from morning headaches? _____ Yes _____ No
23. Do you sweat at night? _____ Yes _____ No
24. Do you feel refreshed and well rested upon wakening? _____ Yes _____ No
25. Do you experience leg discomfort such as creepy-crawly or achy sensation that compels you to move your legs or get up and walk? _____ Yes _____ No
26. Do your arms or legs jerk/kick in your sleep? _____ Yes _____ No
27. Do you grind your teeth while you sleep? _____ Yes _____ No
28. Do you have frequent nightmares? _____ Yes _____ No
29. Have you ever walked or talked in your sleep? _____ Yes _____ No
30. Have you ever injured yourself or a bed partner acting out your dreams while asleep? _____ Yes _____ No
31. Do you experience vivid-like dreams soon after falling asleep or close to waking up? _____ Yes _____ No
32. Have you ever found yourself unable to move or paralyzed for a short time upon falling asleep or awakening? _____ Yes _____ No
33. Have you every experienced sudden muscle weakness during vigorous laughter when angry? _____ Yes _____ No
34. Have you ever experienced sleep attacks or sudden onset of severe drowsiness? _____ Yes _____ No
35. Do you suffer from allergies? _____ Yes _____ No
36. Do you suffer from chronic nasal congestion? _____ Yes _____ No
37. Do you smoke? If yes, how much? _____ Yes _____ No
38. Have you ever had nasal or sinus surgery? If yes, when? _____
39. On average, how many alcoholic beverages do you consume in a week? _____
40. On average, how many caffeinated beverages do you consume in a day? _____

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EPWORTH SLEEPINESS SCALE:

41. How likely are you to fall asleep in the following situations?

Sitting and reading:	_____Never	_____Slight	_____Moderate	_____High
Watching television:	_____Never	_____Slight	_____Moderate	_____High
Sitting inactive in a public place:	_____Never	_____Slight	_____Moderate	_____High
As a passenger in a car for 1 hour or more:	_____Never	_____Slight	_____Moderate	_____High
Lying down to rest in the afternoon:	_____Never	_____Slight	_____Moderate	_____High
Sitting and talking to someone:	_____Never	_____Slight	_____Moderate	_____High
Sitting quietly after lunch:	_____Never	_____Slight	_____Moderate	_____High
In a car stopped at a traffic light:	_____Never	_____Slight	_____Moderate	_____High

42. Do you have or are you currently being treated for:

_____ Acid reflux/heartburn
_____ Angina
_____ Anxiety
_____ Asthma
_____ Bipolar disorder
_____ Chronic pain
_____ Chronic nasal congestion
_____ Congestive heart failure
_____ Depression
_____ Diabetes
_____ Drug/alcohol problems
_____ Emphysema/COPD
_____ Frequent Urination
_____ Heart attack
_____ High blood pressure
_____ Irregular heart rhythm
_____ Seizures
_____ Stroke
_____ Thyroid disease

43. Please list any other medical problems:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature:_____ **Date:**_____