LYNCHBURG PULMONARY
ASSOCIATES, INC.

Michael G. Milam, MD
Albert M. Baker, MD
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Please fill out the enclosed paperwork and bring to your appointment.

Medicare patients that do not have a supplement policy are required to pay their 20% coinsurance responsibility for services rendered on the date of the appointment.

For **Self pay patients**, our office has a minimum payment requirement of $100 towards the initial office visit. This must be paid at the time of service. A payment plan arrangement may be set up for any remaining balance.

Thank you.

LYNCHBURG PULMONARY
ASSOCIATES, INC.

2011 Tate Springs Road
Lynchburg, Virginia 24501

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www.lynchburgpulmonary.com

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Lynchburg Pulmonary Associates

LYNCHBURG PULMONARY ASSOCIATES, INC.

Referring Doctor _____ **Primary Doctor**_____
Patient's Name_____ ☐ Male ☐Female
Marital Status ☐ S ☐ M ☐ D ☐W **Race** ☐Asian ☐Black/African American ☐White ☐Other_____
Ethnicity ☐Hispanic ☐Non-Hispanic ☐Other_____ **Language** ☐English ☐Spanish ☐Other_____
Patient's Address_____**City**_____**State**____ **Zip**_____
Social Security #_____ **Date of Birth**_____
Telephone (Home) _____(Cell)_____Email Address_____
Patient Employer_____ **Patient Work Telephone**_____

Spouse_____ **DOB**_____ **Spouse's Social Security #**_____
Spouse Employer_____ **Spouse Work Telephone**_____
Emergency Contact_____ Relationship to Patient_____
Emergency Contact Telephone (Home)_____ (Cell)_____

Person Responsible for Payment_____Relationship_____
(Mailing Address please **DO NOT** use P.O. Box)
_____
Social Security#_____ **Date of Birth** _____**Telephone** (Home)_____
Employer's Name_____
Employer's Address_____
Work Telephone_____ **Cell**_____ Email_____

Primary Insurance Carrier_____
Address_____
Name of Policyholder_____
Relationship_____ Policy# _____Group #_____
Second Insurance Carrier_____
Address_____
Name of Policyholder_____
Relationship_____ Policy #_____Group#_____

AUTHORIZATION FOR TREATMENT AND FINANCIAL AGREEMENT

Regardless of insurance benefits, or the designation of some other responsible party above, I understand that I am financially responsible for the fees. Although the Practice will take reasonable steps to obtain reimbursement from the insurance company or the persons listed above as being financially responsible, I agree that it is ultimately my responsibility to seek reimbursement for the medical bills from the insurance company, or the financial party. **I understand and agree that I will be responsible for any and all Collection Agency and or Attorney fees should my delinquent account be turned over for collections. At the time of the visit, I understand it is my responsibility to obtain a current referral (if required) and pay any deductibles, co-payments, and/or coinsurance not covered by the insurance plan or a governmental program.** Further, I authorize the Practice to file claims on my behalf for covered services and assign all insurance or other payor benefits to be paid directly to the doctor. I permit a copy of this authorization to be used in place of the original.

I have read, and I understand this document:

Patient/Parent/Guardian Signature: _____

Date: _____

RELEASE OF INFORMATION

Practice Philosophy on Patient Privacy

The practice recognizes the importance of patient privacy. As such, it is the policy of this Practice to treat all medical information as confidential and absent extraordinary or emergency circumstances; the Practice will not disclose a patient's medical information without appropriate patient consent.

Before consenting to the release of medical information, each patient has the right to review the written Notice of Privacy Policy of this Practice, which gives a more complete description of the Practice's policies on the use and disclosure of patients' medical information. Each patient may obtain a copy of such Notice upon request. The Practice reserves the right to change its Notice of Privacy Policy and all patients have the right to receive an amended copy of the Notice upon request.

Also, each patient has the right to request in writing that this Practice restrict how protected and private medical information is used or disclosed to carry out treatment, payment, or other health care operations. Please note that this Practice is not required to agree to such requested restrictions, but if it does, the restriction will be binding upon the Practice. Additionally, the Practice may refuse to treat any patient who refuses to consent to the use and disclosure of medical information for treatment, payment, or other health care operation purposes.

Patient Consent for Use and Disclosure of Medical Information to Carry Out Treatment, Payment and Health Care Operations

I consent to the release of information regarding services rendered by the Practice to my insurance company, or any governmental payor of the medical expenses as listed above, or any other persons/entities as may be reasonably necessary for billing and collection purposes. I also consent to the release of medical information to my family physician and other treating physicians, as well as to any physicians to whom the Practice may refer me for purposes of further treatment. I also consent to the use and/or release of medical information about me for purposes of health care operations, including quality assurance activities or other activities to review the Practice's treatment and services and to evaluate the performance of the staff in caring for me. In addition, if the patient is a minor child, I, as parent or guardian, consent to the release of medical information to the child's other parent, or the person(s) that I have listed as being responsible for the medical bill. I understand that this consent to release information may include the release of personal and private medical information, if such release of information is necessary for reimbursement and billing purposes, or for purposes of subsequent treatment. Further, this consent is valid for the disclosure of medical information contained in hard copy or in electronic form, including but not limited to, electronic mail, ("Email") and facsimile.

This consent to release medical information may be revoked in writing by me at any time and such revocation shall be effective immediately, except to the extent that the Practice has taken action in reliance upon my consent.

Patient/Parent/Guardian Signature: _____

Date: _____

LPA
LYNCHBURG PULMONARY ASSOCIATES, INC.

PATIENT NOTIFICATION RECEIPT AND FAMILY ACCESS TO PROTECTED HEALTH INFORMATION

Patient's Name: _____ **Date:** _____

Patient's Address: _____

Patient's Date of Birth: _____ **Patient's SSN:** _____

Patient Notification Receipt

I understand that as part of my healthcare, Lynchburg Pulmonary Associates, Inc. (LPA) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as basis for planning and carrying out medical care and treatment; a means of communication among the many health professionals who contribute to my medical care and treatment; a source of information for applying my diagnosis and surgical information to my bill; a means by which third party payers can verify that services were actually provided; and a tool for routine healthcare operations such as quality assurance, audits and assessments.

I have been provided with the LPA Notice of Privacy Practices that provides a complete description of Protective Health Information uses and disclosures. I understand that I have the right to complain, consent, object, restrict and/or request correction or amendment of my Protected Health Information. I understand that all such requests must be in writing and that LPA is not required to agree to any corrections or restrictions that I may request. I understand that I may also revoke any consent that I may have given, in writing, except to the extent that LPA has already taken action in reliance thereon.

ACCESS TO PATIENT CARE AND PROTECTED HEALTH INFORMATION

I hereby give permission to the person(s) listed below to seek treatment and/or receive Protected Health Information on the above named patient. In order to obtain information by telephone, the party calling the practice must share the patient identifier with the staff.

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____
3. Name: _____ Relationship: _____

In Addition:

1. With this authorization, Lynchburg Pulmonary Associates, Inc. may call 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 (Treatment, Payment, and Healthcare Operations) including appointments, labs/test, insurance/billing items, forms, letters, general office correspondence, etc.
2. With this authorization, Lynchburg Pulmonary Associates, Inc. may mail to my home or other designated location any items that assist the practice in carrying out TPO including appointments, labs/test, insurance/billing items, forms, letters, general office correspondence, etc.

By signing this form, I am authorizing Lynchburg Pulmonary Associates to use and disclose my Protected Health Information to the individuals I have listed above to act on my behalf to schedule/change appointments, receive reminders, pick up prescriptions and discuss my account/billing.

I may revoke this authorization in writing at any time.

Patient/Parent/Guardian Signature: _____ **Date:** _____

Lynchburg Pulmonary Associates, Inc.

LYNCHBURG PULMONARY ASSOCIATES, INC.

Health History Questionnaire (fill out all pages)

Name: **Date:**

Date of Birth: **Height:** **Weight:**

Primary Care Doctor: **Other Doctors:**

REASON FOR TODAY'S VISIT:

VACCINES:

Year of last pneumonia vaccine (pneumovax): _____ Never ☐ Unknown ☐

Year of last influenza (flu) vaccine? _____ Never ☐ Unknown ☐

Shingles / Zoster vaccine? _____ Never ☐ Unknown ☐

Prevnar vaccine? _____ Never ☐ Unknown ☐

Medical Problems / Hospitalizations (not for surgeries)	**Surgeries & Date (write on back if necessary)**
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

Your Family History:

Father Alive? Yes ☐ No ☐ Medical Problems? _____

Mother Alive? Yes ☐ No ☐ Medical Problems? _____

Number of Brothers: _____ Medical Problems? _____

Number of Sisters: _____ Medical Problems? _____

Number of Children: _____ Medical Problems? _____

Social History:

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

	FT	PT
Working now	☐	☐
Retired	☐	
Disabled	☐	
Not working	☐	

Current Employer:

List jobs you have performed in past:

1.

2.

3.

Have you ever smoked tobacco? Yes ☐ No ☐ Are you still smoking? Yes ☐ No ☐

How many packs each day? _____ For how many years have you smoked? _____

Do you want to quit smoking? Yes ☐ No ☐

What methods have you tried to quit smoking? _____

How many servings of caffeine do you drink daily? _____

How many servings of alcohol per week?(12 oz. beer, glass of wine, 1.5 oz. liquor)_____

Have you ever used any recreational drugs? Yes ☐ No ☐

Have you ever had a substance abuse issue? Yes ☐ No ☐ When:_____

Exposure History:

Any animals at home: Dogs ☐ Cats ☐ Birds ☐ Farm Animals ☐ Other ☐ _____

Any problems with water leakage, dampness, or mold at home? Yes ☐ No ☐

Have you been exposed to asbestos or sand dust? Yes ☐ No ☐

Have you been exposed to radiation or strong fumes? Yes ☐ No ☐

Name	Date:

Circle all that apply to you

GENERAL

Appetite loss Fatigue Fever
Night sweats Weight gain Weight loss
Chills

KIDNEYS

Blood in urine Burning/pain with urination
Frequent urination Impotence
Frequently waking up to urinate # per night:_____
Difficulty urinating Incontinence
Kidney Stones Sexually transmitted diseases

SKIN

Dryness Hives Itching
Nail Changes Rash

MUSCLE/SKELETAL

Back pain Joint pain Joint swelling
Muscle pain Muscle weakness Leg/arm weakness

EYES/EARS/NOSE/MOUTH/THROAT

Changes in vision Eye redness Hearing loss
Runny nose Nasal congestion Postnasal drip
Seasonal allergy Sinus pain Hoarseness
Sore throat Neck pain Neck swelling
Nosebleeds Dentures

NEUROLOGICAL

Decreased memory Dizziness
Headache Difficulty walking
Seizures Passing out

LUNGS

Coughing up blood Cough
Sputum or phlegm Shortness of breath
Wheezing Pain with breathing
Chronic Mucus Production

PSYCHIATRIC

Anxiety Depression Panic attacks

HEART/VASCULAR

Calf cramps Chest pain
Heart Murmurs Chest Pressure
Leg Swelling Irregular heartbeat/Palpitations
Shortness of breath when lying flat
Swelling of lower extremities

ENDOCRINE

Cold intolerance Heat Intolerance
Excessive thirst

STOMACH/INTESTINAL

Abdominal pain Diarrhea
Constipation Difficulty Swallowing
Heartburn Nausea
Black or bloody stools Indigestion
Liver/Gall Bladder issues Vomiting

HEMATOLOGY

Abnormal bleeding Blood clots: Legs ☐ Lung ☐
Easy bruising Enlarged lymph nodes
Easy bleeding

SLEEP SYMPTOMS

Choking Headache on awakening
Stop breathing during sleep Abnormal sleepiness
Sleepiness when driving Unable to sleep flat
Wake up gasping Sleep talking
Bed wetting Sleep walking
Loss of strength when emotional (laughing, crying, etc.)
Feel paralyzed on awakening or when dozing off
Leg jerking/electrical shocks in legs
Inability to keep legs still Snoring
Toss & Turn Fall out of bed
Nightmares Vivid dreams
Gasping for air Struggling to breath

Name	Date
Local Pharmacy:	Address:
Mail Order Pharmacy:	Address:

MEDICATION ALLERGIES:

Medication/Reaction	Medication/Reaction

Please list all Medications or provide us with a current list.

MEDICATIONS:

MEDICATIONS YOU ARE TAKING:	DOSE (ex: mg, ml, etc)	How often do you take it

Anything else we need to know?

LYNCHBURG PULMONARY
ASSOCIATES, INC.

2011 Tate Springs Rd.
Lynchburg, VA 24501
Telephone: (434) 947-3963
Fax: (434) 947-5935

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

We are committed to preserving the privacy of your health information generated and maintained by Lynchburg Pulmonary Associates, Inc. We are required by law to maintain the privacy of your health information and provide you with this notice of our legal duties and privacy practices with respect to your protected health information. Lynchburg Pulmonary Assoc. will abide by the terms of this notice; however, we reserve the right to change the terms of this notice and to make a new notice effective with respect to your health information that we maintain. You may request a copy of the revised notice by contacting our office. This notice describes the ways in which we may use or disclose your health information and also describes your rights and our duties regarding use and disclosure of your health information. This notice is also published on our website.

WRITTEN ACKNOWLEDGMENT

You will be asked to sign a statement acknowledging receipt of a copy of this notice.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

The following describes the different ways we may use and disclose your health information and includes some examples of types of uses or disclosures:

Treatment: Your medical information may be used and disclosed by us for providing and coordinating your healthcare. We may disclose health information about you to doctors, nurses, healthcare students, and other providers involved in your care and treatment. For example, a nurse may disclose your health information to an x-ray technician or another physician providing medical treatment to you.

Payment: Your medical information may be used and disclosed by us for the purpose of determining coverage, billing, claims management, reimbursement and collections of unpaid account or to assist another heath care provider in obtaining payment for their health care bills. For example, we may send a bill to your insurance company that may include information that identifies you, your diagnosis and any procedures performed. We may also disclose your medical information as required by your health insurance plan before it approves or pays for the health care services we recommend for you.
You may request non-disclosure of your information if you pay in full, out-of-pocket, prior to the delivery of the service.

Health Care Operations: Your medical information may be used and disclosed during routine operations including quality assessment review, employee performance review, training of healthcare students, licensing, and other activities necessary for our operations. For example, we may use your health information to review our treatment and services and to evaluate our performance in providing you care.

Appointment Reminders: We may use or disclose your health information to contact you to remind you of your appointment by mail or by telephone.

Treatment Alternatives: We may use or disclose your health information for purposes of contacting you to inform you of treatment alternatives or other health related benefits and services that may be of interest to you. For example, we may contact a home health agency to discuss services they provide which might assist you.

Business Associates: We will share your health information with "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your medical information, we will have a written agreement that contains terms that will protect the privacy of your medical information. For example, the medical practice may hire a billing company to submit claims to your health care insurer. Your medical information will be disclosed to this billing company, but a written agreement between our office and the billing company will prohibit the billing company from using your medical information in any other way than we allow.

Individuals Involved in Your Health Care: Unless you object, we may disclose your health information to a member of your family, a close friend or any other person you identify who is directly involved in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may also use or disclose your medical information to a person or organization to assist in disaster relief efforts for the purpose of notifying to family or other individuals involved in your health care regarding your condition, status and location.

Required by Law: We may use and/or disclose your health information to the extent that the use and disclosure is required by law and the use or disclosure complies with and is limited to the relevant requirements of such law.

Public Health Activities: We may disclose your health information to public health authorities authorized to receive and collect health information for the purpose of controlling disease, injury or disability. We may also disclose your health information at the direction of the public health authority, to any other government agency that is collaborating with the public health authority.

Food and Drug Administration: We may disclose your medical information to a person subject to the jurisdiction of the Food and Drug Administration to collect or report product defects or problems, track products, enable product recalls/repairs/replacements or to conduct post marketing surveillance, etc.

Communicable Disease: We may disclose your medical information to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition if authorized by law to notify such person.

To Your Employer: As required by law, we may disclose your health information at the request of your employer to conduct an evaluation relating to medical surveillance of the work place or to evaluate whether you have a work related injury or illness.

Abuse or Neglect: We may disclose your health information to a public health or government body authorized to receive reports of abuse or neglect as required or permitted by state or federal law if we reasonably believe that you have been a victim of abuse, neglect or domestic violence.

Health Oversight: We may disclose your health information to a health oversight agency authorized by law to conduct health oversight activities. These may include activities necessary for oversight of the health care system, government benefit programs relevant to beneficiary eligibility, entities subject to government regulatory programs for which health information is necessary for determining compliance with program standards and entities subject to civil rights laws.

Judicial or Administrative Proceedings: We may disclose your health information in response to an order of a court or administrative tribunal to the extent expressly authorized and in certain conditions in response to a subpoena, discovery request or other lawful request.

Law Enforcement: We may also disclose your health information, as to law enforcement officials as required by law. Examples of law enforcement requirements include: (1) information requests for identification and location of a suspect, fugitive or missing person, (2) pertaining to victims of a crime, if under limited circumstances, we are unable to obtain the individual's agreement, (3) suspicion that death has occurred as a result of criminal conduct, (4) evidence of criminal conduct on the premises, and in an medical emergency to alert law enforcement that a crime has been committed.

Coroners and Funeral Directors: We may disclose your health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining the cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose your health information to funeral directors, as required by law, as necessary to carry out their duties.

Organ Donation: We may disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of cadaver organs, eyes or tissue for the purpose of facilitating organ, eye or tissue donation and transplantation.

Criminal Activity: Consistent with applicable laws and ethical conduct, we may disclose your medical information if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person in the public. We may also disclose your medical information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: We may use or disclose health information of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities. We may also disclose your health information for the purposes of a determination by the Department of Veteran Affairs of your eligibility for benefits or to foreign military authority if you are a member of that foreign military service. We may also disclose your medical information to authorized federal officials for purposes of national security and intelligence activities, including for the provision of protective services to the President or other persons as authorized by the law.

Worker's Compensation: Your medical information may be disclosed to the extent necessary to comply with laws relating to worker's compensation or as required by laws that provide benefits for work related injuries or illness.

Inmates: We may use or disclose your medical information if you are an inmate of a correctional facility and your physician created or received your medical information in the course of providing care to you.

Research: We may disclose your health information for research purposes when it has been established that the research meets the requirements of federal and state laws.

Use and disclosure of your medical information for any other reason other than those set forth above will be made only with your written authorization. You may revoke your authorization in writing at any time. You understand, however, the revocation will not apply to any actions we have already taken.

Marketing/ Fundraising: Any disclosures of protected health information that we make for marketing purposes or disclosures which constitute the sale of protected health information will require an authorization. You have the right to opt out of any communication involving fundraising.

Your Rights

Following is a statement of your rights with respect to your medical information and a brief description of how you may exercise these rights.

Right to inspect and copy your medical information: You may inspect and obtain a copy of your medical information that may be used to make decisions about your health care. Usually this information includes medical and billing records, but does not include psychotherapy notes, information compiled related to a civil, criminal, or administrative action and medical information that is subject to law that prohibits access to medical information in certain circumstances. You must submit your request in writing. We may deny your request in limited circumstances. You may request to have this decision reviewed. We may charge a fee for the cost of copying, postage, or other supplies associated with your request. Please contact our Privacy Officer if you have questions about access to your medical record.

Right to request restrictions: You may request a restriction or limitation on the health information that we use or disclose about you for purposes of treatment, payment or health care operations. You may also request that your health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction and to whom the restriction is to apply.

We are not required to agree to your request, except for a restriction on a disclosure to a health plan where services have been paid in full, out-of-pocket. If we do agree to your request, we will abide by the restriction unless the information is needed to provide emergency treatment to you or unless we otherwise notify you that we can no longer honor your request. You must make your request in writing to our Privacy Officer.

Right to request confidential communications: You may request that we communicate with you about your health care in a certain way or at certain location. You must make your request in writing to our Privacy Officer and specify how or where you wish to be contacted. We may condition this accommodation by asking you for information as to how payment will be handled or other information necessary to honor your request.

Right to request amendment of your health information: If you feel your health information maintained by us is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we maintain this information. To request an amendment, your request must be made in writing and submitted to our Privacy Officer. In addition, you must provide a reason to support your request. We may deny your request for an amendment. If we deny your request, you have the right to file a disagreement with us.

Right to receive an accounting of disclosures: This accounting of disclosures is for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes information we may disclose have pursuant to your authorization or made directly to you. The right to receive this information is subject to certain exceptions, restrictions and limitations. To receive this listing, your request must state a time period, which may not be longer than six years and may not include dates prior to April 14, 2004. You must submit your request in writing to our Privacy Officer.

Right to a paper copy of this notice: You may ask us to give you a paper copy of this notice at any time. Please request one from our Privacy Officer or request one when you are in the office.

Right to receive notification in the event of a breach: You will receive a notification of any breaches of your unsecured protected health information.

Notice of Organized Health Care Arrangement

We are a participant in Archetype Health (Archetype). Archetype, a clinically integrated network, is an organized health care arrangement under HIPAA. An organized health care arrangement is an organized system of health care in which the participants jointly conduct health care operations functions, such as utilization review, quality assessment and improvement activities, or payment activities. As of the date of this notice, a current list of Archetype's participants who participate in the organized health care arrangement, their locations of operations, and more information about Archetype may be found at www.archetypehealth.com.

COMPLAINTS:

You may complain to us if you believe your privacy rights have been violated by us. To file a complaint, please contact our Privacy Officer who will assist you. You may file a complaint in writing to include as much detail as possible why you believe your privacy rights were violated. We will not retaliate against you for filing a complaint. If you do not wish to file a complaint with us, you may contact the Secretary of Health and Human Services.

PRIVACY CONTACT:

If you have any questions about this Notice, Please contact our Privacy Officer. Our privacy Officer will discuss with you any of your privacy questions, concerns or complaints.

EFFECTIVE DATE OF THIS NOTICE:

April 14, 2003

Revised 8/8/2013:lm
Revised 11/18/2013: sch
Revised 12/04/2015:sch