LYNCHBURG PULMONARY ASSOCIATES, INC.

Michael G. Milam, MD
Albert M. Baker, MD
Joseph B. Khoury, MD
John L. Plankeel, MD

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

Tel: 434.947.3963
Fax: 434.947.5935

www.lynchburgpulmonary.com

Follow us on Facebook
Lynchburg Pulmonary Associates

LPA CHART#

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?

LPA CHART#

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 CHART#

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: _____Telephone: _____
2. Name: _____Relationship: _____Telephone: _____
3. Name: _____Relationship: _____Telephone: _____

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**: _____