

TCPS Patient Registration Form

Patient's Name: _____ Preferred Name: _____

Last

First

MI

Sex: Male Female

Social Security#: _____ Date of Birth: ____/____/____

Address: _____

City / State/ Zip: _____

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

Email: _____

Referring Physician: _____

Primary Care Provider: _____

AGREEMENT OF FINANCIAL RESPONSIBILITY

(Please initial on each line)

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

_____ Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider, if applicable.

_____ It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits, and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.

_____ We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

_____ If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) / deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

_____ If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.

(See Back)

_____ Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

_____ Please understand some insurance coverage have Out-of-Network benefits that have co-insurance changes, high co-payments, and limited annual benefits. If you receive Out-of-Network benefit services, your portion of financial responsibility may be higher than the In-Network rate.

CONSENT FOR TREATMENT AUTHORIZATION

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and / or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing, and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing, medication administration, and treatment for the condition, which has brought me to seek care at this practice. I understand that if additional testing, invasive, or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) / procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents and financial agreement.

Signature of Patient / Personal Representative

Date

Printed Name of Patient / Personal Representative

SOCIAL SECURITY NUMBER

Printed Name of Witness

Employee Job Title

Signature of Witness

Date

Tri-County Pulmonary and Sleep Clinic
Acknowledgement of Receipt for
Notice of Privacy Practices

I acknowledge that I have read and / or received a copy of Tri-County Pulmonary and Sleep Clinic Patient of Privacy Practices. I have read it and have had an opportunity to ask questions (as it relates to my healthcare), and I agree to ALL of its terms.

Patient's Name

Today's Date

Date of Birth

(If you would like to add a representative with access to your records please fill out the bottom. If not, please leave the bottom blank)

Patient with the signature above, approve for the following person(s) to have access to my medical records:

Patient's Representative's Name

Relationship to Patient

Patient's Representative's Name

Relationship to Patient

Tri- County Pulmonary & Sleep Clinic
NEW PATIENT INTAKE FORM

Patient's Name: _____ Date of Birth: ____/____/____

Emergency Contact: _____

Telephone: _____ Relationship to Patient: _____

Pharmacy Name: _____ Location: _____

Have you taken a flu shot since? Yes No Date: ____/____/____

Have you taken the pneumonia vaccine within the past 10 years? Yes No Date: ____/____/____

Have you taken the COVID-19 Vaccine? Yes No Date: ____/____/____

Do you have a Living Will? Yes No

Are you considered a Full Code or DNR (Do Not Resuscitate?) _____

Please list any past or current medical conditions you have been diagnosed with:

Please list current medications and dosages or provide a list:

Medication	Dosage (mg, units)	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

Please list any allergies to medications and specify what reaction is experienced:
 Medication Allergies: I do not have any medication allergies

Medication	Noted Reaction
1.	
2.	
3.	
4.	
5.	

Please list Surgical History:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please list any pertinent past family medical history:

Disease	Relationship (Mother/ Father, etc.)
1.	
2.	
3.	
4.	
5.	

Do you drink alcoholic beverages? Yes No; If so, How often? _____ times per Week Month

Have you ever smoked cigarettes? Yes No Do you currently smoke? Yes No

How long have you smoked? _____ How many packs per day? _____

Do you use any other type of tobacco products? Yes No; If so, what type? _____

Do you drink caffeine? Yes No; If so, what kind/ how often? _____

Do you use recreational/ illicit drugs? Yes No; If so, please describe: _____

Updated STOP-Bang Questionnaire

Snoring?

Yes No
 Do you Snore Loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?

Tired?

Yes No
 Do you often feel Tired, Fatigued, or Sleepy during the daytime (such as falling asleep during driving or talking to someone)?

Observed?

Yes No
 Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep?

Pressure?

Yes No
 Do you have or are being treated for High Blood Pressure?

Body Mass Index more than 35 kg/m²?

Yes No

Age older than 50 year old?

Yes No

Neck size large? (Measured around Adams apple)

Yes No
 For male, is your shirt collar 17 inches/43 cm or larger?
 For female, is your shirt collar 16 inches/41 cm or larger?

Gender = Male?

Yes No

Scoring Criteria:

Epworth Sleepiness Scale¹¹

How likely are you to nod off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times.

Even if you haven't done some of these things recently, try to work out how they would have affected you. It is important that you answer each question as best you can.

Use the following scale to choose the most appropriate number for each situation.

	Would never nod off 0	Slight chance of nodding off 1	Moderate chance of nodding off 2	High chance of nodding off 3
Sitting and reading				
Watching TV				
Sitting, inactive, in a public place (e.g., in a meeting, theater, or dinner event)				
As a passenger in a car for an hour or more without stopping for a break				
Lying down to rest when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a meal without alcohol				
In a car, while stopped for a few minutes in traffic or at a light				

Add up your points to get your total score. A score of 10 or greater raises concern: you may need to get more sleep, improve your sleep practices, or seek medical attention to determine why you are sleepy.