Lung Center

Pulmonary, Sleep & Critical Care Specialists

Robert Buss, MD

Luther Corley, MD

Muhammad Shafi, MD

Diwas Shahi, MD

Jason Smith, MD

Mark Tafazoli, MD

Marijo-Anne L. Molina, MD

Kara Allen, CRNP

Jessica Burkeen, CRNP

Carol Bullock, CRNP

Emily Cork, CRNP

Reiga Evans, PA-C

Miranda Hambrick, CRNP

Todd Pridmore, CRNP

Paige Tibbs, CRNP

Jennifer Tootle, CRNP

Kelly Vazquez, CRNP, DNP

Huntsville Office
420 Lowell Drive SE
5th floor
Huntsville, AL 35801
P: (256) 265-5864
F: (256) 265-5865

Madison Office
8371 Hwy. 72 West
Suite 204
Madison, AL 35758
P: (256) 817-5977
F: (256) 817-5926

Decatur Office
1874 Beltline Rd SW
Suite 100
Decatur, AL 35601
P: (256) 973-6790
F: (256) 973-6791

Dear Patient,

We would like to take this opportunity to thank you for choosing the Huntsville Hospital Lung Center for your medical care and to welcome you to our office. We are pleased that you have chosen us to provide you with medical services.

Our website (*huntsvillehospital.org/huntsville-hospital-lung-center*) will help answer any questions about our office. We want you to know about our office services and what to expect at the time of your first visit.

We prefer that you mail, fax, or drop off the completed new patient forms prior to your appointment. If unable to do so, please bring the completed forms with you to your appointment.

We ask that all new patients arrive **30 minutes** prior to your appointment time, so you can be seen by the provider as close to your scheduled time as possible. Please be sure to remember to bring the following items to your appointment:

- Identification card
- Insurance card
- Medication bottles
- Co-payment and/or deductible

If you are unable to keep your appointment for any reason or if you are going to be **15 minutes** or more late, please call our office as soon as possible. We will be happy to reschedule a more convenient time for you.

Sincerely,

Sam Brunson, MSHA, MBA
Administrator
Huntsville Hospital Lung Center

Lung Center
Pulmonary, Sleep & Critical Care Specialists

Huntsville: (256) 265-5864
Madison: (256) 817-5977
huntsvillehospital.org/hhlung

Patient Information

Name: _____DOB:_____Today's Date: _____
Address:_____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
SSN: _____ Sex: ☐Male ☐Female
Occupation: _____ Employer: _____
Employer's Address: _____ Employer's Phone: _____

Spouse's Name: _____ Spouse's DOB: _____ Spouse's SSN: _____
Spouse's Occupation: _____ Spouse's Employer: _____
Spouse's Employer's Address: _____ Spouse's Employer's Phone: _____

In case of emergency, notify: _____ Relationship: _____
City: _____ State: _____ Phone: _____

If patient is a minor, list person(s) other than emergency contact above who has permission to bring child to office for treatment:
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____
Name: _____ Relationship: _____ Phone: _____

Insurance *(provide patient information unless patient is a minor, then provide guarantor's information)*

Primary

Insurance Name: _____ Relationship to patient: _____
Subscriber's Name: _____ Co-pay amount: _____
Subscriber's ID/Contract Policy #: _____ Group #: _____
Subscriber's SSN: _____ Subscriber's DOB: _____
Subscriber's Employer: _____ Employer's Phone: _____

Secondary

Insurance Name: _____ Relationship to patient: _____
Subscriber's Name: _____ Co-pay amount: _____
Subscriber's ID/Contract Policy #: _____ Group #: _____
Subscriber's SSN: _____ Subscriber's DOB: _____
Subscriber's Employer: _____ Employer's Phone: _____

Person responsible for this account: _____ Phone: _____

I agree payment will be made at the time of service. I agree to pay all co-pays, non-covered or routine charges, deductibles and co-insurance amounts that apply. In the event this account is turned over to a collection agency for collection, I will be responsible for all collection fees, court costs and attorney's fees. I authorize HH Physician Care to release information to insurance carriers and for insurance carriers to release information to HH Physician Care concerning my illness, treatment and payments (including workmen's compensation) and I hereby assign to the physician all payments for medical services rendered to myself or my dependents if assignment applies.

_____ _____ _____
Signature Date Time

HH Lung Center
Pulmonary, Sleep & Critical Care Specialists

Huntsville: (256) 265-5864
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huntsvillehospital.org/hhlung

Pulmonary History and Symptom Form

General Information

Appointment Date: _____ Appointment with:_____
Name: _____ DOB:_____ Age: _____
Sex: ☐Male ☐Female
Referring Physician: _____ Family Physician: _____
Pharmacy: _____
Do you have an Advanced Directive (Living Will)? ☐Yes ☐No

Your Visit

What brings you to our office today?_____
How long have you had this problem? _____
Are there any factors that make this better or worse? _____

List any tests done for this problem already:
1. _____
2. _____
3. _____

Medications

List current medications with dosages including over-the-counter or herbal:
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Drug Allergies

List any drug allergies/reactions:
1. _____ 2. _____ 3. _____

Diseases / Illness History

List any illnesses or diseases that you are being treated for or have been treated in the past:
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Surgery and Operation History

List any surgeries or operations you have had:
1. _____ 3. _____
2. _____ 4. _____

Pulmonary History

Have you had problems with (please circle):
1. ☐Yes ☐No Shortness of breath If yes, how long? _____
2. ☐Yes ☐No Cough
3. ☐Yes ☐No Coughing phlegm
4. ☐Yes ☐No Coughing blood
5. ☐Yes ☐No Coughing/choking after eating
6. ☐Yes ☐No Cough at night
7. ☐Yes ☐No Wheezing
8. ☐Yes ☐No Runny nose
9. ☐Yes ☐No Itchy eyes
10. ☐Yes ☐No Sinusitis
11. ☐Yes ☐No Post nasal drip If yes, does it occur year round? Yes / No
12. ☐Yes ☐No Heartburn

☐Yes ☐No Do you feel like these issues affect your life?

For Office Use Only:				
Wt:	BP:	Neck Circ:	Pulse:	Pulse ox:
Allergies				Ht:

Social History

Marital Status: ☐Single ☐Engaged ☐Married ☐Separated ☐Divorced ☐Widowed
Work: ☐Part Time ☐Full Time ☐Retired ☐Disabled Occupation: _____ ☐Day Shift ☐Night Shift
Children: ☐Yes ☐No How many? _____
Religious Affiliation: _____

Risk Factors

Tobacco use: ☐Yes ☐No
Type: ☐Cigarettes ☐Cigars ☐Snuff ☐Vapor If yes, how many years?:_____ Amount per day:_____
If you do not currently smoke, but did in the past, when did you quit smoking?_____
How long did you smoke before quitting?_____
Alcohol use: ☐Yes ☐No If yes, how many drinks per day?_____
Caffeine use: ☐Yes ☐No
Recreational drug use: ☐Yes ☐No
Are you exposed to chickens, pigeons, or pet birds? ☐Yes ☐No

Family History

	Age	Serious Health Problems	Cause of Death
Father			
Mother			
Brother			
Sister			

Medical Problems (Please mark any that are applicable)

General

☐Weight Loss
If yes, _____lbs. since when_____
☐Fever
☐Chills
☐Night Sweats

Skin/Breasts

☐Bruising
☐Rash/Itching
☐Lumps
☐Color Change

Hematology/Lymphatic

☐Anemia
☐Bleeding
☐Enlarged Nodes

Musculoskeletal

☐Arthritis
☐Weakness
☐Fracture

Endocrine

☐Thyroid
☐Diabetes

Sleep

☐Snoring
☐Daytime Drowsiness
☐Morning Headaches
☐Waking at Night Choking
☐Waking at Night Short of Breath

Eyes

☐Vision Loss
☐Trauma
☐Color Blind
☐Glasses/Contacts
☐Cataracts

ENT

☐Deafness
☐Dizziness
☐Mouth Sore
☐Throat Sore
☐Nose Bleed
☐Hoarseness
☐Tooth Problems

Cardiovascular

☐Angina
☐Chest Pain
☐Rheumatic Fever
☐Palpitations
☐Heart Attack
☐Hypertension

Gastrointestinal

☐Trouble Swallowing
☐Vomiting
☐Diarrhea
☐Cough after you eat

Genitourinary

☐Kidney Stones
☐Increased Urine
☐Hysterectomy/Tubal
☐Hormones
☐Birth Control Pills
☐Incontinence
☐Prostate
☐Menstrual Irregularity

Neurological

☐Stroke
☐Seizure
☐Paralysis

Psychiatric

☐Bad Nerves
☐Depression
☐Hallucination
☐Sleep Disturbance

Pain

☐Pain Level: __ /10
☐Pain Location: _____
☐Pain Intensity: _____
☐Pain Description:_____
_____

Health System

Race and Ethnicity Form

Name:_____ DOB:_____

This classification provides a minimum standard for maintaining, collecting and presenting date on race and ethnicity for all Federal reporting purposes. This is not to be used as determinants of eligibility for participation in any Federal Program.

Race (select one or more):

☐ White (not of Hispanic origin): All persons having origins in any of the original peoples of Europe, North Africa, or Middle East.

☐ Black (not of Hispanic origin): All persons having origins in any of the Black racial groups of Africa.

☐ Hispanic: All persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race.

☐ Asian or Pacific Islander: All persons having origins in any of the original peoples of the Far East, Southeast Asia, the Indian Subcontinent, or the Pacific Islands. This area includes, for example, China, India, Japan, Korea, the Philippine Islands, and Samoa.

☐ American Indian or Alaskan Native: All persons having origins in any of the original peoples of North America, and who maintain cultural identification through tribal affiliation or community recognition.

☐ Declined

Ethnicity (select one):

☐ Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be in addition to "Hispanic or Latino."

☐ Non-Hispanic or Latino

☐ Declined

Preferred Language: _____

Signature:_____ Date:_____

HH System Clinics Registration Update Sheet

Patient: _____ Date of Birth: _____ Fin #: _____

Authorization to Call

I authorize HH System Clinics to leave the following messages on my answering machine/voicemail:

☐Reminder appointments calls

☐ Lab and/or Test results

HH System Clinics Advance Directive Policy

In our practices we have decided that we will initiate resuscitative measures anytime they are needed.

Financial Fees and Assistance

Financial Fees: I understand the following fee will be charged:

- A fee of $25 per form for completion of comprehensive forms. A fee will NOT be assessed for simple forms such as Work Excuse, School Excuse or application for Indigent Assistance for Medications.

Financial Assistance: I understand that financial assistance may be available for individual patients who are uninsured or who otherwise meet financial aid criteria. The hospital's overall ability to remain financially stable and provide essential health care services to all members of our community is dependent upon financial resources available to cover services provided to patients. My assistance in providing such information is necessary to determine possible financial aid available to me. If I am uninsured and need financial assistance, I may contact a Financial Counselor and make a request to see if I qualify at (256) 265-9438.

Authorization of Treatment

I hereby consent and authorize my physician and/or Allied Health professional to render usual and customary medical/emergency treatment that they deem advisable and necessary. I also authorize HH System Clinics to electronically request my medication history if my pharmacy participates in electronic prescribing in order to assist the provider in prescribing necessary medication therapy.

Assignment of Benefits, Agreement, and Guaranty

I authorize HH System Clinics to release any information regarding services rendered to me to third party payers in consideration of payment for my care or to other healthcare providers involved in my care. I understand payment of all insurance benefits, basic and major medical for this period of service must be made directly to HH System Clinics. If the check must be made out to me, I understand the check must be sent to this address: PN Billing P.O. Box 2705 Huntsville, AL 35804. I understand the HH System Clinics must collect for all charges not covered by insurance payments. Payment for all collection costs, securing, or attempting to collect and secure including reasonable attorney fees or Collection Agency fees, whether suit be necessary or otherwise is the financial responsibility of the patient and guardian. Patients who are considered a legal adult are financially responsible for all services rendered.

HH Health System Notice of Privacy Practices Acknowledgement

I acknowledge that a copy of the Notice of Privacy Practices for HH Health System has been made available to me. In connection with the Notice, I also acknowledge that I have been provided with an opportunity to ask questions regarding

Health System

Patient: _____ Date of Birth: _____ Fin #: _____

the Notice and its contents. I understand that the most current version of the Notice will be posted with the Health System and on www.huntsvillehospital.org.

Express Permission to Contact Patient by Cell Phone

I agree in order for HH System Clinic to service my account or to collect monies I owe, HH System Clinics and/or our agents may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. HH System Clinics may also contact me by sending text messages

or emails, using any email address I provided. Methods of contact may include pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable. I have read this disclosure and agree that HH System Clinics, its employees, and/or agents may contact me as described.

Photography Consent

I authorize photography for purposes of clinical treatment and staff education. I understand that any images or photographs will be used solely for these purposes and that I have the right to revoke this authorization or to refuse to be photographed at any time. I understand that only hospital authorized or issued equipment will be used to take photographs, and that my privacy and confidentiality will be maintained in the use of these images.

☐ Consent to Photography for Medical Treatment and Staff Education

☐ Decline Consent to Photography for Medical Treatment and Staff Education

Signature of Patient/Authorized Representative on behalf of patient: _____

Date: _____ Time: _____

Printed Name of Person Authorized to sign for patient: _____

Basis of Authority to sign for Patient: _____

For Use by Health System Personnel Only (Complete if Patient Acknowledgment is not obtained)

The patient was provided with a copy of the Notice of Privacy Practices and a good faith attempt was made to obtain the patient's signature acknowledging receipt of the Notice. An Acknowledgment was not obtained because _____.

Witness/Employee Signature: _____ Employee ID: _____

Date: _____ Time: _____

HUNTSVILLE HOSPITAL HEALTH SYSTEM
101 SIVLEY ROAD • HUNTSVILLE, AL 35801 • 256-265-1000

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name _____ SS Number (Optional)_____

Date of Birth _____ Address _____

Phone Number (____)_____Date of Service_____ Patient Number

I authorize the use or disclosure of the above named individual's health information as described below:

1. Huntsville Hospital is authorized to make the disclosure.

2. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)

☐ Facesheet	☐ Physician Orders	☐ Laboratory Results	Records Release Format
☐ Discharge Summary	☐ Outpatient Record	☐ Imaging Results	☐ e-delivery (Healthport Connect)
☐ History and Physical	☐ Emergency Dept. Record	☐ Bill / Claim Form	☐ CD
☐ Operative Note	☐ EKG Report	☐ Itemized Statement	☐ Paper
☐ Pathology Report	☐ EBC Application	☐ Other_____	
☐ Consultation Report	☐ Autopsy Report		
☐ Progress Notes			

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

4. This information may be disclosed to, and used by, the following individual or organization:

   Name: _____

   Address: _____

5. For the purpose of _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

7. Unless otherwise revoked, the authorization will expire on the following date, event, or condition:

   _____

   If I fail to specify an expiration date, event or condition, this authorization will expire in six months from the date of signing.

8. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

9. I understand that as the recipient, I am responsible for the security of these medical record copies and the health information contained therein, whether in paper format or on CD/DVD.

10. I understand that I need not sign this form in order to ensure health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

    or

    I understand that if I refuse to sign this form, under specific conditions the organization can refuse:
    Treatment Enrollment in the health plan Eligibility for benefits

_____ _____ _____
SIGNATURE DATE TIME

_____ _____ _____ _____
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT SIGNATURE OF WITNESS DATE TIME