Pulmonary, Sleep & Critical Care Specialists

Robert Buss, MD

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Miranda Hambrick, CRNP

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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:

- **If you are currently on CPAP, please bring your SD card**
- 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

Sam Brunson, MSHA, MBA
Administrator
Huntsville Hospital 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

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

Pediatric Sleep History and Symptom Form (New Patients)

Name: ______________________ Gender: ☐Male ☐Female Age:_________ DOB: ____________________
Referring Physician: ______________________ Primary Physician: ______________________
What brings your child to our office today? ______________________

Child's Main Sleep Complaints:
- ☐ Daytime sleepiness
- ☐ Insomnia
- ☐ Snoring
- ☐ Interruptions in breathing
- ☐ Leg jerks
- ☐ Other:______________________

Parent's Main Sleep Complaint (about child's sleep)
- ☐ Daytime sleepiness
- ☐ Insomnia
- ☐ Snoring
- ☐ Interruptions in breathing
- ☐ Leg jerks
- ☐Other:______________________

How long have the complaints bothered your child? ☐Last 3 months ☐6-12 months ☐ 1-2 years ☐ >2 years
How would you rate the severity of your child's complaint? ☐Mild ☐Moderate ☐ Severe

Has your child had a previous sleep study? ☐Yes ☐No
If "Yes", when: _____________ Where: ______________________ Physician: ______________________
What was recommended? ______________________

Sleep Schedule:
Total sleep time in 24hrs______
1. During the week, what time does your child normally go to bed? ____ AM/PM awaken ____ AM/PM
2. During the weekend, what time does your child normally go to bed ____ AM/PM awaken ____ AM/PM
3. How long does it take your child to get to sleep? _______ mins/hours
4. Approximately how many times does your child awaken during their sleep cycle? __________
   How long to get back to sleep? __________
5. What are the usual reasons that awaken your child?
   ☐ Urination ☐ Heat ☐ Heartburn ☐ Light ☐ Pain ☐ Shortness of breath
   ☐ Noise ☐ Cold ☐ Body Jerks ☐ Sibling ☐ Other______________________
6. ☐Yes ☐No Does your child sleep through the night?
7. ☐Yes ☐No Does your child sleep in parents' bed/bedroom?
8. ☐Yes ☐No Does anyone leave the bedroom because of your child's sleep problem?
9. ☐Yes ☐No Does your child awaken feeling tired and not refreshed?
10. ☐Yes ☐No Does your child take naps on arrival home from school/work?
11. ☐Yes ☐No Are short naps refreshing for your child?
12. ☐Yes ☐No Does your child fall asleep while driving or riding in a car?
13. ☐Yes ☐No Does your child have trouble at school or work because of sleepiness?
14. ☐Yes ☐No Does your child snore loud enough for others to complain?
15. ☐Yes ☐No Does your child stop breathing while sleeping?
16. ☐Yes ☐No Does your child ever awaken short of breath or choking?
17. ☐Yes ☐No Does your child ever awaken with heart burn, belching, or coughing?
18. ☐Yes ☐No Does your child ever awaken with chest pain or chest heaviness?
19. ☐Yes ☐No Does your child ever awaken with heart racing or pounding?
20. ☐Yes ☐No Does your child ever wake up with morning headache?
21. ☐Yes ☐No Does your child have a poor memory?
22. ☐Yes ☐No Does your child have trouble concentrating?
23. ☐Yes ☐No Has your child's family relationship been affected because they are tired or sleepy?
24. ☐Yes ☐No Does your child feel the uncontrollable urge to sleep while mad, happy, or sad?

Questions continue on next page.

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

25. ☐Yes ☐No Does your child feel their knees buckle, arms weaken, or jaw drop when mad, happy, or sad?
26. ☐Yes ☐No Does your child experience vivid dream-like scenes upon awakening or falling sleep?
27. ☐Yes ☐No Does your child ever feel unable to move (paralyzed) when waking from or falling asleep?
28. ☐Yes ☐No Does your child have leg cramps at bedtime?
29. ☐Yes ☐No Does your child experience a crawling and aching feeling in their arms or legs which makes them want to move them?
30. ☐Yes ☐No Do your child's legs move throughout the night?
31. ☐Yes ☐No Does your child awaken suddenly with a jerk soon after falling asleep?
32. ☐Yes ☐No Does your child remember their dreams?
33. ☐Yes ☐No Does your child have nightmares?
34. ☐Yes ☐No Does your child act out their dreams (talk or move)?
35. ☐Yes ☐No Does your child sleepwalk?
36. ☐Yes ☐No Does your child awaken from sleep confused/inconsolable?
37. ☐Yes ☐No Does your child awaken from sleep panicked/anxious?
38. ☐Yes ☐No Is your child unable to fall asleep in 15 minutes or less?
39. ☐Yes ☐No Does your child wake up several times during the night and cannot get back to sleep?
40. ☐Yes ☐No Does your child wake up 1 to 2 hours early in the morning?
41. ☐Yes ☐No Does your child have thoughts racing through their mind while trying to sleep?
42. ☐Yes ☐No Does your child watch the clock while trying to fall asleep?
43. ☐Yes ☐No Does your child wake up with sore, achy muscles?
44. ☐Yes ☐No Does your child wake up feeling depressed or sad?
45. ☐Yes ☐No Does your child clench their teeth during sleep?
46. ☐Yes ☐No Does your child grind their teeth during sleep?
47. ☐Yes ☐No Does your child have morning jaw pain?

Review of Symptoms: Please check all that apply to your child at this time.

Sleep
☐ Daytime sleepiness
☐ Dry mouth
☐ Snore
☐ Sore throat
☐ Apnea
☐ Daytime naps
☐ Insomnia

General
☐ Night sweats
☐ Weight gain
☐ Fatigue
☐ Weight loss

Eyes / ENT
☐ Sinus trouble
☐ Difficulty hearing
☐ Difficulty seeing
☐ Nose bleed

Cardiovascular
☐ Chest pain
☐ Shortness of breath
☐ Rapid/skipped heartbeats

Urinary
☐ Nighttime urination
☐ Urinary incontinence

Musculoskeletal
☐ Muscle pain
☐ Joint pain
☐ Back pain
☐ Leg jerks

Gastrointestinal
☐ Heart burn
☐ Irritable bowel
☐ Difficulty swallowing

Psychological
☐ Depression
☐ Anxiety
☐ Hallucinations

Pulmonary
☐ Chronic cough
☐ Shortness of breath
☐ Wheezing
☐ Use of Oxygen

Neurological
☐ Memory loss
☐ Dizziness
☐ Difficulty walking
☐ Difficulty talking
☐ Tremors
☐ Numbness/tingling
☐ Morning headaches

Birth History:

Did the child's mother receive regular prenatal care while pregnant? ☐Yes ☐No
Were there any complications during pregnancy with this child? ☐Yes ☐No
If yes, explain: ____
Were there any complications post-delivery with this child? ☐Yes ☐No
If yes, explain: ____
Birth Weight:__________ #Weeks of Gestation: ________ Length of labor: _________ APGAR score: _______@ 5 mins
Type of Delivery? ☐SVD (vaginal) ☐C-section
Any birth defects/trauma? ☐Yes ☐No If yes, please explain: ____
Jaundice? ☐Yes ☐No Prolonged neonatal stay? ☐Yes ☐No If yes, please explain: ______________________________
Other: ____

Social History:

Number of siblings: _____
Does your child have their own room? ☐Yes ☐No
Does your child sleep in their own bed? ☐Yes ☐No
Are there any pets in the house? ☐Yes ☐No If yes, do the pets sleep with the child? ☐Yes ☐No
Is there any smoking in the house (2nd hand tobacco smoke)? ☐Current ☐Past ☐Never
Home family status: ☐Married ☐Separated ☐Divorced ☐Joint Custody ☐Civil Union ☐Foster Care
Does your child have special needs? ____

To the best of your knowledge, does your child use any of the following:

Alcohol use: ☐Current ☐Past How much? ____________
Illicit drug use: ☐Current ☐Past What drug? ________________
Nicotine abuse: ☐Current ☐Past Type/Packs per day? ________________
Caffeine: ☐Current ☐Past How many cups/glasses/cans per day? ________

Past Medical History: Please check any of the following conditions that apply to your child or your child's family:

	Child	Father	Mother	Sibling	Grandfather	Grandmother	Description
Acid Reflux							
Arthritis Pain							
Asthma							
Cancer							
Depression							
Diabetes							
Emphysema/COPD							
Heart Arrhythmia							
High Blood Pressure							
High Cholesterol							
Narcolepsy							
Migraine Headache							
Psychiatric Problem							
Restless Legs							
Seizures / Epilepsy							
Sleep Apnea							
Tuberculosis							
Thyroid Disease							
Other							

Do you wish your child to be on life support? ☐Yes ☐No
Do you have someone to make health decisions for you for your child in case you were incapacitated? ☐Yes ☐No
If yes, please list the names of who can make health decisions for your child: ______________________________

Past Surgeries: What surgeries has your child had in the past? (Please mark if applicable and include date of surgery)

☐Abdominal surgery ___/___/___ ☐Ear Tubes ___/___/___ ☐Heart surgery ___/___/___
☐Appendectomy ___/___/___ ☐Circumcision ___/___/___ ☐Gallbladder ___/___/___
☐Hernia ___/___/___ ☐Brain/Head ___/___/___ ☐Tonsillectomy ___/___/___
☐Other: ________________________________ ___/___/___

Current Medications: Please indicate any vitamins, herbs, and over the counter medications.

1.____________________ 4.______________________ 7.______________________ 10.__________________
2.____________________ 5.______________________ 8.______________________ 11.__________________
3.____________________ 6.______________________ 9.______________________ 12.__________________

Allergies: Please list any medication, food, or chemicals which your child is allergic to or has a major side effect to.

1.____________________ 3.______________________ 5.______________________ 7.__________________
2.____________________ 4.______________________ 6.______________________ 8.__________________

Epworth Sleepiness Scale:

How likely is your child to fall asleep in the following situations?

	(0) None	(1) Low	(2) Moderate	(3) High
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (ex: theater, meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon when circumstances permit				
Sitting down talking with someone				
Sitting quietly after lunch without alcohol				
In a car, while stopped for a few minutes with traffic				
			Epworth Total	**___ / 24**

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

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)

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