Patient Information: Respiratory Consultants of Georgia, LLC

Please Fill Out Completely:

Patient's Name: ______________________ SSN: ______________
First M.I. Last

Date of Birth: ______________ Age: ______ Referred By __ Friend/Relative __ Yellow Pages __ Newspaper Ad __ Physician ______________

Patient's Address: ______________________________
Address City State Zip

Patient's Phone (Primary): __________ Other __________ Patient's Phone (Secondary): __________ Other __________

Marital Status: [ ]Married [ ]Single [ ]Divorced Sex: [ ]M [ ]F
Married, Single, Divorced M,F

Employer: ______________ Employer Phone: ______________

Responsible Party: ______________________ Date of Birth: ______________
First M.I. Last

Resp. Party Address: ______________________________
Address City State Zip

Resp. Party Phone: Primary ______________ Secondary ______________

Emergency Contact Name: ______________ Emergency Contact Relationship: ______________

Phone: ______________

Referred By: ______________

Primary Insurance Information

Primary Insurance Co.: ______________ Sex: ☐ Male ☐ Female

Policy Holder: ______________________ Member ID No.: ______________
First M.I. Last

Group Number: ______________ Group Name: ______________

Relationship: ______________

SSN: ______________ Date of Birth: ______________

Secondary Insurance Information

Secondary Insurance Co.: ______________ Sex: ☐ Male ☐ Female

Policy Holder: ______________________ Member ID No.: ______________
First M.I. Last

Group Number: ______________ Group Name: ______________

Relationship: ______________

SSN: ______________ Date of Birth: ______________

I understand terms are for services rendered. (If these terms create a problem, please see the business office about making other arrangements before you are examined.) I will be responsible for all charges incurred by me. Should collection proceedings become necessary, I agree to pay all costs of collection including a reasonable attorney's fee and waive all rights to claim personal property exempt under the laws of the state of Georgia. I hereby assign to and authorized payment directly to Respiratory Consultants of Georgia, LLC. All benefits payable under the terms of any insurance policy listed above if insurance is filed by the office. I realize the insurance benefits may not pay all of the bill and agree to pay the difference or the entire bill, if necessary. I authorize the release of any medical information necessary to process my insurance claims or to continue my medical care. I acknowledge that I have been provided access to notice of privacy practices of Respiratory Consultants of Georgia, LLC.

Signature ______________ Signature: ______________ Date ______________
Patient Responsible Party

RESPIRATORY CONSULTANTS
OF GEORGIA

Suzette A. Chin, MD

Timothy Lin, MD

Melissa Bruce Rhodes, MD, FCCP

Acknowledgement of Receipt of

"Notice of Privacy Practices"

For Protected Health Information

Patient Name ________________________________ Date of Birth ______________

I, acknowledge that I have received a copy of Respiratory Consultants of Georgia LLC. "Notice of Privacy Practices" for Protected Health Information on the date set forth below.

Permission is given to leave medical information in the special manner and to the specified person (s)

___You may leave messages on my home answering machine

___You may call my work number

___You may leave messages on my office voice mail

___You may leave messages on my cell phone voice mail _______________

___You may share medical and account information with my spouse.

Name_________________________ Number _________________

___You may share my medical and account information with my children.

Name_________________________ Number__________________

Name_________________________ Number__________________

___You may share my medical and account information with

Name_________________________ Number__________________

___You may only give my medical and account information to no one but myself.

Special requests and limitations:

____

____

__________________________ ___________________

Signature of Patient Date

21 Pointe North Dr Cartersville Ga, 30120 • Phone: 678.721.0705 • Fax: 678.721.5116

BREATHINGBETTER.ORG

Suzette A. Chin, MD FCCP
Timothy Lin, MD FCCP
Melissa Bruce Rhodes, MD FCCP

Cancellation/Missed Appointment Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment/cancellation policy due to the high number of patients not showing up for scheduled appointments or cancelling at the last minute. When patients cancel or no show within 24 hours, it takes away from patients who are needing care and have to wait for appointments. This policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellation of an Appointment:

In order to be respectful of the medical needs of other patients, please be courteous and call Respiratory Consultants of Georgia promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we **require** that you call at least **24** hours in advance, and calling early in the day is appreciated. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

How to Cancel Your Appointment:

To cancel appointments, please call 678-721-0705. If you do not reach the receptionist you may leave a detailed message on the voice mail. If you would like to reschedule your appointment, please be sure to leave us your phone number and let us know the best time to return your call.

Late Cancellations:

Late cancellations –meaning cancelling an appointment without a 24 hour notice --will be considered as a "no-show".

Suzette A. Chin, MD FCCP
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No-Show Policy

A "no-show" is someone who misses an appointment without cancelling it with a 24 hour notice minimum or just not showing up for an appointment. "No-shows" inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show". A "no-show" will result in a **fee of $25.00** billed to the patient's account. This fee will need to be paid **prior** to being seen at their next scheduled visit. If the patient "no shows" a second time in the same calendar year, then the fee will be increased to $50.00.

RESPIRATORY CONSULTANTS
OF GEORGIA

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By signing this document, I ______________________________, have fully read and understand the cancellation policy for Respiratory Consultants of Georgia. I understand that the terms of this cancellation policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

____

Printed name of patient/parent/guardian

______________________________ ____/____/____

Signature of patient/parent/guardian Month Day Year

Please return signed document to the front desk.
A copy is available for you if requested

21 Pointe North Drive • Cartersville, GA, 30120 • Phone: 678.721.0705 • Fax: 678.721.5116
BREATHINGBETTER.ORG

RESPIRATORY CONSULTANTS OF GEORGIA

Suzette A. Chin, MD
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Financial Policy

Welcome and thank you for choosing our practice for your medical care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any questions you may have concerning a bill.

In order to achieve our goal of providing you with the best care possible, we need your assistance and your understanding of our financial policy:

Our Office Hours are:

- Monday through Friday 8:30am to 5:00 pm

Things to bring with you EACH appointment:

- Health Insurance Card
- Drivers License
- Method of Payment

Appointments:

- Please arrive for your appointment 15 minutes early.
- If you are more then 10 minutes late for your appointment, you will be marked as a NO SHOW and will need to reschedule your appointment at another time.
- It is your responsibility to verify that the physician in currently under contract with your insurance plan and that you have obtained all necessary referrals BEFORE your scheduled appointment. (Failure to confirm this will result in you responsibility for any and all charges.)
- Please inform the receptionist of any demographic changes (phone number, address, Insurance information, etc.) Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage will result in you being responsible for any service not covered by your insurance carrier.

Payment in full is due at the time services are rendered:

- Co-Pays and all non covered items and charges are the insured/patient's financial responsibility and are due during the check-in process. Failure to produce payment at check-in will result in your appointment being rescheduled.
- Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service.
- As a courtesy to our patients, we gladly accept cash, checks, money order, Visa, MasterCard.
- Failure to pay balance will result in discharge from the practice.

"In Network" vs. "Out of Network" Insurance

- Your insurance coverage and benefits are a contract between you and your insurance company and, therefore all disputes must be handled between you and your insurance company.
- We are contracted with multiple insurers to accept assignment of benefits.

Suzette A. Chin, MD
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- If you have insurance coverage under a plan with which we do not have contract, you will be treated as a "self pay" patient and will be provided documentation to assist you in filling your own claim.

Additional Paperwork:

- Any paperwork needed to be filled out by the physician will result in a $25 charge.
- Payment will be expected before patient can receive his/her paperwork.
- 72 hour minimum required time for all paperwork to be completed by your physician.

Auto Accidents/ Worker's Compensation:

- Motor Vehicle Accidents (MVAs) will be filed to your auto insurance as a courtesy to you. Failure to receive payment within 30 days will result in your responsibility to pay.
- Our Office will send appropriate workers compensation claim form for services rendered on you behalf as a courtesy to you. If and when a claim is denied, we will expect full payment from you within 30 days of receipt of our bill (a good faith deposit 25% is required for a longer term of repayment.)

Payment Plans:

- Our Office will be happy to work with you in order to pay any balance due to our practice.
- Please contact our billing department to work out payment plan with our practice.
- Please allow 5 mailing days prior to each due date for each payment received by our practice.

Please mail all payments to our office at:

21 Pointe North Drive

Cartersville Ga, 30120

Or over the phone at:

678-721-0705

RESPIRATORY CONSULTANTS OF GEORGIA

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By signing this document, I ______________________________, have fully read and understand the financial policy for Respiratory Consultants of Georgia. I understand that the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for all services rendered to the patient herein.

____
Printed name of patient/parent/guardian

______________________________ ______/______/______
Signature of patient/parent/guardian Month Day Year

Please return signed document to the front desk. A copy is available for you if requested

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Respiratory Consultants of Georgia, LLC

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my health care, this medical practice originates and maintains health records describing my health history, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I am also aware Respiratory Consultants of Georgia will be reviewing and updating current and historical medications from my pharmacy. This information is used by my treating physicians for prescribing. I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my treatment information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality of care.

I understand and have been provided with a *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to request restriction s as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

I authorize Respiratory Consultants to mail reminder post card to my home address:

☐ Accepted ☐ Denied

____
Signature of Patient or Legal Representative

______________________________ June 2013
Date Notice Effective Date or Version

☐ I request the following restrictions to the use or disclosure of my health information:

____

____

Office use only:		
☐ Accepted ☐ Denied		
Signature	Title	Date

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RESPIRATORY CONSULTANTS
OF GEORGIA
SLEEP CENTER

EPWORTH SLEEPINESS SCALE

Name:______________________ *Today's Date:* ______________

Your age (years) __________ *Your sex (male = M; female = F):* ___

How likely are you to doze 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 have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze

1 = slight chance of dozing

2 = moderate chance of dozing

3 = high chance of dozing

SITUATION	**CHANCE OF DOZING (0-3)**
Sitting and reading	____
Watching TV	____
Sitting, inactive in a public place (e.g. a theater)	____
As a passenger in a car for an hour without a break	____
Lying down to rest in the afternoon when circumstances permit	____
Sitting and talking to someone	____
Sitting quietly after a lunch without alcohol	____
In a car, while stopped for a few minutes in traffic	____
TOTAL	____

TC 105

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Phone: 678-721-0705
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RESPIRATORY CONSULTANTS OF GEORGIA SLEEP CENTER

AMERICAN ACADEMY OF SLEEP MEDICINE WAKE SLEEP ACCREDITED MEMBER CENTER

NEW PATIENT SLEEP QUESTIONNAIRE

NAME: ______________________________ DATE: ________________

YES	NO	
___	___	I feel sleepy during the day
___	___	I snore
___	___	I feel tired when I wake up in the morning
___	___	I have been told I stop breathing
___	___	I am restless when I sleep
___	___	I wake myself gasping or choking
___	___	I have memory loss or difficulty concentrating
___	___	I sleep walk
___	___	I sleep talk
___	___	I act out my dreams
___	___	I get fatigue during the day
___	___	I wake-up with morning headaches
___	___	I wake up more than 3 times per night
___	___	I take naps more than 3 times per week
___	___	I find myself dosing off when I really did not want to
___	___	I have had muscle weakness when startled or laughing
___	___	I have felt paralyzed upon falling asleep or waking up
___	___	I have seen images in my room upon falling asleep or waking up
___	___	My legs kick or jerk at night
___	___	I have an uncontrollable urge to move my legs when I am sitting or lying down
___	___	I get leg cramps
___	___	I have difficulty falling asleep
___	___	I have difficulty staying asleep
___	___	I get anxious, depressed or easily irritable
___	___	I am often not tired at bed time
___	___	I would like to sleep-in later in the mornings
___	___	I like to go to bed early
___	___	I like to wake up early in the mornings

What time do you go to bed? ______________ How long does it take you to fall asleep? __________

How would you describe the quality of your sleep: **a.** Good **b.** Poor **c.** Some good nights some bad

Do you take medications to help you sleep and if so, what do you take ________________________

I wake up at (what time) _______ I get out of bed at (what time) _______

How many 8oz. servings of caffeinated beverages do you drink including, coffee, tea, soda ____________

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