MID-SOUTH PULMONARY SPECIALISTS, P.C.

R. NEAL AGUILLARD, M.D., FCCP
Diplomate in Internal Medicine
Diplomate in Pulmonary Disease
Diplomate in Critical Care Medicine
Diplomate of the Board of Sleep Medicine

JOSEPH A. BLYTHE, M.D., FCCP
Diplomate in Internal Medicine
Diplomate in Pulmonary Disease
Diplomate in Critical Care Medicine
Diplomate, American Academy Hospice and Palliative Medicine

PAUL R. DEATON, M.D.,
Diplomate in Internal Medicine
Diplomate in Pulmonary Disease
Diplomate in Critical Care Medicine

ROY C. FOX, M.D.
Diplomate in Internal Medicine
Diplomate in Pulmonary Disease
Diplomate in Critical Care Medicine

LISA KENNEDY, M.D., FCCP
Diplomate in Pulmonary Disease
Diplomate in Critical Care Medicine

GLENN J. WILLIAMS, M.D., Ph.D.
Diplomate in Internal Medicine
Diplomate in Pulmonary Disease
Diplomate in Critical Care Medicine
Diplomate of the American Board of Pediatrics

JAMES M. ANDREWS, M.D., FCCP
Diplomate in Internal Medicine
Diplomate in Pulmonary Medicine
Diplomate in Critical Care Medicine
Diplomate of the Board of Sleep Medicine

ROBERT C. McEACHERN, M.D., FCCP
Diplomate in Internal Medicine
Diplomate in Pulmonary Medicine
Diplomate in Critical Care Medicine
Diplomate of the Board of Sleep Medicine

MATTHEW W. MABIE, M.D.
Diplomate in Internal Medicine
Diplomate in Pulmonary Medicine
Diplomate in Critical Care Medicine

EDWIN O. TAYLOR, M.D.
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Diplomate in Pulmonary Disease
Diplomate in Critical Care Medicine

WILLIAM I. MARIENCHECK, M.D.
Diplomate in Internal Medicine
Diplomate in Pulmonary Disease
Diplomate in the Board of Sleep Medicine

GARRETTSON S. ELLIS, M.D.
Diplomate in Internal Medicine
Diplomate in Pulmonary Disease
Diplomate in Critical Care Medicine

RICHARD L. BOSWELL, M.D.
Diplomate in Pulmonary Disease
Diplomate in Critical Care Medicine

ERROL M. HOOK, ACNP

Dear Patient:

You are scheduled to see a physician located in the White Station Tower at 5050 Poplar Avenue, Suite 800.

Please complete the enclosed forms and bring them with you. If you need assistance in completing these forms, please arrive at our office 15 minutes before your scheduled appointment and our staff will be happy to assist you.

We ask that you bring with you the following items:

- Any recent chest x-rays or CAT scans
- All medication that you are currently taking
- All insurance information including referrals (if required by your insurance company)

Please do NOT wear colognes as many of our patients are very sensitive to fragrances.

Please understand that we are a **SPECIALTY MEDICAL PRACTICE** and give all our patients quality medical care; therefore, you may experience a LENGTHIER wait than you are accustomed. If you are unable to keep your appointment, please call and we will be happy to reschedule it for you. **There will be a $20.00 fee for appointments not canceled 24 hours in advance.**

If you have any questions, please call us at (901) 276-2662 between the hours of 8:00 a.m. and 4:30 p.m. We look forward to meeting you.

MEDICAL STAFF/PRESCRIPTION REFILLS
901-276-2663
901-276-8042 FAX

5050 POPLAR AVENUE, SUITE 800
MEMPHIS, TN 38157
MAIN PHONE: 901-276-2662
MAIN FAX: 901-274-1871

BILLING DEPARTMENT
901-276-9944
901-276-8631 FAX

MID-SOUTH PULMONARY SPECIALISTS

5050 POPLAR AVE. SUITE 800
MEMPHIS, TN 38157
(901) 276-2662

PATIENT INFORMATION

NAME (Last, First Middle)		MRN	SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP	HOME PHONE	CITY, STATE ZIP	HOME PHONE		
PRIMARY CARE PHYSICIAN		REFERRING PHYSICIAN			
PRIMARY EMPLOYER		SECONDARY EMPLOYER (if Applicable)			
ADDRESS		ADDRESS			
CITY, STATE ZIP		CITY, STATE ZIP			
WORK PHONE		WORK PHONE			

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS	SECONDARY/BILLING ADDRESS (if Applicable)			
CITY, STATE ZIP	CITY, STATE ZIP			
HOME PHONE	HOME PHONE			
RELATIONSHIP TO PATIENT				

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#	
NAME OF INSURED	GROUP#	
ADDRESS OF INSURANCE COMPANY	COPAY AMT $	
CITY, STATE ZIP	DEDUCTIBLE $	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

I authorize medical treatment by my physician. I am responsible for my bill. I agree to pay all cost associated with collecting services in the event I fail to pay the balance due. I authorize payment of Medicare/Medicaid and other health insurance benefits be made on my behalf. I authorize the release of my medical information to CMS, insurance companies or their agent all information needed to determine benefits for services rendered. This authorization remains in effect until I revoke it in writing.

I have received a copy of the Mid-South Pulmonary Specialists, P.C. Notice of Privacy Practices for Health Related Information.

SIGNATURE OF PATIENT/GUARDIAN ____________________ DATE ____________

AS000007.0506

MID-SOUTH PULMONARY SPECIALIST, P.C.
MEDICATION VERIFICATION SHEET

PATIENT NAME ______________________________ CHART/MRN# ____________________

DATE OF VISIT ______________________________ ALLERGIES: ____________________

NAME OF PHARMACY __________________________ PHONE # ______________________

MEDICATION	DOSE	FREQUENCY
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		

ARE YOU CURRENTLY TAKING ANY BIRTH CONTROL? YES ________ NO ________

______________________________ ______________

SIGNATURE DATE

MID-SOUTH PULMONARY SPECIALISTS, P.C.
AUTHORIZATION FOR RELEASE OF INFORMATION

NAME:_____________________ **SS#**__________________________

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF MY HEALTH INFORMATION CONTAINED IN MY MEDICAL RECORDS TO THE FOLLOWING PERSONS:

____

____

BY SIGNING THIS FORM, I AUTHORIZE MID-SOUTH PULMONARY SPECIALISTS, P.C. TO LEAVE A MESSAGE ON MY ANSWERING MACHINE OR WITH THE PERSON ANSWERING THE TELEPHONE REGARDING APPOINTMENTS, ETC.

THE FOLLOWING INFORMATON IS TO BE DISCLOSED:

___ PHYSCIAN NOTES	___CT REPORTS	___OTHER ____________
___ LAB RESULTS	___BONE DENSITY REPORTS	____________________
___ X-RAY REPORTS	___ TEST RESULTS	____________________
___ MRI SCANS	___ COMPLETE RECORD	____________________

PATIENT ACKNOWLEDEMENTS:

By signing below, I agree with the following information:

I understand that any disclosure of information carries with it the potential for re-disclosure and that the information then may not be protected by federal confidentiality rules.

I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing. I also understand that the revocation will not apply to information already released based on this authorization. UNLESS OTHERWISE REVOKED BY A SPECIFIC DATE REQUESTED, THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE SIGNED.

I understand that authorizing disclosure of this health information is voluntary. I do not need to sign this form to assure treatment. HOWEVER, IF THIS AUTHORIZATION IS NEEDED FOR PARTICIPATION IN A RESEARCH STUDY, MY ENROLLMEN IN THE RESEARCH STUDY MAY BE DENIED. **Also, if this authorization is needed for the sole purpose of creating protected health information to disclose to a third party, my treatment may be denied.**

I understand that I am entitled to a copy of this form.

____ _____________________

Signature of patient or legal representative **Date**

____

Relationship to patient

Mid-South Pulmonary Specialists Patient Health History

Patient Name______________________________ Date______________________________
Address__________________________________ Date of Birth________________________
____ Social Security Number_________________

Explain why you are here to see the doctor today.______________________________________
____
____

Past Medical History

List the date of your most recent vaccinations

Flu______________________
Pneumonia________________
Tetanus__________________

List all **ALLERGIES**

____
____
____

Check if you have had the following conditions or procedures.

Condition		Procedure	
Asthma	___	Appendectomy (appendix)	___
Emphysema	___	Hysterectomy (uterus)	___
COPD	___	Cholecystectomy (gall bladder)	___
Sarcoidosis	___	Sinus surgery	___
Pulmonary Fibrosis	___	Lung surgery	___
Collapsed lung	___	Heart Surgery	___
Histoplasmosis	___	Aneurysm surgery	___
Tuberculosis	___	Bronchoscopy	___
Chronic bronchitis	___	Cataract surgery	___
Bronchiectasis	___	Colon Surgery	___
Heart Disease	___	Prostate Surgery	___
Hypertension	___	Brain Surgery	___
Blood clot-lung	___	Tracheostomy	___
Cancer	___	Lung biopsy	___
Rheumatoid Arthritis	___		
Scleroderma	___		
Lupus	___		
Thyroid Disorder	___		
Sleep Apnea	___		
Sinusitis	___		
Cataracts	___		
Glaucoma	___		
Seizure	___		
Cystic Fibrosis	___		
Sickle Cell Disease	___		
Alpha-1 Antitrypsin Deficiency	___		
Acid reflux (GERD)	___		
HIV/AIDS	___		
Stroke	___		
Hepatitis	___		
Diverticulitis	___		
Ulcers	___		
Diabetes	___		

List any other surgeries, procedures or medical problems:

____
____
____
____
____
____
____
____
____
____
____
____

Family History

Check if any of your family members (mother, father, brother, sister, children) had any of the following medical conditions:

Diabetes	___	Emphysema	___
Stroke	___	Lung Cancer	___
Heart Disease	___	Asthma	___
Blood Clots	___	Pulmonary fibrosis	___
Hypertension	___	Cystic Fibrosis	___
Cancer	___	Tuberculosis	___

Social History

Have you ever smoked? Y N How much? ________ packs per day for _________ years

Do you drink alcoholic beverages? Y N How much? ________________________________

Have you ever been exposed to chemicals, dusts or fumes? Y N What types of work have you done in your lifetime? ____

____

System Review. Check if you have experienced any of the following in the past month.

General
- weight loss __
- weight gain __
- weakness __
- fatigue __
- fever __
- rash __
- hair loss __

Head and Neck
- headache __
- vision changes __
- hearing loss __
- earache __
- nasal stuffiness __
- sinusitis __
- nosebleed __
- sore throat __
- hoarseness __
- bleeding gums __
- swollen glands __
- goiter __

Musculoskeletal
- joint pain __
- arthritis __
- gout __
- muscle pain __
- muscle cramps __
- muscle weakness __

Hematologic
- anemia __
- easy bruising __
- blood clots

Breasts
- lumps __
- pain __
- nipple discharge __

Cardiac
- high blood pressure __
- chest pain __
- shortness of breath __
- leg swelling __
- palpitations __
- passing out __
- aneurysm __

Gastrointestinal
- heartburn __
- loss of appetite __
- nausea __
- vomiting __
- vomiting blood __
- bloody bowel movements __
- diarrhea __

Neurologic
- fainting __
- seizure __
- headache __
- numbness __
- weakness __
- tremor __
- memory loss __

Endocrine
- thyroid problems __
- goiter

Respiratory
- wheeze at rest __
- wheeze with activity __
- cough __
- sputum production __
- coughing up blood __
- chest pain __
- shortness of breath
  - at rest __
  - lying down __
  - at night __
  - with activity __

Genitourinary
- frequent urination __
- painful urination __
- bloody urine __
- incontinence __
- prostate problems __
- heavy menstrual period __
- vaginal discharge __

Sleep Disorders
- snoring __
- stop breathing during sleep __
- daytime sleepiness __
- never feel rested __
- frequent naps __
- fall asleep while driving __
- early morning headache __
- leg swelling __

PATIENT NOTICE OF PRIVACY PRACTICES FOR HEALTH RELATED INFORMATION

MID-SOUTH PULMONARY SPECIALISTS, P.C.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY!

If you consent, Mid-South Pulmonary Specialists, P.C. is permitted by federal privacy laws to make uses and disclosures of your protected health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment and applying for future care or treatment. It also includes billing documents for those services.

EXAMPLES OF USES OF YOUR HEALTH INFORMATION FOR TREATMENT PURPOSES ARE:

- Nurse obtains treatment information about you and records it in a health record.
- After your appointment with the physician, the physician may call the primary care physician to report his findings and suggestions for treatment.

EXAMPLE OF USE OF YOUR HEALTH INFORMATION FOR PAYMENT PURPOSES.

- Mid-South Pulmonary Specialists, P.C. submits requests for payment to your health insurance company. The health insurance company requests information from us regarding your medical care given. We provide them with information regarding the treatment given to get paid for our services.

EXAMPLE OF USE OF YOUR INFORMATION FOR HEALTH CARE OPERATIONS.

- We may obtain services from business associates such as quality improvement, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We share information about you as necessary to obtain these services.

YOUR HEALTH INFORMATION RIGHTS!

The health and billing records we maintain are the physical property of Mid-South Pulmonary Specialists, P.C. You have the following rights with respect to your Protected Health Information.

- Request a restriction on certain uses and disclosures of your health information in writing to our office. We are not required to grant the request but will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by requesting one at our office.
- Right to inspect and copy your health and billing record. You may deliver the request in writing to our main location at 266 S. Cleveland, Ste 203, Memphis, TN, 38104. In the event the request for access is denied, you have the right to appeal to the Compliance Officer.
- Right to request your health care record be amended to correct incomplete or incorrect information by delivering a written request to our main office using the form provided upon request. Mid-South Pulmonary Specialists, P.C. is not required to make such amendments; you may file a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information.
- Right to receive an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our main office using the form we provide to you upon request. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care.
- Right to confidential communication by requesting that communication of your health information is made by alternative means or at an alternative location by delivering the request in writing to our main office using the form we provide upon request.

If you want to exercise any of the above rights, please contact the Compliance Officer, Mid-South Pulmonary Specialists, P.C. in person or in writing, during normal business hours at the main office located at 266 S. Cleveland, Ste 203, Memphis, TN, 38104; or call (901) 276-2662. The Compliance Officer will provide you with assistance on the steps to take to exercise your rights.

YOU HAVE THE RIGHT TO REVIEW THIS NOTICE BEFORE SIGNING THE CONSENT AUTHORIZING USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS PURPOSES.

MID-SOUTH PULMONARY SPECIALISTS, P.C RESPONSIBILITIES TO OUR PATIENTS!

- Maintain the privacy of your health information as required by law;
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and

- Accommodate your reasonable requests regarding methods to communicate health information with you.
- Accommodate your request for an accounting of disclosures.

Mid-South Pulmonary Specialists, P.C. reserves the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy or by visiting our office and picking up a copy.

TO REQUEST INFORMATION OR FILE A COMPLAINT

If you have questions, need additional information, or want to report a problem regarding the handling of your information, you may contact the Compliance Officer for Mid-South Pulmonary Specialists, P.C. at (901) 276-2662.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint to our office to the Compliance Officer. You may also file a complaint by mailing it to the Secretary of Heath and Human Services.

WE CANNOT AND WILL NOT REQUIRE YOU TO WAIVE THE RIGHT TO FILE A COMPLAINT WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES (HHS) AS A CONDITION OF RECEIVING TREATMENT FROM THE OFFICE.

WE CANNOT AND WILL NOT RETALIATE AGAINST YOU FOR FILING A COMPLAINT WITH THE SECRETARY OF HEALTH AND HUMAN SERVICES (HHS).

OTHER USES AND DISCLOSURES

Patient Contact: We may contact you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits and services that may be of interest to you.

Communication with Family: Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Required by law: We may be required by law to report suspected abuse or neglect, or similar injuries and events.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, or information related to recalls of dangerous products to public health authorities, and similar information.

Health Oversight Agencies: We may be required to release your information to assist in investigations and audits, eligibility for government programs, and other reasons related to the administration of healthcare.

Judicial/Administrative Proceedings: We may disclose information in response to a subpoena, discovery request, or other lawful process.

Law Enforcement: We may disclose your protected health information when required by court order, or when law require reporting of wounds or other physical injury.

Deaths: We may report information regarding deaths to coroners, medical examiners, and funeral directors.

Research: We may use or disclose information for approved medical research.

Threat to Health and Safety: To avert a serious threat to health or safety, we may disclose you information consistent with applicable laws.

Government Functions: We may disclose your information as authorized by law for national security purposes, Armed Forces personnel, or public assistance program personnel.

Workers compensation: We may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Other Uses and Disclosures: For any disclosure not mentioned, we will ask for your written authorization before using or disclosing any identifiable health information about you. Any authorized disclosure may be evoked for any future uses and disclosures.

FOR ANY QUESTIONS, REQUESTS, OR COMPLAINTS PLEASE CONTACT:

COMPLIANCE OFFICER
MID-SOUTH PULMONARY SPECIALISTS, P.C.
266 S. CLEVELAND, STE 203
MEMPHIS, TN 38104
(901) 276-2662

EFFECTIVE DATE: MARCH 1, 2003