



**Saint Francis  
Hospital - Memphis**

**Sleep Center**

5959 Park Avenue  
Memphis, Tennessee 38119

Office (901) 765-2751  
Fax (901) 765-2733

**Dear Patient:**

We are looking forward to seeing you for your sleep study evaluation. We have enclosed some paperwork to expedite your visit with us and to help the doctor with this evaluation. Please fill these out with black ink only and bring them with you, along with your insurance card. If your insurance requires a referral we will automatically have one from your primary care physician. You will be responsible for paying your co-pay at the time of the visit. We do not accept credit cards. If you are unable to keep this appointment, please call us 48 hrs in advance.

Your sleep study will be scheduled after the evaluation. Your sleep study will be made available to the referring physician approximately 10 days from the date of the study.

Our sleep evaluations are held inside the hospital. Come through the front main entrance, get on the first set of elevators next to the gift shop and come to the 7<sup>th</sup> floor. You will need to press the black call button at the entrance of the patient area. The Sleep Center is at the left end of the floor in room 737. Do Not come more than 15 minutes before your scheduled time. Do Not bring children unless they have someone to supervise them.

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Sincerely,

Dr. William I. Mariencheck, M.D.

Appt. Date \_\_\_\_\_ Time \_\_\_\_\_



**NOTICE OF PRIVACY PRACTICES**

Version No. 2 – December 8, 2003

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

**I. Who Presents this Notice**

This Notice describes the privacy practices of Saint Francis Hospital and related entities (the “Hospital”) and members of its workforce, as well as the physician members of the medical staff and allied health professionals who practice at the Hospital. The Hospital and the individual health care providers together are sometimes called “the Hospital and Health Professionals” in this Notice. While the Hospital and Health Professionals engage in many joint activities and provide services in a clinically integrated care setting, the Hospital and Health Professionals each are separate legal entities. This Notice applies to services furnished to you at Saint Francis Hospital, Saint Francis Nursing Home, Saint Francis Senior Healthcare Center, and Total Care Imaging Center as a Hospital inpatient or outpatient or any other services provided to you in a Hospital-affiliated program involving the use or disclosure of your health information.

**II. Privacy Obligations**

The Hospital and Health Professionals each are required by law to maintain the privacy of your health information (“Protected Health Information” or “PHI”) and to provide you with this Notice of legal duties and privacy practices with respect to your Protected Health Information. When the Hospital and Health Professionals use or disclose your Protected Health Information, the Hospital and Health Professionals are required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure). Special privacy obligations, described in Section IV.D. apply to you if you are admitted to the Hospital’s psychiatric unit or chemical dependency treatment center.

**III. Permissible Uses and Disclosures Without Your Written Authorization**

In certain situations, which are described in Section IV below, your written authorization must be obtained in order to use and/or disclose your PHI. However, the Hospital and Health Professionals do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures for Treatment, Payment and Health Care Operations. Your PHI, but not your “Highly Confidential Information” (defined in Section IV.C below), may be used and disclosed to treat you, obtain payment for services provided to you and conduct “health care operations” as detailed below:

- Treatment. Your PHI may be used and disclosed to provide treatment and other services to you—for example, to diagnose and treat your injury or illness. In addition, you may be contacted to provide you appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. Your PHI also may be disclosed to other providers involved in your treatment.
- Payment. Your PHI may be used and disclosed to obtain payment for services provided to you—for example, disclosures to claim and obtain payment from your health insurer, HMO, or other company that arranges or pays the cost of some or all of your health care (“Your Payor”) to verify that Your Payor will pay for healthcare.
- Health Care Operations. Your PHI may be used and disclosed for health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care delivered to you. For example, PHI may be disclosed to the Hospital Customer Service Representative in order to resolve any complaints you may have and ensure that you have a comfortable visit.

Your PHI also may be disclosed to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection or compliance. In addition, PHI may be shared with business associates who perform treatment, payment and health care operations services on behalf of the Hospital and Health Professionals.

B. Use or Disclosure for Directory of Individuals in Hospital. The Hospital may include your name, location and telephone number in Hospital, and general health condition in a patient directory without obtaining your authorization *unless* you object to inclusion in the directory or are located in a specific ward, wing or unit the identification of which would reveal that you are receiving treatment for (1) mental health and developmental disabilities; (2) alcohol and drug abuse; (3) HIV/AIDS; (4) communicable disease(s); (5) genetic testing; (6) child abuse and neglect; (7) domestic and elder abuse; or (8) sexual assault. Information in the directory may be disclosed to anyone who asks for you by name.

C. Disclosure to Relatives, Close Friends and Other Caregivers. Your PHI may be disclosed to a family member, other relative, a close personal friend or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if (1) your agreement is obtained; (2) you do not object to the disclosure after being provided an opportunity to object; or (3) it can be reasonably inferred that you do not object to the disclosure.





If you are not present, or the opportunity to agree or object to a use or disclosure cannot practicably be provided because of your incapacity or an emergency circumstance, the Hospital and/or Health Professionals may exercise professional judgment to determine whether a disclosure is in your best interests. If information is disclosed to a family member, other relative or a close personal friend, the Hospital and/or Health Professionals would disclose only information believed to be directly relevant to the person's involvement with your health care or payment related to your health care. Your PHI also may be disclosed in order to notify (or assist in notifying) such persons of your location or general condition or death.

D. Public Health Activities. Your PHI may be disclosed for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

E. Victims of Abuse, Neglect or Domestic Violence. Your PHI may be disclosed to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence if there is a reasonable belief that you are a victim of abuse, neglect or domestic violence.

F. Health Oversight Activities. Your PHI may be disclosed to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

G. Judicial and Administrative Proceedings. Your PHI may be disclosed in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

H. Law Enforcement Officials. Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena.

I. Deceased Patients. Your PHI may be disclosed to a coroner or medical examiner as authorized by law.

J. Organ and Tissue Procurement. Your PHI may be disclosed to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

K. Research. Your PHI may be used or disclosed without your consent or authorization if an Institutional Review Board approves a waiver of authorization for disclosure.

L. Health or Safety. Your PHI may be used or disclosed to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

M. Specialized Government Functions. Your PHI may be used and disclosed to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances.

N. Workers' Compensation. Your PHI may be disclosed as authorized by and to the extent necessary to comply with Tennessee law relating to workers' compensation or other similar programs.

O. As Required by Law. Your PHI may be used and disclosed when required to do so by any other law not already referred to in the preceding categories.

**IV. Uses and Disclosures Requiring Your Written Authorization**

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described above in Section III, your PHI may be used or disclosed only when you provide your written authorization on an authorization form ("Your Authorization"). For instance, you will need to execute an authorization form before your PHI can be sent to your life insurance company or to the attorney representing the other party in litigation in which you are involved.

B. Marketing. Your written authorization ("Your Marketing Authorization") also must be obtained prior to using your PHI to send you any marketing materials. (However, marketing materials can be provided you in a face-to-face encounter without obtaining Your Marketing Authorization. The Hospital and/or Health Professionals are also permitted to give you a promotional gift of nominal value, if they so choose, without obtaining Your Marketing Authorization.) In addition, the Hospital and/or Health Professionals may communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers of care settings without Your Marketing Authorization

**Notice of Privacy Practices**





C. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and Tennessee law requires special privacy protections for certain highly confidential information about you (“Highly Confidential Information”), including the subset of your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug abuse prevention, treatment and referral; (4) is about HIV/AIDS testing, diagnosis or treatment; (5) is about communicable disease(s); (6) is about genetic testing; (7) is about child abuse and neglect; (8) is about domestic abuse of an adult with a disability; or (9) is about sexual assault. In order for your Highly Confidential Information to be disclosed for a purpose other than those permitted by law, your written authorization is required.

D. Use and Disclosure of Information Upon Admission to a Psychiatric Unit or Chemical Dependency Treatment Center. Information regarding your care in the Hospital’s psychiatric unit or chemical dependency treatment center is subject to special protections under Tennessee and federal law. The terms of this Notice shall apply to your PHI unless otherwise described in the Section IV.D.

- Psychiatric Treatment. To facilitate the continuity of your care, the Hospital will disclose PHI to mental health providers involved in your treatment or supervising those involved in your treatment for the purpose of treating you or consulting about your treatment. To the extent reasonably necessary to obtain timely payment, your PHI will be disclosed to the organization(s) that pay for services rendered to you. On occasion, your PHI may be used for health care operations but, to disclose PHI about your overall medical condition, without clinical details, to your family member, relative, conservator, guardian, foster parent or friend seeking information about your care. If you are sixteen (16) years of age or older, the Hospital and Health Professionals will not respond to other inquiries about your treatment and will not disclose information revealing that you are a patient of the psychiatric unit to other individuals who call the Hospital to seek information without your written Authorization. The following people may also give a written Authorization to disclose your PHI: (1) your conservator; (2) your attorney in fact under a power of attorney who has the right to make disclosures of your PHI; (3) if you are a minor younger than sixteen years of age, your parent, legal guardian or legal custodian; (4) your guardian ad litem; (5) your treatment review committee; or (6) the executor your estate. The Hospital and Health Professionals will comply with state law in reporting your PHI for public health activities or health oversight activities. If you disclose information related to child abuse or other types of actual or threatened abuse, the Hospital and/or Health Professionals may be required to report such information to governmental authorities responsible to investigate such abuse. If you commit a crime on the premises, your PHI may be used report the crime. To the extent possible, you will be notified or a protective order will be sought prior to disclosing information to a judicial or administrative proceeding. Your PHI will not be used for marketing.
- Chemical Dependency Treatment. If you are a recipient of chemical dependency treatment, your PHI is protected by federal confidentiality laws (42 U.S.C. 290dd-3, 290ee-3, and 42 CFR Part 2). Violations of these laws is a crime and may be reported to appropriate authorities. Your PHI will be disclosed to Hospital personnel within the chemical dependency treatment program that have a need to know your PHI to perform their job duties or to medical personnel in the event of a medical emergency. Your authorization will be obtained prior to disclosing any PHI to obtain payment for services rendered to you, such as for example, to your insurance company. On occasion, your PHI may be used for health care operations but will remove your identifying information. The Hospital and Health Professionals will not respond to inquiries about your treatment and will not disclose information revealing that you are a patient of the chemical dependency center to unauthorized individuals who call the Hospital to seek information. Your PHI will not be disclosed to a family member, relative or any other person seeking information about your care unless your written Authorization is obtained. If you are a minor or have a personal representative (such as a guardian or person authorized under a power of attorney), you will be consulted prior to sharing information with such person. If you refuse to grant permission or are unable to grant permission, information may be shared with your personal representative only to the extent permitted or required by state law. The Hospital and Health Professionals will comply with federal and state law in reporting your PHI for public health activities or health oversight activities. If you disclose information related to child abuse, the Hospital and/or Health Professionals may be required to report such information to governmental authorities responsible to investigate such abuse. If you commit a crime on the premises your PHI may be used to report the crime. To the extent possible you will be notified or a protective order will be sought prior to disclosing information to a judicial or administrative proceeding. Your PHI will not be used for marketing.

V. **Your Rights Regarding Your Protected Health Information**

A. For Further Information: Complaints. If you desire further information about your privacy rights, are concerned that your privacy rights have been violated or disagree with a decision made about access to your PHI, you may contact the Hospital Privacy Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Hospital Privacy Office will provide you with the correct address for the Director. The Hospital and Health Professionals will not retaliate against you if you file a complaint with the Hospital Privacy Office or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on the use and disclosure of your PHI (1) for treatment, payment and health care operations, (2) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While all requests for additional restrictions will be carefully considered, the Hospital and Health Professionals are not required to agree to a requested restriction. If you wish to request additional restrictions, please obtain a request form from the Hospital Privacy Office and submit the completed form to the Hospital Privacy Office. A written response will be sent to you.

C. Right to Receive Confidential Communications. You may request, and the Hospital and Health Professionals will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations.

**Notice of Privacy Practices**





D. Right to Revoke Your Authorization. You may revoke Your Authorization, Your Marketing Authorization or any written authorization obtained in connection with your Highly Confidential Information, except to the extent that the Hospital and/or Health Professionals have taken action in reliance upon it, by delivering a written revocation statement to the Hospital Customer Service Representative identified below. A form of Written Revocation is available upon request from the Hospital Customer Service Representative.

E. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by the Hospital and/or Health Professionals in order to inspect and request copies of the records. Under limited circumstances, you may be denied access to a portion of your records. You should take note that, if you are a parent or legal guardian of a minor, certain portions of the minor's medical record will not be accessible to you (for example, records relating to substance abuse treatment of a juvenile, prenatal care and/or family planning services). If you desire access to your records, please obtain a record request form from the Hospital Privacy Office and submit the completed form to the Hospital Privacy Office. If you request copies, you will be charged in accordance with federal and state law. You also will be charged for postage costs, if you request that the copies be mailed to you.

F. Right to Amend Your Records. You have the right to request that PHI maintained in your medical record file or billing records be amended. If you desire to amend your records, please obtain an amendment request form from the Hospital Privacy Office and submit the completed form to the Hospital Privacy Office. Your request will be accommodated unless the Hospital and/or Health Professionals believe that the information that would be amended is accurate and complete or other special circumstances apply.

G. Right to Receive An Accounting of Disclosures. Upon request, you may obtain an accounting of certain disclosures of your PHI made during any period of time prior to the date of your request provided such period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. If you request an accounting more than once during a twelve (12) month period, you will be charged. For more information about these charges, contact our Health Information Management Release of Information representative.

H. Right to Receive Paper Copy of this Notice. Upon request, you may obtain a paper copy of this Notice, even if you have agreed to receive such notice electronically.

**VI. Effective Date and Duration of This Notice**

A. Effective Date. This Notice is effective on December 8, 2003.

B. Right to Change Terms of this Notice. The terms of this Notice may be changed at any time. If this Notice is changed, the new notice terms may be made effective for all PHI that the Hospital and Health Professionals maintain, including any information created or received prior to issuing the new notice. If this Notice is changed, the new notice will be posted in waiting areas around the Hospital and on the Hospital's Internet site at [www.saintfrancishosp.com](http://www.saintfrancishosp.com). You also may obtain any new notice by contacting the Hospital Privacy Office.

**VII. Hospital Privacy Office**

You may contact the Hospital Privacy Office at:

Customer Service Representative  
Saint Francis Hospital or  
Total Care Imaging Center  
5959 Park Avenue  
Memphis, TN 38119  
Telephone Number: (901) 765-1832  
E-mail: [sfh@tenethealth.com](mailto:sfh@tenethealth.com)

Saint Francis Nursing Home  
5959 Park Avenue  
Memphis, TN 38119  
Telephone Number: (901)765-3150

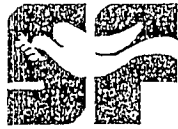
<p>HIM Release of Information Saint Francis Hospital or Total Care Imaging Center 5959 Park Avenue Memphis, TN 38119 Telephone Number: (901) 765-2089</p> <p>Saint Francis Senior Healthcare Center 5084 Old Summer Road Memphis, TN 38122 Telephone Number: (901) 888-2646</p>
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OR

Corporate Privacy Office  
Tenet HealthSystem  
13737 Noel Road, Suite 100  
Dallas, TX 75240  
E-mail: [PrivacySecurityOffice@tenethealth.com](mailto:PrivacySecurityOffice@tenethealth.com)  
Ethics Action Line (EAL): 1-800-8-ETHICS

**Notice of Privacy Practices**





**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ MR #: \_\_\_\_\_

Address: \_\_\_\_\_

I authorize St Francis Hospital to release to or obtain from:

\_\_\_\_\_  
(Name and Address)

\_\_\_\_\_  
(Specify: Attorney, Insurance, Self, etc.)

for the following purpose: \_\_\_\_\_

I authorize release of information covering treatment from: \_\_\_\_\_  
(Dates)

Information to be released:

- Abstract (History and Physical, Discharge Summary, Operative Report, and Pathology Report, if applicable)
- Other (specify) \_\_\_\_\_

I understand there will be a copying fee for these records.

This authorization expires six months from the below date, and it covers only treatment prior to that date. I understand that this consent may be withdrawn by me at any time.

I also understand that any disclosure of records concerning diagnosis and/or treatment related to alcohol and/or drug abuse is covered by Title 42 of the Code of Federal Regulations. If my records contain information governed by Title 42 of the Code of Federal Regulations, I authorize the release of such information as indicated above.

This authorization shall also include any information related to the diagnosis and/or treatment of any psychiatric or mental illness or of any state of infection with the Human Immunodeficiency Virus (HIV) (AIDS Virus).

The hospital is hereby released and discharged of any liability, and the undersigned will hold the hospital harmless for complying with this authorization.

\_\_\_\_\_  
Patient (or person authorized to consent for minor or patient who is unable to sign)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION:** This information has been disclosed to you from records whose confidentiality is protected. Statutes/regulations prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

PERMISSION FOR PHONE CONTACT

ANY MESSAGE PERTAINING TO MY MEDICAL  
CARE, APPOINTMENTS, BILLING, MAY BE LEFT ON MY  
ANSWERING MACHINE

YES \_\_\_\_\_ NO \_\_\_\_\_

OR

WITH THE BELOW LISTED INDIVIDUALS

FAMILY:

\_\_\_\_\_

EMPLOYER:

\_\_\_\_\_

# 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 C. TAYLOR, M.D.  
Diplomate in Internal Medicine  
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.

We would like to give you information regarding your appointment with the St. Francis Sleep Disorder Center. You will receive two charges for today's visit: one from St. Francis Hospital for the facility fee and one from Mid-South Pulmonary Specialists, P.C for the physician's evaluation and/or interpretation fee. Because all related charges must be billed as an outpatient service your insurance company may apply these charges towards your deductible.

Mid-South Pulmonary Specialists employs Dr. William Mariencheck and Dr. Robert McEachern. Services performed by these doctors will be billed by Mid-South Pulmonary Specialists, P.C.

We request that you obtain and bring with you a referral from you primary care physician if it is required by your insurance company. Please be prepared to pay co-payments and/or deductibles on the day of your evaluation. If you do not have insurance coverage, please call the Billing Department at (901) 276-9944 to make payment arrangements BEFORE your appointment at the sleep center.

## FINANCIAL RESPONSIBILITY STATEMENT

I agree to and authorize medical treatment as deemed necessary by Dr. William Mariencheck or Dr. Robert McEachern. I further understand that I am responsible for any amounts charged for the evaluation and interpretations, and that neither of the above doctors nor Mid-South Pulmonary Specialists, P.C. accepts responsibility for collecting insurance claims or negotiating settlements on disputed claims.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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: 901-274-1873

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

PULMONARY & CRITICAL CARE MEDICINE CONSULTANTS

## PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

MID-SOUTH PULMONARY SPECIALISTS, P.C.  
5050 POPLAR AVE, SUITE 800  
MEMPHIS, TN 38157

PATIENT PROFILE

LAST NAME M.I. FIRST NAME BIRTHDATE SOCIAL SECURITY #  
ADDRESS CITY STATE ZIP CODE  
( ) ( )  
HOME PHONE # CELL PHONE# WORK PHONE # NAME OF RESPONSIBLE PARTY  
EMPLOYMENT INFORMATION:  EMPLOYED  RETIRED  UNEMPLOYED  OTHER

EMPLOYER ADDRESS CITY STATE ZIP CODE

SPOUSE INFORMATION/EMPLOYMENT.

NAME: \_\_\_\_\_ EMPLOYER \_\_\_\_\_  
ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_  
CITY, STATE, ZIP \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_  
\_\_\_\_\_ WORK PHONE # \_\_\_\_\_  
BIRTHDATE SOCIAL SECURITY #

EMERGENCY CONTACT.

NAME ADDRESS PHONE # RELATIONSHIP TO PATIENT

REFERRAL INFORMATION:

NAME OF REFERRING PHYSICIAN ( ) PHONE #

INSURANCE INFORMATION:

PRIMARY INS. NAME \_\_\_\_\_ SECONDARY INS. CO \_\_\_\_\_  
ADDRESS \_\_\_\_\_ ADDRESS \_\_\_\_\_  
PHONE # \_\_\_\_\_ PHONE # \_\_\_\_\_  
POLICY # \_\_\_\_\_ POLICY # \_\_\_\_\_  
GROUP # \_\_\_\_\_ GROUP # \_\_\_\_\_

FINANCIAL RESPONSIBILITY/AUTHORIZATION TO FILE INSURANCE:

THIS FORM APPLIES TO MEDICARE/MEDICAID BENEFITS, AND ANY OTHER INSURANCE BENEFITS INCLUDING SECONDARY BENEFITS.

I AUTHORIZE MEDICAL TREATMENT AS DEEMED NECESSARY BY PHYSICIANS OF MID-SOUTH PULMONARY SPECIALISTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNTS CHARGED FOR SERVICES. MID-SOUTH PULMINARY DOES NOT ACCEPT RESPONSIBILITY FOR COLLECTING INSURANCE CLAIMS OR NEGOTIATING A SETTLEMENT ON A DISPUTED CLAIM. I AGREE TO PAY ALL COSTS ASSOCIATED WITH COLLECTING SERVICES IN THE EVENT I FAIL TO PAY THE BALANCE DUE INCLUDING COLLECTION FEES, ATTORNEY AND COURT COSTS.

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE/MEDICAID AND OTHER HEALTH INSURANCE BENEFITS BE MADE ON MY BEHALF. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO CMS AND ITS AGENTS OR MY DESIGNATED INSURANCE COMPANY AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. 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

DATE

# HEALTH HISTORY

Welcome to our practice. As a new patient, please fill out the information found below to the best of your ability.

Patient Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Date: \_\_\_\_\_  
 Patient # \_\_\_\_\_

Chief Complaint: \_\_\_\_\_

History of present illness:

Location: \_\_\_\_\_  
(Where is the pain/problem?)

Quality: \_\_\_\_\_  
(Example: normal versus abnormal color, activity, etc.)

Severity: \_\_\_\_\_  
(How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)

Duration: \_\_\_\_\_  
(How long have you had this pain/problem?, or, When did it start?)

Timing: \_\_\_\_\_  
(Does the pain/problem occur at a specific time?)

Context: \_\_\_\_\_  
(Where were you at the onset of this pain/problem?)

Associated signs/symptoms \_\_\_\_\_  
(What other associated problems have you been having?)

Modifying factors \_\_\_\_\_  
(What makes the pain/problem worse or better?, or, Have you had previous episodes?)

**Past Medical History**

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Measles	no	yes	Anemia	no	yes	Back trouble	no	yes	Hepatitis	no	yes
Mumps	no	yes	Bladder Infections	no	yes	High Blood Pressure	no	yes	Ulcer	no	yes
Chickenpox	no	yes	Epilepsy	no	yes	Low Blood Pressure	no	yes	Kidney Disease	no	yes
Whooping Cough	no	yes	Migraine Headaches	no	yes	Hemorrhoids	no	yes	Thyroid Disease	no	yes
Scarlet Fever	no	yes	Tuberculosis	no	yes	Date of last chest x-ray			Bleeding Tendency	no	yes
Diphtheria	no	yes	Diabetes	no	yes	Asthma	no	yes	Any other disease	no	yes
Smallpox	no	yes	Cancer	no	yes	Hives or Eczema	no	yes	<small>(please list):</small>		
Pneumonia	no	yes	Polio	no	yes	AIDS or HIV+	no	yes			
Rheumatic Fever	no	yes	Glaucoma	no	yes	Infectious Mono	no	yes			
Heart Disease	no	yes	Hernia	no	yes	Bronchitis	no	yes			
Arthritis	no	yes	Blood or Plasma Transfusions	no	yes	Mitral Valve Prolapse	no	yes			
Venereal Disease	no	yes				Stroke	no	yes			

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital, City, State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (Include nonprescription) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Patient social history:**

Marital status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_  
 Use of alcohol: Never: \_\_\_\_\_ Rarely: \_\_\_\_\_ Moderate: \_\_\_\_\_ Daily: \_\_\_\_\_  
 Use of tobacco: Never: \_\_\_\_\_ Previously, but quit: \_\_\_\_\_ Current packs / day: \_\_\_\_\_  
 Use of drugs: Never: \_\_\_\_\_ Type/Frequency: \_\_\_\_\_  
 Excessive exposure at home or work to: Fumes: \_\_\_\_\_ Dust: \_\_\_\_\_ Solvents: \_\_\_\_\_ Air-borne Particles: \_\_\_\_\_ Noise: \_\_\_\_\_

**Family medical history:**

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Review of Systems: Please indicate any personal history below:

Constitutional Symptoms

Good general health lately... No Yes  
 Recent weight change... No Yes  
 Fever... No Yes  
 Fatigue... No Yes  
 Headaches... No Yes

Eyes

Eye disease or injury... No Yes  
 Wear glasses/contact lenses... No Yes  
 Blurred or double vision... No Yes

Ears/Nose/Mouth/Throat

Hearing loss or ringing... No Yes  
 Earaches or drainage... No Yes  
 Chronic sinus problem or rhinitis... No Yes  
 Nose bleeds... No Yes  
 Mouth sores... No Yes  
 Bleeding gums... No Yes  
 Bad breath or bad taste... No Yes  
 Sore throat or voice change... No Yes  
 Swollen glands in neck... No Yes

Cardiovascular

Heart trouble... No Yes  
 Chest pain or angina pectoris... No Yes  
 Palpitation... No Yes  
 Shortness of breath w/walking  
 or lying flat... No Yes  
 Swelling of feet, ankles or hands... No Yes

Respiratory

Chronic or frequent coughs... No Yes  
 Spitting up blood... No Yes  
 Shortness of breath... No Yes  
 Wheezing... No Yes

Gastrointestinal

Loss of appetite... No Yes  
 Change in bowel movements... No Yes  
 Nausea or vomiting... No Yes  
 Frequent diarrhea... No Yes  
 Painful bowel movements  
 or constipation... No Yes  
 Rectal bleeding or blood in stool... No Yes  
 Abdominal pain... No Yes

Genitourinary

Frequent urination... No Yes  
 Burning or painful urination... No Yes  
 Blood in urine... No Yes  
 Change in force of strain  
 when urinating... No Yes  
 Incontinence or dribbling... No Yes  
 Kidney stones... No Yes  
 Sexual difficulty... No Yes  
 Male - testicle pain... No Yes  
 Female - pain with periods... No Yes  
 Female - irregular periods... No Yes  
 Female - vaginal discharge... No Yes  
 Female - # of pregnancies... \_\_\_\_\_  
 Female - # of miscarriages... \_\_\_\_\_  
 Female - date of last pap smear... \_\_\_\_\_

Musculoskeletal

Joint pain... No Yes  
 Joint stiffness or swelling... No Yes  
 Weakness of muscles or joints... No Yes  
 Muscle pain or cramps... No Yes  
 Back pain... No Yes  
 Cold extremities... No Yes  
 Difficulty in walking... No Yes

Integumentary (skin, breast)

Rash or itching... No Yes  
 Change in skin color... No Yes  
 Change in hair or nails... No Yes  
 Varicose veins... No Yes  
 Breast pain... No Yes  
 Breast lump... No Yes  
 Breast discharge... No Yes

Neurological

Frequent or recurring headaches... No Yes  
 Light-headed or dizzy... No Yes  
 Convulsions or seizures... No Yes  
 Numbness or tingling sensations... No Yes  
 Tremors... No Yes  
 Paralysis... No Yes  
 Head injury... No Yes

Psychiatric

Memory loss or confusion... No Yes  
 Nervousness... No Yes  
 Depression... No Yes  
 Insomnia... No Yes

Endocrine

Glandular or hormone problem... No Yes  
 Excessive thirst or urination... No Yes  
 Heat or cold intolerance... No Yes  
 Skin becoming dryer... No Yes  
 Change in hat or glove size... No Yes

Hematologic/Lymphatic

Slow to heal after cuts... No Yes  
 Bleeding or bruising tendency... No Yes  
 Anemia... No Yes  
 Phlebitis... No Yes  
 Past transfusion... No Yes  
 Enlarged glands... No Yes

Allergic/Immunologic

History of skin reaction or other adverse  
 reaction to:  
 Penicillin or other antibiotics... No Yes  
 Morphine, Demerol,  
 or other narcotics... No Yes  
 Novocain or other anesthetics... No Yes  
 Aspirin or other pain remedies... No Yes  
 Tetanus antitoxin  
 or other serums... No Yes  
 Iodine, Merthiolate or  
 other antiseptic... No Yes  
 Other drugs/medications: \_\_\_\_\_

Known food allergies: \_\_\_\_\_

Environmental allergies: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of Patient, Parent or Guardian

Date

Doctor's Review



**Saint Francis  
Sleep Center**

Tenet HealthSystem

5959 Park Avenue  
Memphis, Tennessee 38119

CURRENT MEDICATION SHEET

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Do You have any known drug allergies? Yes/ No

If yes, please list: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you on oxygen? Yes / No If yes, How many liters? \_\_\_\_\_ How many hours a day? \_\_\_\_\_

Who supplies your oxygen? \_\_\_\_\_

What is your pharmacy of choice? \_\_\_\_\_

Address: \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING ANY OTHE  
THE COUNTER MEDICATIONS:

Medicine: \_\_\_\_\_ Dosage: \_\_\_\_\_ Prescribing Dr.: \_\_\_\_\_ Reason: \_\_\_\_\_









(page 5) Name: \_\_\_\_\_

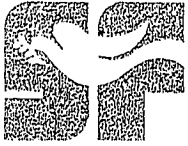
54. How many accidents involving a motor vehicle have you been in over the past two years? \_\_\_\_\_

55. How many work related injuries have occurred to you over the past two years?  
\_\_\_\_\_

56. Do you use recreational drugs? yes                  no  
Type? \_\_\_\_\_ How often? \_\_\_\_\_

Do you have or have you had any of the following problems?

- |   |  |
|---|--|
| <input type="checkbox"/> arthritis                      | <input type="checkbox"/> asthma                  |
| <input type="checkbox"/> back problems                  | <input type="checkbox"/> coronary artery disease |
| <input type="checkbox"/> coronary artery bypass surgery | <input type="checkbox"/> diabetes                |
| <input type="checkbox"/> emphysema/chronic bronchitis   | <input type="checkbox"/> encephalitis/meningitis |
| <input type="checkbox"/> fibromyalgia syndrome          | <input type="checkbox"/> heartburn/reflux        |
| <input type="checkbox"/> heart failure                  | <input type="checkbox"/> hypertension            |
| <input type="checkbox"/> migraine headache              | <input type="checkbox"/> Parkinson's disease     |
| <input type="checkbox"/> sinus problems                 | <input type="checkbox"/> seizure                 |
| <input type="checkbox"/> stroke                         | <input type="checkbox"/> thyroid problem         |
| <input type="checkbox"/> psychiatric problem            | <input type="checkbox"/> depression              |
| <input type="checkbox"/> anxiety                        | <input type="checkbox"/> other _____             |



# Saint Francis Sleep Center

Tenet HealthSystem

5959 Park Avenue  
Memphis, Tennessee 38119

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Date: \_\_\_\_\_

## EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling 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 effected you.

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

0=I would NEVER doze

1=I have a SLIGHT CHANCE of dozing

2=I have a MODERATE CHANCE of dozing

3=I have a HIGH CHANCE of dozing

*Situation:* \_\_\_\_\_ *Chance of dozing:* \_\_\_\_\_

- 1) Sitting and reading \_\_\_\_\_
- 2) Watching TV \_\_\_\_\_
- 3) Sitting, inactive in a public place \_\_\_\_\_
- 4) Lying down to rest in the afternoon when circumstances permit \_\_\_\_\_
- 5) Sitting and talking to someone \_\_\_\_\_
- 6) Sitting quietly after lunch without alcohol \_\_\_\_\_
- 7) In a car, while stopped for a few minutes in traffic \_\_\_\_\_

Total: \_\_\_\_\_

Name \_\_\_\_\_  
DOS \_\_\_\_\_

Study No. \_\_\_\_\_  
LOC \_\_\_\_\_

BECK INVENTORY

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group, which best describes the way you have been feeling the PAST WEEK, INCLUDING TODAY!

Check the box beside the statement you picked. If several statements in the group seem to apply equally well, check each one. Be sure to read all the statements in each group before making your choice.

- |   |   |    |   |
|---|---|----|---|
| 1 | <input type="checkbox"/> 0 I do not feel sad<br><input type="checkbox"/> 1 I feel sad<br><input type="checkbox"/> 2 I am sad all the time and can't seem to snap out of it<br><input type="checkbox"/> 3 I am so sad or unhappy that I can't stand it   | 8  | <input type="checkbox"/> 0 I don't feel I am any worse than anybody else<br><input type="checkbox"/> 1 I am critical of myself for my weaknesses or mistakes<br><input type="checkbox"/> 2 I blame myself all the time for my faults<br><input type="checkbox"/> 3 I blame myself for everything that happens                           |
| 2 | <input type="checkbox"/> 0 I am not particularly discouraged about the future<br><input type="checkbox"/> 1 I feel discouraged about the future<br><input type="checkbox"/> 2 I feel I have nothing to look forward to<br><input type="checkbox"/> 3 I feel that the future is hopeless and that things cannot improve. | 9  | <input type="checkbox"/> 0 I don't have any thoughts of killing myself<br><input type="checkbox"/> 1 I have thoughts of killing myself, but I would not carry out<br><input type="checkbox"/> 2 I would like to kill myself<br><input type="checkbox"/> 3 I would kill myself if I had the chance                                       |
| 3 | <input type="checkbox"/> 0 I do not feel like a failure<br><input type="checkbox"/> 1 I feel I have failed more than the average person<br><input type="checkbox"/> 2 As I look back on my life, all I can see is a lot of failures<br><input type="checkbox"/> 3 I feel I am a complete failure as a person            | 10 | <input type="checkbox"/> 0 I don't cry any more than usual<br><input type="checkbox"/> 1 I cry more now than I used to<br><input type="checkbox"/> 2 I cry all the time now<br><input type="checkbox"/> 3 I used to be able to cry, but now I can't cry even though I want to   |
| 4 | <input type="checkbox"/> 0 I get as much satisfaction out of things as I used to<br><input type="checkbox"/> 1 I don't enjoy things the way I used to<br><input type="checkbox"/> 2 I don't get real satisfaction out of anything anymore<br><input type="checkbox"/> 3 I am dissatisfied or bored with everything      | 11 | <input type="checkbox"/> 0 I am no more irritated now than I ever am<br><input type="checkbox"/> 1 I get annoyed or irritated more easily than I used to<br><input type="checkbox"/> 2 I feel irritated all the time now<br><input type="checkbox"/> 3 I don't get irritated at all by the things that used to irritate me              |
| 5 | <input type="checkbox"/> 0 I don't feel particularly guilty<br><input type="checkbox"/> 1 I feel guilty a good part of the time<br><input type="checkbox"/> 2 I feel quite guilty most of the time<br><input type="checkbox"/> 3 I feel guilty all of the time  | 12 | <input type="checkbox"/> 0 I have not lost interest in other people<br><input type="checkbox"/> 1 I am less interested in other people than I used to be<br><input type="checkbox"/> 2 I have lost most of my interest in other people<br><input type="checkbox"/> 3 I have lost all of my interest in other people                     |
| 6 | <input type="checkbox"/> 0 I don't feel I am being punished<br><input type="checkbox"/> 1 I feel I may be punished<br><input type="checkbox"/> 2 I expect to be punished<br><input type="checkbox"/> 3 I feel I am being punished   | 13 | <input type="checkbox"/> 0 I make decisions about as well as I ever could<br><input type="checkbox"/> 1 I put off making decisions more than I used to<br><input type="checkbox"/> 2 I have greater difficulty in making decisions than before<br><input type="checkbox"/> 3 I can't make decisions at all any more                     |
| 7 | <input type="checkbox"/> 0 I don't feel disappointed in myself<br><input type="checkbox"/> 1 I am disappointed in myself<br><input type="checkbox"/> 2 I am disgusted with myself<br><input type="checkbox"/> 3 I hate myself   | 14 | <input type="checkbox"/> 0 I don't feel I look any worse than I used to<br><input type="checkbox"/> 1 I am worried that I am looking old or unattractive<br><input type="checkbox"/> 2 I feel that there are permanent changes in my appearance that make me look unattractive<br><input type="checkbox"/> 3 I believe that I look ugly |

Patient Name \_\_\_\_\_

BECK INVENTORY -CONTINUED

- 15  0 I can work about as well as before  
 1 It takes an extra effort to get started at doing something  
 2 I have to push myself very hard to do anything  
 3 I can't do any work at all
- 16  0 I can sleep as well as before  
 1 I don't sleep as well as before  
 2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep  
 3 I wake up several hours earlier than I used to and cannot get back to sleep
- 17  0 I don't get more tired than usual  
 1 I get tired more easily than I used to  
 2 I get tired from doing almost anything  
 3 I am too tired to do anything
- 18  0 My appetite is no worse than usual  
 1 My appetite is not as good as it used to be  
 2 My appetite is much worse now  
 3 I have no appetite at all anymore
- 19  0 I haven't lost much weight, if any, lately  
 1 I have lost more than 5 pounds  
 2 I have lost more than 10 pounds  
 3 I have lost more than 15 pounds
- \*\* I am purposely trying to lose weight by eating less  Y or  N
- 20  0 I am no more worried about my health than usual  
 1 I am worried about physical problems such as aches and pains; or upset stomach; or constipation  
 2 I am very worried about physical problems and it's hard to think of much else  
 3 I am so worried about my physical problems that I cannot think about anything else
- 21  0 I have not noticed any recent change in my interest in sex  
 1 I am less interested in sex than I used to be  
 2 I am much less interested in sex now  
 3 I have lost interest in sex completely

If you drink alcohol, please answer the following by circling Y or N

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever felt you ought to cut down on your drinking?   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have people annoyed you by criticizing your drinking?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever felt bad or guilty about your drinking?  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? |

Patient Name \_\_\_\_\_

/mda: 263-2