THE PULMONARY & SLEEP CLINIC

Michael Loggan, M.D., FCCP
Cynthia Spilker, M.D., FCCP
Jacqueline Smith, M.D., FCCP
Sonica Saini, M.D., MPH
Patrick Perkins, M.D., FCCP

2521 Glenn Hendren Drive, Suite 402 Liberty, Missouri 64068
9151 NE 81st Terrace, Suite 200 Kansas City, Missouri 64158 **P** 816-781-8445 **www.libertyhospital.org**

Patient

LAST NAME | FIRST NAME | MIDDLE NAME | PREVIOUS LAST | NICKNAME

SOCIAL SECURITY | BIRTHDATE | SEX

BILLING ADDRESS STREET | CITY | STATE | ZIP CODE

COUNTY | RACE | LANGUAGE | ETHNICITY

MARITAL STATUS | PRIMARY CARE PROVIDER

HOME PHONE NUMBER | DAY PHONE NUMBER | CELL PHONE NUMBER

ALTERNATE PHONE FOR EMERGENCY | E-MAIL

Insurance

PAYER NAME

ADDRESS | CITY | STATE | ZIP CODE

PLAN NUMBER | POLICY NUMBER

GROUP NAME | GROUP NUMBER | EFFECTIVE DATE

SIGNATURE | DATE

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Guarantor: Person Responsible for this Account

LAST NAME | FIRST NAME | MIDDLE NAME | PREVIOUS LAST | NICKNAME

SOCIAL SECURITY | BIRTHDATE | SEX

☐ CHECK IF ADDRESS IS SAME AS PATIENT

BILLING ADDRESS STREET | CITY | STATE | ZIP CODE

COUNTY | RACE | LANGUAGE | ETHNICITY

MARITAL STATUS | PRIMARY CARE PROVIDER

HOME PHONE NUMBER | DAY PHONE NUMBER | CELL PHONE NUMBER

INSURANCE HOLDER ☐ YES ☐ NO

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Patient Name: _____

Today's Date: _____ Date of Birth: _____

Referring Dr: _____ Primary Dr: _____

Reason for Visit Today: _____

Please check any symptoms YOU have had in the last three months?

Constitutional:
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise (no energy)
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss
- ☐ Other:

HEENT:
- ☐ Ear drainage
- ☐ Other:
- ☐ Ear pain
- ☐ Eye discharge
- ☐ Eye pain
- ☐ Hearing loss
- ☐ Nasal drainage
- ☐ Sinus pressure
- ☐ Other:

_____

- ☐ Sore Throat
- ☐ Visual changes
- ☐ Other:

_____

- ☐ Chronic cough
- ☐ Cough
- ☐ TB Exposure
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Other:

_____

Cardiovascular:
- ☐ Chest pain

- ☐ Leg pain
- ☐ Edema
- ☐ Palpitations

- ☐ Other:

_____

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Blood in stools
- ☐ Change in stools
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heart burn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Other:

_____

Genitourinary:
- ☐ Dysuria (burning)
- ☐ Hematuria
- ☐ (blood in urine)
- ☐ Frequency
- ☐ Incontinence
- ☐ Urinary retention
- ☐ Other:

_____

Skin:
- ☐ Itching
- ☐ Rash
- ☐ Other:

_____

Neurological:
- ☐ Dizziness
- ☐ Numbness
- ☐ Weakness:

_____

- ☐ Gait disturbance (problems walking)
- ☐ Headache
- ☐ Memory loss
- ☐ Seizures
- ☐ Tremors
- ☐ Other:

_____

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Other:

_____

Metabolic/Endocrine:
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger

Other

_____

Musculoskeletal:
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle weakness
- ☐ Neck pain
- ☐ Other:

_____

Hematology:
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Enlarged Lymph Nodes
- ☐ Other:

_____

Immunologic:
- ☐ Contact allergy
- ☐ Environmental allergy
- ☐ Food allergy
- ☐ Seasonal allergy
- ☐ Other:

_____

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Patient Name: _____

Today's Date: _____ Date of Birth: _____

Medical History:

Please check any of the following problems with which YOU have ever been diagnosed.
Please put the approximate year you were diagnosed with the problem.

Medical History:

	Year Diagnosed
☐ Allergies	_____
☐ Anemia	_____
☐ Angina	_____
☐ Anxiety	_____
☐ Arthritis	_____
☐ Asthma	_____
☐ Atrial fibrillation	_____
☐ Blood clots	_____
☐ Cancer (Type)	_____
☐ Cardiac Arrhythmia	_____
☐ COPD	_____
☐ Coronary Artery Disease	_____
☐ Depression	_____
☐ Diabetes	_____
☐ Elevated Lipids	_____
☐ Gallbladder Disease	_____
☐ GERD (Heartburn/Reflux)	_____
☐ Headache, migraine	_____
☐ Heart Disease	_____
☐ Heart Valve Disorder	_____
☐ Hepatitis/Liver Disease	_____
☐ Hypertension	_____
☐ Irritable Bowel Disease	_____
☐ Myocardial Infarction	_____
☐ Osteoporosis	_____
☐ Renal Disease	_____
☐ Seizure Disorder	_____
☐ Stroke	_____
☐ Thyroid Disease	_____
☐ Other (specify below)	

_____

Pulmonary (Lung) Problems:

	Year Diagnosed
☐ Alpha 1 Antitrypsin Deficiency	_____
☐ Asthma	_____
☐ Bronchiectasis	_____
☐ Chronic Bronchitis	_____
☐ COPD	_____
☐ Emphysema	_____
☐ Pleural Effusion (fluid around lung)	_____
☐ Pneumonia	_____
☐ Pneumothorax (collapsed lung)	_____
☐ Positive TB test	_____
☐ Pulmonary Emboli (blood clots)	_____
☐ Pulmonary Fibrosis	_____
☐ Pulmonary Hypertension	_____
☐ Restless Legs Syndrome	_____
☐ Sleep Apnea	_____
☐ Tuberculosis	_____
☐ Other (specify below)	_____

_____

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Patient Name: _____

Today's Date: _____ Date of Birth: _____

Medical History:

Please check any of the following problems with which YOU have ever been diagnosed.
Please put the approximate year you were diagnosed with the problem.

Surgical History:

	Year Diagnosed		Year Diagnosed
☐ Angioplasty	_____	☐ D & C	_____
☐ Appendectomy	_____	☐ Gastric Bypass	_____
☐ Arthroscopy	_____	☐ Hernia Repair	_____
☐ Back Surgery	_____	☐ Hip Replacement	_____
☐ Bilateral tubal ligation	_____	☐ Hysterectomy	_____
☐ Blood transfusion	_____	☐ Knee Replacement	_____
☐ Breast augmentation	_____	☐ LASIK	_____
☐ CABG	_____	☐ Mastectomy	_____
☐ Cardiac Pacemaker	_____	☐ Myomectomy	_____
☐ Carpal Tunnel Release	_____	☐ ORIF (Surgery to repair a broken bone)	_____
☐ Cataract Extraction	_____	☐ Thyroidectomy	_____
☐ Cholecystectomy	_____	☐ Tonsillectomy	_____
☐ Colectomy	_____	☐ Other (specify below)	_____
☐ Colostomy	_____	_____	

Lung Surgeries/Procedures:

	Year Diagnosed		Year Diagnosed
☐ Bronchoscopy	_____	☐ Pneumonectomy (removed whole lung)	_____
☐ Chest Tube	_____	☐ Thoracentesis (drain fluid)	_____
☐ Lobectomy (removed part of lung)	_____	☐ VATS (scope surgery for fluid)	_____
☐ Lung Biopsy	_____	☐ Other (specify below)	_____
		_____	

Write in any additional health problems or surgeries; use back of page if needed.

_____

_____

_____

_____

_____

_____

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Patient Name: _____

Today's Date:_____ Date of Birth: _____

Allergies:

Drug	Reaction	Drug	Reaction

Name of Pharmacy_____

Name of Mail Order Pharmacy_____

Medications: Please fill in your current medications and any you have stopped in the last three (3) months; please request second page if necessary.

Medication	Dosage	Directions	Start Date	Stop Date	Dr. Who Prescribed	Why you take medication

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Patient Name: _____

Today's Date:_____ Date of Birth: _____

Social History:

Occupation: _____

Do you currently use Tobacco? Yes___ No___
Have you previously used tobacco? Yes___ No____
If Prior, Date Quit: _____

Average Packs per Day? _____ Number of Years Smoked? _____
Check if you use Chewing Tobacco ____ Vaping ___ E-Cigarettes ____ Marijuana _____
Other Drugs: _____

Do you consume Alcohol? Yes___ No___ Number of Alcoholic Drinks per Day? _____

Do you have any birds in your home? Yes___ No____
Any other pets in your home? Yes___ No ___ If so, what kind? _____

Family History:

Do you have any FAMILY HISTORY of the following conditions:
DO NOT INCLUDE YOURSELF OR SPOUSE, DO NOT INCLUDE RELATIVES BY MARRIAGE ONLY.

Condition:	Family Member(s) Affected	Age of Onset	Cause of Death	Condition:	Family Member(s) Affected	Age of Onset	Cause of Death
ADD/ADHD				Elevated Lipids			
Alcoholism				Genetic Disease			
Allergies				Hearing Loss			
Alzheimer's				Hypertension			
Arthritis				Irritable Bowel Syndrome			
Asthma							
Blood Disorder				Learning Disability			
Cancer	Type:						
Cardiac (heart)				Mental Illness			
Diseases				Migraines			
Coronary Artery Disease				Obesity			
				Osteoporosis			
Depression				Peripheral Vascular			
Developmental Delay							
				Disease			
Diabetes				Renal (kidney) Disease			
Eczema							
Other (specify below):				Seizures			
				Stroke			
				Thyroid Disease			

Add any additional family health history below; use back of page if needed.

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Permission to Disclose Information to Those Involved in My Care

I hereby allow The Pulmonary & Sleep Clinic to disclose the following information. (check all that apply)
This form does not authorize releasing copies of my medical records.

- ☐ Appointment times and dates
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Tests that have been performed
- ☐ Test results
- ☐ Billing/payment information

Other health information (describe)_____
To the following people who are involved with my healthcare and/or payment information:
(check all that apply and list names and telephone numbers)

- ☐ Spouse_____ Phone:_____
- ☐ Friend_____ Phone:_____
- ☐ Child(ren)_____ Phone:_____
- ☐ Other_____Phone:_____

Can confidential messages (i.e. appointment information, prescription information, test results) be left on your answering machine or voicemail? (circle how you wish to receive messages, and provide the phone number)

- ☐ No, DO NOT leave any messages
- ☐ Yes, at home, cell phone or work: Home Phone:_____

Cell Phone:_____Work Phone:_____

- ☐ Yes, only at home Home Phone:_____
- ☐ Yes, only on cell phone Cell Phone:_____

I understand that in certain situations The Pulmonary & Sleep Clinic may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form.

I understand that I have the right to revoke (stop) my permssion at any time.

Patient Name (please print):_____ Date of birth:_____

Patient/Guardian Signature:_____Date:_____

If patient is a minor, please complete the following information:

Mother's name/contact number:_____

Father's name/contact number:_____

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Financial Policy

1. Fees are due and payable at the time of your appointment. If we are contracted with your insurance, you will be billed any remainder after we hear from them. As a courtesy, we accept cash, checks, Visa, Discover, and Master Card.
2. To ensure correct billing, if you have an HMO or PPO insurance with a designated primary care physician, please make sure you have selected a designated physician in our office. If you present us with the incorrect insurance card or information, you will be required to pay the entire fee including any lab services.
3. All co-pays must be paid at the time of your service.
4. Not all services are a covered benefit in all contracts. If you have a question regarding benefits, you need to call your insurance company prior to your office visit and check your benefits. Your insurance policy is a contract between you and your insurance company.
5. All services must be paid in full within 30 days after your insurance has paid their portion. If your visit is due to a Motor Vehicle Accident, payment in full is due at the time of the service.
6. The person who brings a child for care is ultimately responsible for their bill. The physician will not get involved in court decisions or support disputes.
7. Accounts become past due after 30 days. We reserve the right to send an account to collections if not paid in full.
8. All returned checks must be paid with cash or money order within 5 working days or they will be turned over to the prosecuting attorney's office. In addition a $25 returned check fee will be added to your account.
9. If you have any questions, please call our billing office at 816-407-4200.

I hereby acknowledge that I have read, understand, and agree to the terms of this document relating to insurance coverage and payment of my bill.

PATIENT/GUARDIAN'S SIGNATURE | PRINT PATIENT'S NAME & BIRTH DATE | DATE

Signature On File

I authorize use of this form on all my insurance submissions. I authorize release of information to all of my insurance companies. I authorize direct payment to the Pulmonary & Sleep Clinic
I permit a copy of this authorization to be used in place of the original. I understand
I am financially responsible for all charges whether or not covered by insurance.

SIGNATURE | DATE

Patient Label

LIBERTY HOSPITAL
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND PATIENT RIGHTS

By signing this document, I acknowledge that I have received a copy of Liberty Hospital's Notice of Privacy Practices and Patient Rights.

Patient Signature: _____Date_____Time___

Patient Representative/Relationship Signature:

_____Date_____Time___

Witness: _____ Date_____Time___

Liberty Hospital Use Only:

If the patient's signature was not obtained, please describe reason why below:

☐ Patient refused to sign Acknowledgement.

☐ Patient unable to sign Acknowledgement due to emergent condition.

Other: Describe below:

_____
_____
_____

Liberty Hospital is required by law to make a good faith effort to obtain a written acknowledgement from the patient receiving treatment regarding receipt of our Notice of Privacy Practices. A patient's failure or refusal of this acknowledgement should not interfere with delivery of treatment. 45 CFR 164.520

Liberty Hospital is required to inform each patient of their patient rights in advance of providing or stopping care. 42 CFR 482.13.a (1) Interpretive Guidelines