RESPACARE
PULMONARY – CRITICAL CARE – SLEEP MEDICINE

489 Union Avenue • Bridgewater, NJ 08807 • Tel (732) 356-9950 • Fax (732) 356-9959
Dr. Louis Arno, M.D. FACP, FCCP ● Dr. Nehal L. Mehta, MD, FCCP, D-ABSM ● Dr. Prashant B. Patel, MD

Dear Patient,

Welcome to Respacare! We are sending you our Patient Information, History, Medication and HIPPA Privacy forms for you to fill out before your office visit. ***DUE TO HIGH PATIENT VOLUME, YOUR APPOINTMENT TIME MAY BE EFFECTED IF THIS PAPERWORK IS NOT COMPLETE WHEN YOU ARRIVE FOR YOUR OFFICE VISIT.***

Be sure to bring these COMPLETED FORMS with you for your visit, as well as the following:

- YOUR INSURANCE CARD(S)
- DRIVER'S LICENSE
- REFERRAL (IF REQUIRED)
- RECENT (CAT SCAN, X-RAY FILMS, LAB REPORTS & EXTERNAL SLEEP STUDY) REPORTS ARE THE RESPONSIBILITY OF THE PATIENT – FILMS AND REPORTS MUST BE BROUGHT IN FOR THIS APPOINTMENT.

In addition, it is very important that you arrive at least ***15 MINUTES*** prior to your appointment time to allow our staff to update your patient records.

For your convenience, we have also enclosed directions to our office.

Sincerely,

The Staff at Respacare

Appointment scheduled for:

Date: _____

Time: _____

MD: _____

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Directions

Via 1-287 North: Exit 13B (Somerville) Route 28 (West). Travel West on Route28 approximately less than one mile to Respacare at 489 Union Avenue (building will be located on the right).

Via 1-287 South: Exit 13 (Somerville) Route 2B (West). Travel West on Route28 approximately less than one mile to Respacare at 489 Union Avenue (building will be located on the right).

Via Route22 West: Route22 West passing under 1-287, exit at sign for Manville/Finderne Avenue bearing right onto Finderne Avenue and follow to next light at top of the hill. Turn left onto Route28, Union Avenue Respacare will be located on the left.

Via Route 22 East: Route 22 East from White House area make a right onto Finderne Avenue at Kemper KIA. Follow Finderne to the light at the top of the hill. Turn left onto Route 28 (Union Avenue). Respacare will be located on the left.

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PLEASE FILL OUT COMPLETELY AND BRING WITH YOU TO YOUR APPOINTMENT

PATIENT INFORMATION

Thank you for choosing Respacare! In order to serve you properly, we need the following information. All information will be confidential.

Date: _____ **Patient Name:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Home Phone:** ( ) _____ **Cell Phone:** ( ) _____

SSN#: _____ **Email:** _____

Gender: M / F **Ethnicity:** Hispanic/Latino
Not Hispanic/Latino

Race: _____ **Please circle one:** Minor/Single/Married/Divorced/Widowed/Separated

Language (Please Check One): English ____ Spanish ____ Indian ___ Other _____

Employer: _____ **Work Phone:** ( ) _____

Who may we thank for referring you? _____

Primary Care Physician: _____ **Phone:** ( ) _____

Office Location: _____ **City:** _____ **State:** ____ **Zip:** _____

Person to contact in case of emergency: _____

Phone: ( ) _____**Alt Phone:** ( ) _____**Relationship:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Pharmacy Name: _____ **Location:** _____

Pharmacy Phone: ( ) _____

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Responsible Party

Name: _____ **Relationship to patient:** _____

Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Employer: _____ **Work Phone:** ( ) _____ **Date of Birth:** _____

Is this person currently a patient at our office? YES / NO

Primary Insurance Information

Name of Insurance: _____ **ID#:** _____

Name of Insured: _____ **Relationship to patient:** _____

Date of Birth: _____ **SSN#:** _____ **Employer:** _____

Employer Address: _____ **City:** _____ **State:** ____ **Zip:** _____

Secondary Insurance Information

Name of Insurance: _____ **ID#:** _____

Name of Insured: _____ **Relationship to patient:** _____

Date of Birth: _____ **SSN#:** _____ **Employer:** _____

Employer Address: _____ **City:** _____ **State:** ____ **Zip:** _____

I authorize the release of any information concerning my (or my child's or guardian's) healthcare, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me, directly to my doctor.

Patient Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

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Date: _____ **Patient Name:** _____

Reason for visit: _____

Please take a few minutes to complete the following questions about symptoms you may be having. This will become part of your permanent medical record. Thank you!

System Review	Questions-Do you have the following?	No	Yes	Comments
Constitutional	Fever	○	○	
	Loss of Appetite	○	○	
	Weakness	○	○	
	Weight gain or loss	○	○	
Eyes	Blurred Vision	○	○	
	Double Vision	○	○	
Ear, Nose Throat	Hoarseness	○	○	
	Nosebleeds	○	○	
Cardiovascular	Chest Pain	○	○	
	Difficulty climbing stairs	○	○	
	Dizziness	○	○	
	Leg swelling	○	○	
	Pain in the legs when walking	○	○	
	Palpitations	○	○	
	Passing out spells	○	○	
	Shortness of breath	○	○	
Respiratory	Asthma/Wheezing	○	○	
	Cough with or without phlegm	○	○	
	Shortness of breath while walking	○	○	
	Spitting up blood	○	○	
Gastrointestinal	Blood in stool	○	○	
	Constipation/Diarrhea	○	○	
Genitourinary	Frequent Urination	○	○	
	Impotent	○	○	
Musculoskeletal	Aching/sore muscles	○	○	
	Weakness	○	○	
Skin	Rash	○	○	
Neurologic	Tremor	○	○	
Psychiatric	Anxious	○	○	
Endocrine	Frequent urination/urination at night	○	○	
	Intolerance to heat or cold	○	○	
Hematologic	Bleed or bruise easily	○	○	
Allergy/Immunology	Frequent infections	○	○	
	Seasonal runny nose, cough, wheezing	○	○	

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Dear Patient,

In order to give you the highest quality of care, please take a few minutes to complete this section about your **PAST, FAMILY and SOCIAL MEDICAL HISTORY.** This will become part of your permanent medical records. Thank you!

Past Medical History: Please check each box if you have had the following problems:

- ❑ Angina
- ❑ Angioplasty
- ❑ Asthma
- ❑ Bypass
- ❑ Diabetes
- ❑ Dialysis
- ❑ Emphysema
- ❑ Heart Attack (MI)
- ❑ Hiatal Hernia
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Murmur
- ❑ Obesity
- ❑ Pacemaker
- ❑ Syncope (Pass Out)
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Ulcer/Gastritis
- ❑ Varicose Veins
- ❑ Other: _____ _____
- ❑ Surgeries: _____ _____

The following section is about your FAMILY'S MEDICAL HISTORY:

Mother Living Age _____ Deceased Age _____

- ❑ Angina
- ❑ Angioplasty
- ❑ Asthma
- ❑ Bypass
- ❑ Diabetes
- ❑ Dialysis
- ❑ Emphysema
- ❑ Heart Attack (MI)
- ❑ Hiatal Hernia
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Murmur
- ❑ Obesity
- ❑ Pacemaker
- ❑ Syncope (Pass Out)
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Ulcer/Gastritis
- ❑ Varicose Veins
- ❑ Other: _____ _____
- ❑ Surgeries: _____ _____

Father Living Age _____ Deceased Age _____

- ❑ Angina
- ❑ Angioplasty
- ❑ Asthma
- ❑ Bypass
- ❑ Diabetes
- ❑ Dialysis
- ❑ Emphysema
- ❑ Heart Attack (MI)
- ❑ Hiatal Hernia
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Murmur
- ❑ Obesity
- ❑ Pacemaker
- ❑ Syncope (Pass Out)
- ❑ Rheumatic Fever
- ❑ Stroke
- ❑ Ulcer/Gastritis

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Brother(s) Number Living _____ Number Deceased _____

Sister(s) Number Living _____ Number Deceased _____

❑ Angina	❑ Emphysema	❑ Obesity
❑ Angioplasty	❑ Heart Attack (MI)	❑ Pacemaker
❑ Asthma	❑ Hiatal Hernia	❑ Syncope (Pass Out)
❑ Bypass	❑ High Cholesterol	❑ Rheumatic Fever
❑ Diabetes	❑ Hypertension	❑ Stroke
❑ Dialysis	❑ Murmur	❑ Ulcer/Gastritis

The following section is about your SOCIAL HISTORY: (Check all boxes that pertain):

Marital Status: ○Married ○Divorced ○Single ○Separated ○Widowed

Occupation(s) Exposure to: ○Dust ○Asbestos ○Fumes ○Chemicals ○Other _____

Exercise type(s): _____ **Minutes:** _____ **Days per week:** _____

Do you smoke? ○Yes ○No ○Never **Packs per day** _____ **Years Quit** _____

Do you drink caffeinated beverages? ○Yes ○No **How much do you consume?** _____

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I understand that if I fail to cancel my scheduled appointment within 24 hours, I will be charged $50.00. I understand that Medicare and other insurance companies will not reimburse me for missed appointments. I understand that these charges are my full responsibility. By signing this I am agreeing to these terms.

Please initial _____

I understand that if my check is returned from the bank, for any reason, my account will be charged $35.00 in addition to the money owed.

Please initial _____

I understand that it is my responsibility to pay any co-pays, co-insurance and deductibles at time of service. If my account should become past due by **90 days**, I understand that the practice will charge a ***5%*** interest on these charges. I understand that Medicare and other insurance companies will not reimburse me for this interest. By signing this I am agreeing to these terms.

Please initial _____

I understand that if my insurance company requires that I need a referral for an office visit or procedure, I will provide RespaCare with a valid referral and make sure I have a valid referral at time of visit. I understand it is my responsibility to make sure I have a valid referral time of service and if I do not, I understand that my insurance company will not pay RespaCare and I will be fully responsible for the visit. By signing this I am agreeing to these terms.

Please initial _____

I understand that RespaCare will make every effort to explain the cost of a procedure or medication. It is my responsibility to be aware of my insurance company's reimbursement guidelines and acknowledge I am fully responsible for anything they will not cover. By signing this I am agreeing to these terms.

Please initial _____

I understand that you will contact me through the phone numbers that I have given to you and consent to the staff of RespaCare leaving messages on these numbers in regards to the treatment and/or payment.

Patient Name _____ Patient Signature _____
(Please Print)

Date _____

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Patient: _____ Birthdate: _____/_____/_____

Home Phone: ( ) _____ - _____ Work / Cell Phone: ( ) _____ - _____

Name of Pharmacy: _____ Pharmacy Phone: ( ) _____ - _____

MEDICATIONS

MEDICATION	DOSAGE	FREQUENCY (How often do you take it?)

Allergies: _____

_____

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Acknowledgement for the Use and Disclosure of Health Information

The department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for the uses and disclosure of health information about the patient to carry out treatment, payment, or health care operations.

As our patients, we want you to know that we will respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We make every effort to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the **minimum necessary information** to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

I, _____, have full opportunity to read and consider the
(Please Print Name Here)

contents of **RESPACARE** Notice of Privacy Practices. I understand that, by signing this form, I am acknowledging the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: _____ **Date**: _____

If a personal representative on behalf of the patient is signing this acknowledgement, complete the following:

Personal Representative's Name: _____

Relationship to patient: _____

Note: Anyone wishing a copy of Section 1 "Uses and Disclosures of HIPPA", please advise the receptionist.

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PERMISSIONS

A) I hereby give permission for **RESPACARE** to release information about my health or have the doctor speak with:

_____ _____
Print Name Relationship to patient

_____ _____
Print Name Relationship to patient

B) In addition, messages pertaining to my treatment and appointments may be left on:

(Please check all that apply):

Home Phone _____

Cell Phone _____

Work Phone _____

_____ _____
Patient's Name (Please Print) Date of Birth

_____ _____
Patient's Signature Date