CHEST MEDICINE ASSOCIATES
The Pulmonary • Critical Care • Sleep Medicine Specialists

Welcome to Chest Medicine Associates

Chest Medicine Associates is a medical practice devoted to specialty care in Pulmonary, Critical Care and Sleep Medicine. Our physicians and staff are committed to providing exceptional quality care, prompt medical attention, and a personalized approach to health care problems. Our physicians and advanced practice providers are trained to prevent, diagnose, and treat lung diseases and sleep disorders.

We welcome you to our practice and are pleased that you and your referring physician have chosen Chest Medicine Associates for your medical care.

_____ has requested a consultation

appointment for you at our office for your pulmonary / sleep care.

Your appointment is scheduled for:

A questionnaire about your health and medical history is enclosed. Please complete and return it to our office as soon as possible. You can mail the completed questionnaire in the enclosed addressed envelope. Or, if you prefer, you can fax it to us at 207-828-0188. **It needs to be returned at least 3 business days prior to your appointment or you may have to reschedule your visit.**

If you would like to learn more about our practice, please visit our website at **www.cmamaine.com**.

If you have any questions or need to change the scheduled appointment, please call our office at 207-828-1122.

Thank you again for choosing us to provide your care.

Sincerely,

Chest Medicine Associates

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Directions to Chest Medicine Associates

100 Foden Road, West Building, Suite 103
South Portland, Maine 04106

Free parking is available on-site.

FROM THE MAINE TURNPIKE, NORTH OR SOUTH – Toll Road (95)
Take Exit 46 toward ME-22/ME-9/Jetport/Congress St. Turn right toward Johnson Rd/ME-9 West. Turn right at Johnson Rd/ME-9 West. Continue straight for 0.9 miles and at the third light turn right onto Foden Road. After driving a short distance turn left into 100 Foden Road.

FROM CUMBERLAND FORESIDE – Interstate (295)
Head south on Foreside Road/State Route 88. Bear right at Kings Highway and take first right towards US-1 South. After half a mile, turn left at US-1 South. Follow road until it merges with I-295 South. Once on I-295 South, take exit 3 for ME-9/Westbrook Street. Turn right onto Westbrook Street. At second light, turn right onto Western Avenue. Once on Western Avenue, at the first light, take a left onto Foden Road. 100 Foden Road will be on your left.

FROM BUXTON
Head southeast on Long Plains Road/ME-22. Turn slight left onto Portland Road/ME-22 and follow for approximately eight miles. Turn right onto Skyway Drive. Follow for approximately half a mile and turn right onto Western Avenue. Follow this road for approximately one mile, and turn right onto Foden Road. 100 Foden Road will be on your left.

FROM MAINE MEDICAL CENTER (BRAMHALL STREET) – Interstate (295)
Head northeast on Bramhall Street toward Hill Street. Turn left onto Congress Street. After half a mile, turn right at St. John Street. Turn left onto Park Avenue. Take slight right to merge onto I-295 South/US-1 South toward South Portland. Follow this road for two miles. Take exit 3 for ME-9/Westbrook Street. Turn right onto Westbrook Street. At second light, turn right onto Western Avenue. Once on Western Avenue, at the first light, take a left onto Foden Road. 100 Foden Road will be on your left.

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PATIENT REGISTRATION

Full Name: _____

Male: ☐ Female: ☐ Date of Birth: _____/_____/_____ Age: _____

Address: _____

City/Town: _____ State: _____ Zip Code: _____

Home Telephone: _____ Cell Phone: _____

Email: _____ Social Security Number: XXX-XX-_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other

Race: ☐ African American ☐ Asian ☐ Indian ☐ Native American

☐ Caucasian (White) ☐ Other _____

Language: ☐ English ☐ Other _____ Interpreter Needed? ☐ Yes ☐ No

Primary Care Physician: _____ Telephone: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

Is your visit covered under Workman's Compensation? ☐ Yes ☐ No

Pharmacy _____Address_____

Emergency Contact: _____ Relationship: _____ Phone:_____

I give permission for_____to receive/discuss information regarding my care with Chest Medicine Associates medical staff.

I acknowledge receipt of the Notice of Privacy Practices prepared by Chest Medicine Associates. Also, I acknowledge that I have had an opportunity to ask questions about the practice's Notice of Privacy Practices (See Pamphlet Enclosed).

_____ _____

Patient Signature Date

100 Foden Road, West Building, Suite 103, South Portland, ME 04106-2351 • Telephone 207.828.1122 • Facsimile 207.828.0188
www.cmamaine.com

CHEST MEDICINE ASSOCIATES
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Financial Policy

We are committed to providing you with the best possible medical care. If you have special needs, we will work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services rendered to you.

- Bring your insurance card(s) at every visit.
- ***Be prepared to pay your copay and any outstanding balance at each visit.*** Payment may be made by cash, check, debit card, Visa, Master Card, Discover or American Express.
- ***Self-pay patients will be expected to bring $100.00 to their initial appointment for a Consultation Visit or a Pulmonary Function Test.*** If you do not have insurance, you will be asked to make payment arrangements for the balance.
- If you have insurance in which we do not participate, our office will file the claim on your behalf. ***It is your responsibility to verify provider's participation status with your insurance company's member services department (number is on your insurance card).***
- If you are unable to pay for necessary medical care, you may be eligible for financial assistance. It is your responsibility to inform us prior to the visit.
- It is your responsibility to bring any required referrals for treatment ***at, or prior to, the visit***. If you do not have the referral, you may be financially responsible.
- If the patient is a minor (less than 18 years old), the parent or guardian must sign below. The parent, guardian, or unaccompanied minor is responsible for any payment due at the time of service and should bring the necessary referrals and insurance card.

If you have questions about your insurance, we are happy to assist you. Specific coverage issues, however, should be directed to your insurance company's member services department (number is on your insurance card.) **It is the patient's responsibility to verify if there are any benefit or pre-existing exclusions on their policy.**

If you ever need to cancel or reschedule an appointment, we ask that you kindly notify us at least 24 hours before your appointment so that we may offer the appointment to someone else who needs our services.

If you do not show up for your appointment without providing at least 24 hours' notice, you will be charged the following fees (exceptions for extenuating circumstances may be made at our discretion):

Sleep study: $250
Consultation Visit or Pulmonary Function Test: $50
Behavioral Sleep Medicine Services $50

We will assess a $25.00 service fee for any checks returned unpaid. If your payment is not received within 30 days of the statement date, your account will be considered delinquent. If your account is delinquent, we will turn your account over to a collection agency and may list your default with credit reporting agencies.

Our practice firmly believes that a strong physician/patient relationship is based upon understanding and good communication. Questions about financial arrangements should be directed to the Chest Medicine Associates Business Office at 207.828.0493.

I have read the above Financial Policy and agree to its terms.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Printed Name Date of Birth

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Last Name:	**First Name:**
Date of Birth:	

Reason for Visit: _____

Do you have any of the following symptoms? Please check (√) NO or YES:

Constitutional
Chills ___NO ___YES
Fatigue ___NO ___YES
Fevers ___NO ___YES
Insomnia ___NO ___YES
Night sweats ___NO ___YES

Eyes/Ears/Nose/Throat/Mouth
Itchy eyes ___NO ___YES
Watery eyes ___NO ___YES
Nasal congestion ___NO ___YES
Frequent sneezing ___NO ___YES
Hoarseness ___NO ___YES
Post nasal drip ___NO ___YES
Snoring ___NO ___YES

Respiratory/Lungs
Cough ___NO ___YES
Shortness of breath ___NO ___YES
Coughing up blood ___NO ___YES
Sharp pain w/ breathing ___NO ___YES
Coughing up mucus ___NO ___YES
Wheezing ___NO ___YES
Tuberculosis exposure ___NO ___YES
Positive TB skin test ___NO ___YES

Cardiovascular/Heart
Chest pressure/pain ___NO ___YES
Swelling in legs/feet ___NO ___YES
Short of breath lying flat ___NO ___YES
Palpitations ___NO ___YES

Gastrointestinal
Trouble swallowing ___NO ___YES
Heartburn ___NO ___YES
Reflux ___NO ___YES

Genitourinary
Blood in urine ___NO ___YES
Night time urination ___NO ___YES

Metabolic/Endocrine
Recent weight gain ___NO ___YES
Amount ____ pounds
Recent weight loss ___NO ___YES
Amount ____ pounds

Neurologic/Psychiatric
Morning Headaches ___NO ___YES
Memory problems ___NO ___YES
Difficulty concentrating ___NO ___YES
Anxiety ___NO ___YES
Depression ___NO ___YES
Sleep disturbance ___NO ___YES

Skin
Rash ___NO ___YES
Itching ___NO ___YES

Musculoskeletal
Joint pain ___NO ___YES
Joint swelling ___NO ___YES
Muscle aches ___NO ___YES
Muscle weakness ___NO ___YES

Hematologic
Easy bleeding ___NO ___YES
Easy bruising ___NO ___YES

Immunology
Hay fever ___NO ___YES
Hives ___NO ___YES

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Allergies

Drug/Food/Environment	Type of Reaction

Prescription Medications

Drug	Dosage Strength	Frequency

Non-Prescription/Over the Counter (OTC) Medications/Herbal Remedies/Vitamins

Drug	Dosage Strength	Frequency

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Personal and Family Histories: Please check (√) all that apply

	Self	Family		Self	Family
Anemia			High cholesterol		
Asthma			HIV		
Cancer Type:			Hypertension		
COPD (chronic bronchitis or emphysema)			Collapsed Lung (pneumothorax)		
Cystic Fibrosis			Pulmonary embolism		
Depression/Anxiety			Pulmonary fibrosis		
Diabetes			Pulmonary hypertension		
Heartburn/Reflux			Sarcoidosis		
Heart disease			Seizures		
Heart failure			Sleep apnea		
Heart valve problem Type:			Stroke		
			Tuberculosis		
Other:					

Surgical History

Please list any surgeries or procedures that you have had:

_____
_____
_____
_____

Social History

Occupation: _____

Previous or Current Occupational Hazards:
___None known ___Dust ___Asbestos ___Toxic fumes
___Toxic chemicals Other: _____

Marital Status: _____
Smoking Status:
___ Never ___ Current Smoker ___ Former Smoker
_____ Packs per day _____ Packs per day Year quit _____
_____ Years smoked _____ Years smoked

Alcohol use: Type: _____ Average # drinks /week _____
___NO ___YES

Caffeine use: Daily amount:_____
___NO ___YES

Please check the type of heating system in your home:

___ Electric baseboard
___ Hot water baseboard
___ Radiant
___ Forced hot air
___ Kerosene Monitor
___ Wood stove

Other: _____

Do you exercise on a regular basis? ___NO ___YES Type: _____

Pets in home:

___ None
___ Bird
___ Rodents
___ Farm Animals
___ Dog
___ Cat

Current Recreational Drug Use:

___NO ___YES Type: _____

Advanced Directives

___ None ___ Living Will ___ DNR ___Other Directive

Heath Care Proxy: _____
Relationship: _____
Phone Number: ( ) _____
Address: _____
_____
_____

Patient Signature: _____ **Date**:_____

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Epworth Sleep Score

How likely are you to fall asleep or doze off in the following situations? Even if you have not done some of these things recently, try to estimate how they would affect you.

Please place a check ☑ in the appropriate box.

	Never	Sometime	Usually	Almost Always
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (like a movie or meeting)				
As a passenger in a car for an hour without a break				
Lying down to rest in the afternoon				
Sitting and talking with someone				
Sitting quietly after lunch (without alcohol)				
In a car while stopped for a few minutes in traffic				

Name:_____ Date:_____

NOTICE OF PATIENT PRIVACY PRACTICES

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.

Each time you visit a healthcare provider, a record of your care and treatment is made and kept. Typically this record (called "protected health information") contains your name, address and phone number, along with your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This Notice applies to all of the records of your care generated by your health care provider. You have a right to a paper copy of this Notice of Privacy Practices.

Our Responsibilities

We at Chest Medicine Associates take the protection of your personal information seriously. We are required to provide you with this Notice of Privacy Practices to tell you about our legal duties and ways we may use and share your information, and to inform you about your rights regarding your health information. We give a small number of examples to describe what the categories mean, but not every use or disclosure can be listed on this Notice.

We will ask you to sign a written acknowledgment of receipt of our Notice. We reserve the right to change the terms of this Notice and post the current Notice in our office and on our website at www.cmamaine.com. You may obtain an updated Notice from our practice at any time.

If you have any questions about this Notice, please contact our Privacy Officer at 207-828-1122.

How We May Use and Disclose Protected Health Information

For Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and related services in our office or with a third party. For example, we may share your protected health information with a pharmacy for filling prescriptions, a laboratory or imaging center if you need diagnostic services, with another physician to whom we refer you, or with a home health agency that provides care to you. We may share information with family members or close friends if they are involved in your care.

For Payment

We will use your protected health information to get paid for your healthcare services. We may share information with your insurance company, or Medicare or Medicaid, to obtain payment for services or to seek pre-approval for a hospital stay or procedures.

For Healthcare or Business Operations

We may disclose your protected health information to support the business activities of this office, such as reviewing our care and our employees, for education and training, for licensing, to support our electronic health record system, or for legal or accounting matters. We may use a sign-in sheet at the registration desk, we may call you by name when we are ready to see you, and we may contact you to remind you of your appointment, which might include leaving a message on an answering machine. If we involve third parties, such as billing services, in our business activities, we will have them sign a "business associate agreement" obligating them to safeguard your protected health information according to the same legal standards we follow.

When Allowed by Law

The law allows us to use or disclose your protected health information in certain situations, including:

- When required by state or federal law;
- As needed in emergency situations, if you are incapacitated;
- To report abuse or neglect;
- To persons authorized by law to act on your behalf, such as a guardian, health care power of attorney or surrogate;
- For disaster relief purposes, such as to notify family about your whereabouts and condition;
- For public health activities such as reporting on or preventing certain diseases;
- To comply with Food and Drug Administration requirements;
- For health oversight purposes such as reporting to Medicare, Medicaid or licensing audits, investigations or inspections;
- Where required by U.S. Department of Health and Human Services to determine our compliance;
- In connection with Workers' Compensation claims for benefits;
- To assist medical examiners, coroners or funeral directors in carrying out their duties;
- To comply with a valid court order, subpoena or other appropriate administrative or legal request, for example if you are involved in a lawsuit or to assist law enforcement where there was a possible crime on the premises. We may also share your information where necessary to prevent or lessen a serious or imminent threat to you or another;
- For medical or scientific research, if the researchers have protocols to ensure your privacy;
- If you are an inmate, we may release your information for your health or safety in the correctional facility;
- We may share your information with appropriate military entities if you are a member or veteran of the armed forces;
- We may be required to disclose information for national security or intelligence purposes.

With your Authorization

Other uses and disclosures will be made only with your written authorization limited to a certain timeframe. For example, we will ask for your written permission before promoting a product or service to you for which we will be paid by a company, and generally before sharing your health information in a way that is considered a sale under the law. If you sign an authorization, you may revoke it at any time, except where we have already shared your information based upon your permission.

Future communications

We may communicate with you via newsletters, mailings or other means regarding treatment options, information on health-related benefits or services, to remind you of an appointment, or other community based activities in which our facility is participating. If you do not wish to receive these materials, please contact our privacy officer.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information.

- This usually includes medical and billing records. You must submit a written request to us, and you agree to pay the reasonable costs associated with complying with your request before we provide you with your record;

- You may ask us to provide your electronic record in electronic format. If we are unable to provide your record in the format you request, we will provide the record in a form that works for you and our office. You may ask us to transmit your record to a specific person or entity by making a written, signed request.

- Under certain circumstances, for example if disclosure might endanger your or another person's health or safety, your provider may not allow you to see or access certain parts of your record. You may ask that this decision be reviewed by a different licensed professional.

You have the right to request to receive confidential communications and request contact from us by alternative means or at an alternative location. For example, you can ask that we use a different address for billing purposes. Please make such a request in writing.

You have the right to request a restriction of your protected health information.

- This means you may ask us not to use or disclose all or part of your protected health information for certain purposes. We will consider your request carefully, and may honor reasonable requests where possible. We ask that you make this request in writing. The law does not require us to agree to every request;

- If you wish to restrict certain sensitive or other health information from your insurer after you or your personal representative have paid out of pocket in full for your services, please discuss this request with us. We will honor your request where we are not required by law to make the disclosure. If your insurance plan "bundles" your services together so that we cannot withhold only one item or service from your claim, we will discuss your options with you.

- You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to receive an accounting of certain disclosures we have made of your protected health information. Please speak with us if you have this request. Please note that we cannot take back any disclosures already made, and we are required to keep our records of your care.

You have the right to request amendment of your protected health information. While we cannot erase your record, we may add your or our written statement to your record to correct or clarify the record where your provider approves. If the provider disapproves, you may submit a statement of disagreement which we must place in your record, and we may submit a rebuttal, which will remain with your record.

Breach notification. We are required to have safeguards in place that protect your health information. In the event that there is a breach of those protections, we will notify you, the U.S. Department of Health and Human Services and others, as the law requires.

You may file a complaint with us by notifying our Privacy Officer with your written complaint. We will not retaliate against you for filing a complaint with us or the Office of Civil Rights.

You may complain to the Office of Civil Rights at the Department of Health and Human Services (OCR) if you believe your privacy rights have been violated by us. You should contact the OCR in writing at:

http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

CHEST MEDICINE ASSOCIATES
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Health Insurance Portability and Accountability Act of 1996

Notice of Privacy Practices

Effective April 14, 2003
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