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

Welcome to Chest Medicine Associates via Telehealth

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, for your pulmonary care.

Your appointment is scheduled at the William L. Medd Health Center (8 Pikes Hill Norway, Maine 04268) 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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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

CHEST MEDICINE ASSOCIATES
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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
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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	*Sometimes*	*Usually*	*Almost Always*
Sitting and reading				
Watching TV				
Sitting quietly after lunch (without alcohol)				
Sitting and talking with someone				
Sitting, inactive in a public place (like a movie or meeting)				
As a passenger in a car for an hour without a break				
In a car, as the driver, stopped for a few minutes in traffic				
Lying down to rest in the afternoon				

Name: _____ *Date:* _____

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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, Celeste Sartor, 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

Privacy Officer: Celeste Sartor (207) 828-1122 x156

CHEST MEDICINE ASSOCIATES
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Health Insurance Portability and Accountability Act of 1996

Notice of Privacy Practices

Effective April 14, 2003
Last Modified: June 14, 2016

100 Foden Road, West Building, Suite 103
South Portland, Maine 04106-2351

Telephone: (207)828-1122 Fax (207)828-0188

www.cmamaine.com

The following consent form is for your review only. You do not need to return this to Chest Medicine but will be signing a copy during your visit at Western Maine Health. This document needs to be signed in front of a witness. Thank you.

CONSENT
2 0 0 0

CONSENT TO PARTICIPATE IN A TELEMEDICINE CONSULTATION

PATIENT LABEL HERE

I. DESCRIPTION, PURPOSE AND BENEFITS OF PROCEDURE

I have been informed that video conferencing equipment will be used to provide a physician consultation via asynchronous store-and-forward technologies, remote monitoring, and/or real-time interactive services. I also have been informed that the consultation will not be the same as a direct patient encounter due to the fact that I will not be in the same room as my telehealth consulting physician. I understand that I will undergo a physical examination by a nurse, physician's assistant or another licensed clinician at the local site who will present his or her findings to the physician providing the telehealth consultation and that I will have an opportunity to speak with the physician and ask questions.

I understand that individuals other than my healthcare providers may be present during the telehealth consultation in order to operate the video conferencing equipment, and that my protected healthcare information also may be shared for scheduling and billing purposes. I further understand that I will be informed of the presence of any non-medical personnel in the consultation area and will have the right to request the following: (i) omit specific details of my medical history/physical examination that are personally sensitive to me if the non-medical personnel need to remain in the consultation area; (ii) ask non-medical personnel to leave the consultation area; and/or (iii) terminate the telehealth consultation at any time.

In electing to participate in a telemedicine consultation, I understand that some parts of the examination involving physical tests may be conducted by clinicians at my location at the direction of the consulting telehealth physician. In an emergent consultation, I understand that the responsibility of the telemedicine consulting physician is to serve as a consultant to my local practitioner and that the consulting physician's responsibility for my medical care will conclude upon the termination of the video conference connection. I further understand that either my health care provider(s) or I can discontinue the telehealth consultation at any time if it is determined that the videoconferencing connections are not adequate to assess my particular medical situation in which case I will be referred to another healthcare provider for an in-person evaluation.

II. LIMITATIONS AND RISKS ASSOCIATED WITH THE TELEHEALTH CONSULT

I understand that certain limitations exist with a telehealth consultation including a provider's ability to perform a comprehensive physical assessment and certain diagnostic tests, as well as to obtain and transmit certain clinical findings via video/audio. I further understand that telehealth is not suitable to provide a diagnosis and treatment plan for every medical condition. Additionally, the treatment of certain medical conditions may require the use of equipment not available in a telehealth consultation. For these reasons, my particular medical needs may require a face-to-face encounter with a clinician. The physician performing the telehealth consultation or designee will inform me whether a telehealth consultation is sufficient to render a diagnosis, or if further evaluation of my medical condition is needed, and whether treatment can be rendered via this modality. If I believe that I am in need of emergency treatment, then I understand that I should call 911 or visit an Emergency Department. I also have been informed that certain medications such as narcotics cannot be prescribed during a telehealth encounter.

The physician performing the telehealth consultation or designee also has explained to me that the usual and most frequent risks and hazards associated with this type of consultation include interruptions to Internet access and/or technical difficulties which may affect the clinical information obtained and transmitted or prematurely end the consultation; and unauthorized access to the videoconferencing equipment which may result in a breach of my protected health information.

PATIENT LABEL HERE

III. ALTERNATIVE COURSES OF TREATMENT

The physician performing this telehealth consultation or designee has explained to me the reasonable alternative treatment or procedures and, as appropriate their usual and most frequent risks and hazards. I understand that the alternative to a telemedicine consultation is a visit to another healthcare provider for an in-person evaluation, diagnosis and treatment which may not occur as quickly as a telehealth consultation can be performed.

IV. BILLING FOR THE TELEHEALTH CONSULT

I understand that billing for this telehealth encounter will consist of both a consulting fee from the physician performing the telehealth consultation and a facility fee from the site from which I am presented for the consultation, and that billing statements will be mailed to me following the telehealth consultation. I further understand that a co-payment is due at the time of the encounter if I am insured with a commercial payor. If I am eligible for MaineCare benefits and choose not to see a healthcare provider via a telehealth consultation, then I understand that MaineCare will pay for my transportation to MaineCare Covered Services as detailed in Section 113 of the MaineCare Benefits Manual (Non-Emergency Transportation Services).

I understand that I have the right to refuse any suggested procedures or treatment. I further understand that the practice of medicine is not an exact science, and practitioners cannot guarantee results. No guarantees have been made to me concerning the results of the proposed telehealth consultation.

I acknowledge that I have read this document carefully, that I understand the limited nature, benefits, risks and alternatives to this telehealth consultation, and that I have had ample time to ask questions and to consider my decision. I hereby consent to participate in the telehealth services described herein for purposes of examination, consultation, diagnosis and treatment.

X _____ AM|PM _____ X _____

Signature of ❑ Patient ❑ Parent ❑ Guardian ❑ Authorized Representative | Date| Time | Witness Signature

Printed name of person signing on behalf of the patient: _____ Patient is a ❑ Minor or _____

Consent given by telephone ❑ Patient ❑ Other _____ Telephone #_____

Printed name of interpreter _____ Reason ❑ Sign ❑ Language ❑ Other _____

X _____ _____ _____

Signature of Physician or Designee | Date| Time | Printed Name

TO BE COMPLETED BY PROVIDER:

Verification of Patient Identity:

❑ State Driver's License ❑ State Identification Card ❑ School/College Identification Card ❑ Passport ❑ Other