Main Line Health
Well ahead.®

The Sleep Group
of Pulmonology Associates

Rochelle Goldberg, M.D., DABSM

Donald D. Peterson, M.D.
ABIM-Sleep

Lauren Rome, M.D., ABIM-Sleep

Eliot Friedman, M.D., ABIM-Sleep

Nicholas Panetta, M.D., FCCP

Nicole DeRose CRNP

Kimberly Nolan CRNP

Paoli Sleep Center
2 Industrial Blvd.
Suite 100
Paoli, PA 19301
484-565-1358
Fax: 484-565-1312

Lankenau Medical Ctr.
100 E Lancaster Ave.
Suite 108
Wynnewood, PA 19096
484-476-3444
Fax: 484-476-2291

Lawrence Park
Main Line Health Center
1991 Sproul Rd.
Suite 500
Broomall, PA 19008
484-476-3649
Fax: 610-325-1399

All centers accredited by the American Academy of Sleep

Dear Patient:

This letter will confirm your appointment on:
_____ at _____.

This appointment is for a consultation with the sleep physician. Please call and confirm 48 hours prior to appointment.

Enclosed you will find a questionnaire pertaining to your sleep habits and problems. Please complete this and bring it with you to your scheduled appointment. The information will be helpful to the doctor in determining a diagnosis.

Our Paoli Sleep Center is located on the side street of Paoli Hospital, at 2 Industrial Blvd., Suite 100.

At the Lankenau Medical Center, we are in Suite 108, in the South Medical Building. Park in Visitors Garage B and come through the breezeway into the building. You will see elevators on the left as you enter, (across from the Walgreens). Take the elevator to the 1st floor. When you exit the elevator, you will see a corridor directly ahead. Follow this corridor past the left turn, and you will come to our suite on the left.

Our Lawrence Park facility is in the Lawrence Park shopping center, 1991 Sproul Rd., Suite 500, Broomall PA. This is also Route 320.
We are in the Main Line Health Center, located on the left, as you enter the shopping center from Sproul Rd.

Please bring your health insurance cards, and I.D. with you to your appointment. We will bill your insurance carrier, however, you will be responsible for any remaining balance. We are contracted with most insurers. Patients are responsible to provide referrals for all HMO insurances, and all office co-pays are required at time of appointment. Cash, check and credit cards are accepted.

If you have any further questions, please call us at:
Paoli 484-565-1358
Lankenau Medical Center 484-476-3444
Lawrence Park 484-476-3649

Thank you.

PULMONOLOGY ASSOCIATES INC. PATIENT REGISTRATION FORM

PATIENT INFORMATION:

Last Name:_____ First: _____ Middle:_____

Address: _____ Apt:_____

City:_____ State:_____ Zip Code:_____

Home Phone #:_____ Work Phone #:_____ Cell #:_____

May We Leave a Message? Y or N Preference? Home/Work/Cell EMAIL_____

Social Sec #:_____Date of Birth:_____ Sex: Male or Female

Marital Status: Single Married Divorced Widowed Spouses Name:_____

Race: American Indian Asian African American Native Hawaiian White Other _____

Ethnicity: Hispanic/Latin Not Hispanic/Latino Other _____ **Preferred Language:** _____

INSURANCE INFORMATION:

Insurance Co: _____Policy #:_____Group #: _____

Subscriber Information (if different from patient):

Name:_____ Social Sec #: _____

Date of Birth: _____ Relationship to Patient:_____

Second Insurance:_____ Policy#:_____Group#:_____

PATIENT EMPLOYMENT INFORMATION:

Employer: _____ Occupation:_____

Address, City, State:_____

IN CASE OF EMERGENCY, WHO SHOULD WE CONTACT?

Name:_____Relationship: SP Parent Child Other

Address, City, State: _____

Home Phone #:_____ Work Phone #:_____ Cell #:_____

FAMILY PHYSICIAN: _____

Address, City, State _____Phone#_____

REFERRING PHYSICIAN: _____

Address, City, State_____Phone#_____

PHARMACY INFORMATION:

Local Pharmacy :_____ Phone #: _____

Address, City, State: _____

Mail Order Pharmacy :_____ Phone #: _____

Address, City, State: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize Pulmonology Associates, Inc. to furnish information to insurance carriers concerning my illness and treatments and I hereby assign to the physicians all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any deductibles or co-insurance payments and non-covered services.

_____ _____

Patient or Guardian Signature Date

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Name: _____ Date of Birth: _____

Age: ____ Primary Care Provider/ Referring Provider: _____

Please tell us About Your Medical History:

Please check any medical problems you have:

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ COPD / Emphysema
- ☐ Depression / Anxiety
- ☐ Diabetes
- ☐ GERD/reflux
- ☐ Heart Disease
- ☐ Hypertension
- ☐ High Cholesterol
- ☐ Overweight
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Other (please list)

_____
_____
_____
_____

What Surgeries have you had? _____
_____

Please list any Allergies to Medication: _____

Please list all your Medications and Doses: _____
_____
_____
_____
_____
_____
_____
_____

Does anyone in your family have a sleep problem? If yes, who? _____
Other family medical history: _____
What is your current occupation? _____
Do you do shift work? If yes, what are your work hours? _____
Do you smoke ☐ No ☐ Yes - how much? _____ Have you ever smoked? ☐ No ☐ Yes
Do you drink alcohol? ☐ No ☐ Yes - how often do you drink? _____
Do you drink caffeinated beverages? ☐ No ☐ Yes

Name: _____

Please check any symptoms you currently have:

General:	☐ Weight gain ☐ Weight loss ☐ Fever ☐ Chills ☐ Fatigue ☐ Other:
Eyes:	☐ Itchy eyes ☐ Seeing spots/lines
Ears, Nose, Throat	☐ Sore throat ☐ Nasal congestion ☐ Other:
Cardiovascular:	☐ Chest pains ☐ Palpitations ☐ Swelling in ankles or legs ☐ Other:
Respiratory:	☐ Wheezing ☐ Shortness of breath ☐ Cough ☐ Other:
Gastrointestinal:	☐ Heartburn ☐ Diarrhea ☐ Constipation ☐ Other:
Musculoskeletal:	☐ Joint pains ☐ Other:
Skin:	☐ New rash ☐ Other:
Neurologic:	☐ Headaches ☐ Dizziness ☐ Head injury ☐ Other:
Psychiatric:	☐ Depression ☐ Other:
Endocrine:	☐ Excessive thirst ☐ Excessive urination ☐ Other:
Heme/Lymph:	☐ Easy bruising ☐ Easy bleeding ☐ Other:
Allergy/Immuno:	☐ Allergies (seasonal/cats, etc.) ☐ Other:

In the following section we would like to find out more about your sleep. You may find it useful to ask your spouse/bed partner to help you out.

In your own words, please describe the sleep issue for which you seek attention today:

_____

_____

_____

_____

_____

_____

How long have you had this problem? _____

What time you typically go to bed? _____

How long does it take for you to fall asleep? _____

Do you wake up during the night? ☐ No ☐ Yes - how many times on average? _____

What wakes you up at night? _____

How many times do you use the bathroom at night? _____

What time do you usually get out of bed to start the day? _____

How many hours do you think you sleep? _____

Are you refreshed in the morning when you wake up? _____

How tall are you? _____ How much do you weigh now? _____

How much did you weigh 1 year ago? _____ 5 years ago? _____ 10 years ago? _____

Have you ever had an overnight sleep study? ☐ No ☐ Yes – when/where? _____

Do you sleep with oxygen, PAP or mouth appliances? ☐ No ☐ Yes – circle answer

Have you ever had snoring or sleep apnea surgery? ☐ No ☐ Yes _____

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Name: _____

Please Answer YES or NO to the following questions.

Do you snore? ☐ No ☐ Yes ☐ Don't Know

Do you stop breathing or choke in your sleep? ☐ No ☐ Yes ☐ Don't Know

Do you find it difficult to wake up in the morning? ☐ No ☐ Yes

Do you get sleepy during the day? ☐ No ☐ Yes

Do you usually nap during the day? ☐ No ☐ Yes

Do you have morning headaches? ☐ No ☐ Yes

Do you have dry mouth during the night or at wake? ☐ No ☐ Yes

Do you fall asleep at inappropriate times during the day, such as while driving, watching TV, or talking to another person? ☐ No ☐ Yes

Do you often have difficulty falling asleep? ☐ No ☐ Yes

Do you get discomfort, or urge to move your legs when trying to sleep? ☐ No ☐ Yes

Do you kick your legs at night? ☐ No ☐ Yes

Do you walk or talk during your sleep? ☐ No ☐ Yes

Do you grind your teeth during sleep? ☐ No ☐ Yes

Do you frequently have disturbing dreams? ☐ No ☐ Yes

Do you ever "act out" your dreams during sleep? ☐ No ☐ Yes

Have you ever felt paralyzed while falling asleep or waking up? ☐ No ☐ Yes

Have you ever felt muscle weakness with strong emotions such as laughing or anger? ☐ No ☐ Yes

Have you ever thought you were dreaming, or seen things in the room as you were falling asleep.? ☐ No ☐ Yes

Any other comments: _____

_____

_____

Epworth Sleepiness Scale

Patient Name: _____ **Today's Date:** _____

For each of the following scenarios, select the likelihood of your falling asleep:

0 = Would *never* doze off
1 = *Slight* chance of dozing
2 = *Moderate* chance of dozing
3 = *High chance* of dozing

Situation or Scenario	0	1	2	3
1. Sitting and reading	☐	☐	☐	☐
2. Watching TV	☐	☐	☐	☐
3. Sitting inactive in a public place (i.e. theater, meeting)	☐	☐	☐	☐
4. As a car passenger for an hour or without a break	☐	☐	☐	☐
5. Lying down to rest in the afternoon	☐	☐	☐	☐
6. Sitting and talking to someone	☐	☐	☐	☐
7. Sitting quietly after lunch (without alcohol)	☐	☐	☐	☐
8. In a car, while stopped in traffic	☐	☐	☐	☐

Total: _____ / 24

Please bring this questionnaire with you to your appointment. THANK YOU!

Request for Release of Medical/Psychological Information
(to request outside medical records to be released to your sleep specialist)

I, _____, _____
(name) (address)

authorize my private physicians
(name of the doctor or hospital)

to release my medical/psychological records, including history, recent examination, results of laboratory test, and diagnostic studies to:

Donald Peterson M.D., Rochelle Goldberg M.D., Lauren Rome M.D.,
Nicholas Panetta, MD and/or Eliot Friedman M.D.

OF

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Broomall, PA 19008
ph: 484-476-3649 fx: 610-325-1399

_____
(patient signature)

_____
(print name)

Authorization for Release of Medical/Psychological Information
(to request your medical records at MLH Sleep Centers to be released to your physicians)

I, _____, _____
(name) (address)

authorize,

Donald Peterson M.D., Rochelle Goldberg M.D., Lauren Rome M.D.,
Nicholas Panetta, MD and/or Eliot Friedman M.D.,

OF

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To release my medical evaluation in the above centers, including results of polysomnograms to:

My private physicians _____
(name of hospital or doctor)

_____
(patient signature)

_____
(print name)

PULMONOLOGY ASSOCIATES, INC.

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Pulmonology Associates, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The notice of Privacy Practices provided by DFP describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Pulmonology Associates, Inc. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Pulmonology Associates, Inc., 100 Lancaster Ave., Suite 230, Wynnewood, PA, 19096.

With this consent, Pulmonology Associates, Inc. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent Pulmonology Associates, Inc. may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential".

With this consent, Pulmonology Associates, Inc. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Pulmonology Associates, Inc. restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Pulmonology Associates, Inc. to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent or later revoke it, Pulmonology Associates, Inc. may decline to provide treatment to me.

Signed by:_____ _____

Signature of Patient or Legal Guardian — Print Name of Legal Guardian, if applicable

_____ _____

Print Patient's Name — Relationship to Patient

_____

Date

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received and understand Pulmonology Associates Inc. *Notice of Privacy Practices* containing a description of the uses and disclosures of my health information: I further understand that Pulmonology Associates Inc. may update *its Notice of Privacy Practices* at any time and that I may receive an updated copy of Pulmonology Associates Inc. *Notice of Privacy Practices* by submitting a request in writing for a current copy of Pulmonology Associates Inc. *Notice of Privacy Practices.*

_____

Printed Patient Name

_____ _____

Patient Signature Date

I permit the following to receive and give information on my behalf:

_____ _____

_____ _____

_____ _____

If completed by patient's personal representative, please print name and sign below.

_____ _____

Printed Patient Personal Representative Name Relationship to Patient

_____ _____

Patient Representative Signature Date

For Pulmonology Associates Official Use Only

Complete this form if unable to obtain signature of patient or patient's personal representative.

Pulmonology Associates Inc. made a good faith effort to obtain patient's written acknowledgement of the *Notice of Privacy Practices* but was unable to do so for the reasons documented below:

- ☐ Patient or patient's personal representative refused to sign
- ☐ Patient or patient's personal representative unable to sign
- ☐ Other: _____

_____ _____

Employee Printed Name Employee's signature

PULMONOLOGY ASSOCIATES PAYMENT POLICY

Thank you for choosing us as your care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of the claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

[redacted] Pulmonology Associates, Inc.

Pulmonary Medicine - Critical Care - Sleep Disorders Medicine

FORM FEE GUIDELINES

Pulmonology Associates, Inc charges a fee for the completion of any which requires medical information and/or a physician's signature.

The fees are as follows:

- Disability Paperwork: $30.00
- FMLA (Family Medical Leave Act) Forms: $30.00
- Workmen's Compensation Forms: $20.00
- Life Insurance Forms: $20.00
- Penndot Forms: $15.00
- PECO Forms: $15.00
- Forms for O2 on Airplane: $10.00
- Jury Duty Obligation: $10.00
- Miscellaneous Medical Forms $10.00

Pre-payment is requested in order for our office to mail the forms. There will be an additional .50 cents charge for postage and handling.

If the doctor feels it is necessary to obtain more information from the patient in order to complete the form, the patient many be required to make an appointment. If this is the case, we will contact you.

Pulmonology Associates, Inc requires at least 5 business days for the completion of any form. After this time, your form will be available for pick up at our front desk. If it is to be sooner, we will contact you.

If copies of your medical records are needed to complete this form, the Release of Information form must be completed.

Pulmonology Associates, Inc.

Pulmonary Medicine - Critical Care - Sleep Disorders Medicine

NO SHOW/CANCELLATION NOTICE

A NO-SHOW/CANCELLATION FEE OF $40 WILL BE BILLED TO YOU IF 48 HOURS NOTICE IS NOT GIVEN TO US PRIOR TO CANCELLATION OF YOUR APPOINTMENT.