GENERAL MEDICAL INFORMATION

Patient Name:_____

Please list respiratory or pulmonary issues you would like to address:_____

_____

❒ NO ❒ YES Do you have shortness of breath *(if yes, please specify)*: _____
If yes, also: How much can you walk (in terms of 1, 2 or 3 blocks, etc) _____

❒ NO ❒ YES Shortness of breath on lying flat. How many pillows do you use to sleep? _____

❒ NO ❒ YES Leg or ankle swelling Baseline weight _____ lbs

❒ NO ❒ YES Do you wheeze *(if yes, specify)*:❒ Morning ❒ Evening ❒ All day ❒ After food ❒ Nasal drip

❒ NO ❒ YES Do you have a cough *(if yes, specify)*: ❒ Dry ❒ Productive ❒ Blood ❒ After food ❒ Nasal drip

❒ NO ❒ YES Does something trigger above symptoms *(if yes, specify)*: _____

Write in type and year of any operation/surgery you have had *(use next page if needed)*:

_____

_____

_____

Mark all current medical illnesses you have:

❒ Afib/Lung or leg clot	❒ Heart burn/stomach	❒ Pacemaker/Stent/MI
❒ Anxiety/Depression	❒ High BP/Cholesterol	❒ Pulmonary Hypertension
❒ Cancer: _____	❒ Kidney issue: _____	❒ Seizure/Stroke/TIA
❒ COPD/Asthma	❒ Liver issue: _____	❒ Sleep apnea
❒ Diabetes/Thyroid	❒ Lung fibrosis/ILD or IPF	❒ Other: _____

Please list past and current occupations: _____

Any past exposure to toxic or industrial ages (dust, chemicals, etc.): _____ Please specify: _____

Any exposure to: ❒ Tuberculosis ❒ Asbestosis ❒ Lead ❒ Other: _____

Serious injuries or accidents with dates_____

Have you had a Bronchoscopy? Yes or No If yes, when? _____ Results: _____

Have you had an Echocardiogram? Yes or NO If yes, when? _____ Results: _____

Have you had a CT scan of Chest? Yes or No If yes, when? _____ Results: _____

List any additional health information you think we need to be aware of:

_____

_____

Are you under the care of a cardiologist (heart doctor)? ❑Yes ❑No Dr._____

Patient Name:_____

Are you under the care of any other specialists? ❑Yes ❑No Dr._____

Have you had the Flu vaccine for the current flu season? Yes or No Date:_____

Have you had a pneumonia vaccine after the age of 60? Yes / NO / N/A (please circle)

Do you have an Advanced Directive? **Yes or No** (circle)

Do you have instructions to: Do Not Intubate? **Yes or No**

Do you have instructions to: Do Not Resuscitate? **Yes or No**

Do you have a Power of Attorney for Medical Services? **Yes or No**

If Yes, who is your Medical Power of Attorney (Name/phone #/relationship)_____

Please provide documentation to the office of your Medical Power of Attorney

List ALL medications and dosage or write see attached list if you brought this with you (include sleeping pills and any mood meds)

ALLERGIES: Please list all medications (prescription & non) that you are allergic to, *including reaction*

Name of Drug or Allergen	**Reaction (rash/shortness of breath/anaphylaxis, etc.)**

Patient Name:_____

Allergies to the following:
❒Pollen ❒Grass ❒Mold ❒Dust ❒Hay ❒Weather ❒Perfumes ❒Animals: _____

Do you have any pets in your home? YES or NO If yes, please specify: _____

Tobacco:
Do you currently or have you in the past used:

Chewing tobacco: Yes or No

Smoking tobacco: Yes or No

Vape products: Yes or No

Illegal drug use: Yes or No

How many years of useage?_____ Year Quit:_____

Alcohol:
Do you currently or have you in the past drank alcohol? Yes or No (circle)

How often do you drink alcohol?_____# per day _____# per week _____#per month
_____# per year

Family History- Please specify if anyone had Asthma/sarcoidosis, etc.

Illness	Family Member(s)	Maternal/Paternal	Onset Age	Died at age…

Please print clearly so that we can process your information quickly and efficiently. Thank you!

Name *(First, M.I., Last)* _____

Date of Birth _____ Age _____ Male / Female Marital Status: S M W D

Address _____ City _____ State _____ Zip Code _____

Social Security # _____ Driver's License # _____

Home Phone: _____ Cell Phone: _____ Email: _____

Language spoken: _____ Race: _____ Ethnicity: _____

Employer _____ Phone _____

Employer Address _____

Primary Care Physician _____ Phone _____

Address:_____

Referring Physician_____ Phone _____

Address:_____

Emergency Contact#1_____relationship_____Phone _____

Emergency Contact#2_____relationship_____Phone _____

Pharmacy Name _____ City: _____ Phone _____

Preferred Hospital Name:_____ Phone _____

Address:_____

Preferred Imaging Facility Name:_____ Phone _____

Address:_____

Responsible Party(IF DIFFERENT FROM PATIENT)

Name _____ Relationship to Patient _____

Address_____

Phone Number _____ Date of Birth _____ Social Security # _____

Employer _____ Phone Number _____

Employer Address_____

Insurance Information
(or copy of insurance card)

Insurance Company _____ Phone Number _____

Address _____

Subscriber ID # _____ Group # _____

Insured's Name _____ Relationship to Patient: Self / Spouse / Dependent

Insured's Employer _____ Phone Number _____

Insured's Social Security # _____ Date of Birth _____ Male / Female

Secondary Insurance Information

Insurance Company _____ Phone Number _____

Subscriber ID # _____ Group # _____

Virtual Staff

**Our office utilizes a team of virtual staff members to assist in our overall operation and will participate in your care. You may be contacted by our virtual team for appointment information, medical care and billing purposes.
____**Initials**

Wait Times / Appointment Times

The goal of our practice is to provide the utmost in care and service. However, the nature of our practice sometimes creates unexpected delays depending on the level of care each of our patients require, thus delaying our patient appointments at times. Please accept our apology for any delays. We will give you the careful attention you deserve and should expect
____**Initials**

Providers & Schedules

Our office utilizes Physicians, Nurse Practitioners and Physician Assistants. You will not be assigned to one particular provider as all of our providers communicate and work together to see everyone. All patients are grouped into a particular clinic based off of your diagnosis and each of our providers see patients in all of the clinics. Our providers have specific training and specializes in all aspects of Pulmonology and Sleep Medicine. We strive to give you the best medical care and feel all of our Doctors, Nurse Practitioners and Physician Assistants are able to provide you the best care and services you deserve. I consent to seeing an APP (nurse practitioner or physician assistant.)
____**Initials**

Patient Name:_____

To help us provide you with timely and high-quality sleep care, please take a moment to review the following important forms you'll be filling out today. Completing these accurately and in full helps avoid any delays in your treatment.

☑ **1. Mask Selector for CPAP Machine**
This tool helps us determine the best-fitting and most comfortable mask style for you. A proper fit is essential for successful CPAP therapy.

☑ **2. Sleep Assessment Form**
This form helps our team evaluate your symptoms and schedule your overnight sleep study faster — ensuring no delay in getting the care you need.

☑ **3. Home Monitor Consent Form**
By signing this, you allow us to provide convenient, effective care from home. This consent is needed for at-home care to be provided.

☑ **4. Sleep Questionnaire & Epworth Sleepiness Scale**
These are **required by insurance** under CCM guidelines for scheduling any sleep study. Completing these forms ensures we can move forward without delay.

Thank you for your cooperation!
If you have any questions while filling out your paperwork, please don't hesitate to ask our staff for help.

Do you have any of the following Sleep Complaints?
(If minor patient who is providing this history/relationship_____)

❑Snoring ❑ Can't fall asleep
❑Stop breathing in my sleep ❑ Talk or walk in my sleep
❑ Sleepy during the day ❑Other: _____

1. What is your bedtime? _____ What time do you normally awaken? _____
   # of naps during the day: _____
   Weekend sleep time _____ Wake time on weekends _____ Do you shift work? _____
2. How long does it take to fall asleep? _____ Do you feel refreshed upon awakening? _____
3. On average how often do you awaken during the night? _____ Why? _____
4. Please list how many caffeinated drinks (including sodas) you take in a day: _____
5. How many cigarettes do you smoke? _____ Alcohol beverages? _____
6. Have you been diagnosed with sleep apnea before? _____ Where & when _____
   If yes, what was your CPAP pressure _____
7. Have you ever dozed off while driving _____
8. Have you ever had your tonsils/adenoids removed?_____
9. If you not had your tonsils/adenoids removed, have you had any infections?_____If so how many per year?_____

Patient Name:_____ Sleep Questionnaire

Please answer the following questions using this scale (consult bed partner if needed):

0= No or Never **1**= Rarely **2**= Sometimes **3**= Often **4**= Frequently **5**= Always

(please circle one)

Sleep Apnea:						
0	1	2	3	4	5	I have been told that I **snore/snort**.
0	1	2	3	4	5	I have been told that I **stop breathing** while asleep.
0	1	2	3	4	5	I awaken with a **dry mouth** in the morning.
0	1	2	3	4	5	I awaken with **headaches**.
0	1	2	3	4	5	I awaken during the night **choking or gasping** for air.
0	1	2	3	4	5	I feel **sleepy** during the day.
0	1	2	3	4	5	I have problems with my work because of **fatigue**.
0	1	2	3	4	5	I have to take naps during the day.
0	1	2	3	4	5	After naps in the day I **am fresh** or **not fresh**(circle relevant only)
Others:						
0	1	2	3	4	5	I **sleep talk**, **sleep walk**, **grind teeth**(circle relevant only)
0	1	2	3	4	5	I have been told I'm a **restless sleeper**.
0	1	2	3	4	5	I excessively **perspire** at night.
0	1	2	3	4	5	I awaken during the night with **heartburn**.
0	1	2	3	4	5	I have asthma/COPD/wheezing attacks during the night.
Insomnia:						
0	1	2	3	4	5	I have trouble **going** (or starting) to sleep at night.
0	1	2	3	4	5	I have trouble **staying or maintaining** sleep at night.
0	1	2	3	4	5	I awaken with feeling of **anxiety or fear**.
0	1	2	3	4	5	I **awaken in the morning**, long before I want to.
0	1	2	3	4	5	I cannot fall asleep because of pain.
Restless leg syndrome or Nocturnal Myoclonus:						
0	1	2	3	4	5	I have **aching or crawling sensations** in my legs.
0	1	2	3	4	5	I **stretch** my legs to relieve the aching/crawling sensations.
0	1	2	3	4	5	Symptoms worsen **during** the evening/night as compared to the day
0	1	2	3	4	5	I have been told I kick during the night.
0	1	2	3	4	5	I have **muscle tension** in my legs even when I'm relaxed.
0	1	2	3	4	5	I experience **leg pain** during the night.
0	1	2	3	4	5	I have been told parts of my body "**jerk**".
Sleep Behavior:						
0	1	2	3	4	5	I have been told that I "**act out my dreams**".
0	1	2	3	4	5	I have fallen asleep while **laughing** or **crying**.
0	1	2	3	4	5	When I **get angry** or **laugh** I feel like I am going limp or pass out
0	1	2	3	4	5	Sometimes I feel that I **cannot wake up** or **move from sleep**.
0	1	2	3	4	5	I have now, or in the past, had **seizures** in my sleep.
0	1	2	3	4	5	I have noticed **tongue bite** or **urination** in my sleep.

Patient Name:_____

Epworth Sleepiness Score (ESS)

Please use the following scale to choose the most appropriate number for each selection:

1= **slight chance** of dozing or sleeping **2**= **moderate chance** of dozing or sleeping **3**=**high chance** of dozing or sleeping

Situation	Chance of dozing or sleeping
Sitting and reading	1 2 3
Watching TV	1 2 3
Sitting inactive in a public place	1 2 3
Lying down in the afternoon	1 2 3
Sitting and talking to someone	1 2 3
Sitting quietly after lunch (no alcohol)	1 2 3
Stopping for a few minutes in traffic while driving	1 2 3
As a passenger in a car for an hour without a break	1 2 3

TOTAL _____/24
≥10 qualifies for further evaluation,
otherwise insurance may not approve

If your appointment is for sleep related issues please type in this URL and fill out the google form as well as the mask selector:

Sleep Google form: https://forms.gle/QaBedWXMn1214Kbz5

Mask Selector: https://mask-selector.sds.resmed.com/s?token=4091d8d9-a0b5-4e5a-96e5-7f63591f01b4

If you already own a sleep machine, please bring this with you to your first appointment.

Remote Patient Monitoring (RPM) Consent Form

(Pulmonary and Sleep Medicine)

Patient Name: _____
Date of Birth: _____

Introduction

You are being offered the opportunity to participate in Remote Patient Monitoring (RPM) for the management of your chronic medical condition(s), in compliance with Medicare and insurance guidelines. This service is provided to improve your medical condition, particularly in the areas of pulmonary and sleep medicine.

RPM Process

RPM involves the use of FDA-approved devices (if required) to monitor your physiological data remotely. This data is securely transmitted to our Electronic Medical Records (EMR) system and will be interpreted by qualified medical providers. The purpose of RPM is to help manage your condition more effectively by providing continuous monitoring and timely adjustments to your treatment.

Terms of Consent

- The use of RPM will be in selective cases where it is deemed appropriate for the management of your condition.
- You will be informed in detail about the specific process, equipment, and expectations.
- Your participation is voluntary, and you may opt out at any time by notifying your healthcare provider.

I understand that:

• I am the only person who should be using the remote monitoring equipment as instructed. I will not use the device for reasons other than my own personal health monitoring.

I understand that I can only participate in this program with one Medical Provider at a time.
• I will not tamper with the equipment.

I understand that I am responsible for any fees associated with misuse (damage) ,loss or failure to return the equipment.
• I understand the devices are only designed for the RPM program.

• The device is meant to collect Readings and transfer those readings to an online website. It is NOT AN EMERGENCY RESPONSE UNIT AND IS NOT MONITORED 24/7. Call 911 for immediate medical emergencies.

• I am aware my daily readings will be transmitted from the monitor to a website located at www.myhealthconnected.net in a safe and secure manner.

I can withdraw my consent to participate in this program, and revoke service at any time by returning the device.

Pulmonics Plus will securely and confidentially store my collected data, and record and store my readings into my Electronic Medical Record monthly.
• I will do my best to take my reading if needed and assist if required.

I am aware that a Remote Patient Monitoring Qualified Health Professional will only view my readings every 30 days, and that this program is NOT a 24/7 Monitoring Service. I will be contacted every 30 days, by phone, to review and discuss my results and progress.

I, have read and understood the information and consent to participate in the Remote Patient Monitoring program as stated above. I am aware that this consent is valid as long as I'm in possession of the RPM equipment/device.
By checking this box you wish to participate in the program ☐
By checking the box you are declining participation in the program ☐

Date: _____ (dd/mm/yyyy) Signature of Patient or Authorized Person _____

(Relationship of Authorized Person)_____

This form is to confirm your authorization to use or disclose your protected health information for a special purpose.

I, _____, give my authorization to use or disclose my protected health information to the following individual(s) or group(s).

This should be names of relatives or friends we may discuss your health issues with or contact when we are unable to reach you.

Name:_____ Cell/Phone:_____

Email:_____

Name:_____ Cell/Phone:_____

Email:_____

Name:_____ Cell/Phone:_____

I authorize **PULMONICS PLUS** or their representative to leave messages via the following methods of communication- home answering machine, work voice mail, cell phone, text message, and email. If you would not like for us to communicate with you via one of these methods then please list the method below:

_____

Please Mark your preferred method of contact (mark only one):
☐ Text
☐ Email
☐ Phone call

I understand that I may revoke this authorization at any time and understand this must be done in writing.

This authorization will end only upon written notice. You must make any additions or deletions from this list in writing.

Print name: _____

Signature: _____ Date: _____

This must be completed in order for ANY information to be disclosed to a spouse, family member, organization, or individual that assists you with your medical care, appointments, etc.

Patient Name: _____ Date of Birth: _____

Assignment of Insurance Benefits:
I hereby authorize direct payment of my insurance benefits to PULMONICS PLUS, or the physician individually, for services rendered to my dependents or me by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits, and whether or not the services I am to receive are covered benefits. I understand and agree that I will be responsible for any co-pay or balance due.

Medicare/Medicaid/Insurance Benefits:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my dependent's or my records that these programs may request. I hereby direct that payment of my dependent's or my authorized benefits be made directly to the PULMONICS PLUS, or the physician on my behalf.

Authorization to Release Non-Public Personal Information:
I certify that I have received and read a copy of the PULMONICS PLUS Patient Information Privacy Policy. I herby authorize PULMONICS PLUS, or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

Authorization to Mail, Call or Email:
I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize the PULMONICS PLUS staff, or my physician to mail, call, or email me with communications regarding my healthcare, including but not limited to appointments reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying PULMONICS PLUS to that effect in writing.

Lab/X-Ray/Diagnostic Services:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Financial Responsibility Agreement:
I understand and agree that I will be financially responsible for any charges that are considered the patient's responsbility per my insurance company or charges that the insurance company may deny. This includes medical service or visit, lab testing, and any other screening service or diagnostic ordered by the physician or staff. I understand and agree that it is my responsibility and the responsibility of the physician, or office, to know if my insurance will pay for medical service or visit. I understand and agree it is my responsibility to know if my insurance has any deductible, copayment, coinsurance, usual and customary limit and I agree to make full payment. I understand and agree it is my responsibility to know if the physician or provider I am seeing is contracted in-network with my insurance plan and if required by your insurance plan, that you have a valid referral from your insurance company or PCP's office. If the physician I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or higher out of pocket expense to me and I understand this and agree to be financially responsible to make full payment. I also understand that it is my responsibility to ensure that a valid prior authorization if required by my insurance, is obtained for any testing or procedures prior to the date of service and I agree to be financially responsible to make full payment. **A 3% convenience fee will be charged with all transactions when using a debit, credit card or check.**

No-Show, Cancellations and Rescheduling:
We understand that circumstances may arise that could affect your availability for your scheduled appointment. Missing your appointment without properly notifying the office, prevents another patient from receiving much needed care. Vice-versa, another patient's failure to notify the office to cancel an appointment may prevent you from being able to schedule a visit due to a seemingly full schedule. Due to the effect on all patients, a **no-show fee of $50 for office visits, $65.00 for testing appointments and $200 for sleep study appointments** may be charged to your account.

No-Show fee(s) are not covered by insurance companies and are the patient's responsibility.

I acknowledge that I have been informed of the no show fee policy and fees. I understand these fees are not covered under my insurance plan, and I will be held responsible.

Patient Signature: _____ Date: _____

Guarantor Signature: _____ Date: _____

(If different from patient)
Guarantor Name: _____

NOTICE OF PRIVACY PRACTICES

EFFECTIVE 5/11/2022

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Pulmonics Plus, including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care

D. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine or an email) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

E. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

F. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

G. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

H. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

I. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities

J. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below. If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law. In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing. We may deny your request. If we deny your request, we will notify you of that denial in writing.

C. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below. We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

V. CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

VI. COMPLAINTS

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number: Pulmonics Plus Attn: HIPAA Officer 141 RVG Pkwy, Ste 101; Waxahachie, TX 75165 972-923-8923. To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

Patient Name: _____(Please Print Name) Patient Date of Birth: _____

SIGNATURES:

Patient/Legal Representative:_____ Date:_____

If Legal Representative, relationship to Patient: _____

Witness (optional) : _____ Date:_____

Informed Consent to Telemedicine Consultation/Visitation/Follow Up

I have been asked by my healthcare provider to take part in telemedicine consultation with Pulmonics Plus and its physicians, physician assistants, nurse practitioners, associates and others deemed necessary to assist in my medical care through a telemedicine consult.

I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine consult is done through a two-way video link-up whereby the physician, other healthcare provider or other staff member at Pulmonics Plus can see and/or hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell: and it may not be equal to a face-to-face visit.
3. Since the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. Pulmonics Plus and affiliated telemedicine consultants cannot be responsible for advice, recommendations and/ or decisions based on incomplete or inaccurate information provided by me or others.
4. I can ask questions and seek clarification of the procedures and telemedicine technology.
5. I can ask that the telemedicine exam and/or video conference be stopped at any time.
6. I know that there are potential risks with the use of this technology. These include but are not limited to:
    - Interruption of the audio/video link
    - Disconnection of the audio/video link by either party accidentally or disruption/disconnection due to internet speed or outage.
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering

    If any of these risks occur, the visit may need to be stopped or switched to an audio only call.
7. The consultation may be viewed by medical and non-medical persons for evaluation, informational, research, education, quality, or technical purposes.
8. I understand the examination may be videotaped for internal quality review or as might be required by my health coverage plan, however the video images will only be used for those purposes unless further authorized below.
9. I will not receive any royalties or other compensation for taking part in this telemedicine consult or associated with any use by Pulmonics Plus.
10. I understand I can make a complaint to management at administrator@pulmonicsplus.com
11. The system that we will be used during the telemedicine visit is in compliance with HIPAA, however, it is your responsibility as the client to be in a private environment in order to ensure that your information, and the information of others during the visit, is protected.
12. It is strictly prohibited for any individual to **record the telehealth** visit in any fashion, sharing any client disclosures or information, taking photos or screen shots, or allowing nonapproved individuals to participate or have access to the visit. Failure to abide by these requirements can result in suspension or dismissal from the practice. Violations of HIPAA may result in litigation.
13. Any dispute arriving from the telemedicine consult will be resolved in Texas and that Texas law shall apply to all disputes or litigation.
14. **All follow up appointments will be performed using telemedicine consults unless otherwise specified by our providers.**

I, the undersigned patient, do hereby understand and consent to all of the above.
I certify that I have read this form or have had it read to me. I volunteer to participate in the telemedicine visits.

Printed Name:_____

Signature:_____ Date:_____

Patient Portal

We highly recommend that you set up access to your patient portal.

Statements with balances due are not mailed out and are posted to your patient portal instead.

It's quick and easy. You will receive an email notification when new information is posted to your portal.

You may log in on any computer or browser by typing in:
https://health.healow.com/pulmonicsplus
or download the Healow App and use Practice Code HGHIBD

Benefits of Patient Portal

*View upcoming and past appointments
*Message the office staff
*Request appointments
***Receive & Review statements with balances**
*View visit history
* Pay your bill online

User Name: your email address provided to the office **Your password** will be your last name & year of birth in the following the format of: LastnameYYYY

I acknowledge that I have received and reviewed information regarding my patient portal and the importance of accessing my portal.

This page is yours to keep

Pulmonics Plus Discounted Programs for Uninsured or High-Deductible Patients

Pulmonics Plus offers affordable programs for patients without insurance or with high-deductible plans to help with sleep and pulmonary care. By participating in these programs, patients can save hundreds or even thousands of dollars each year compared to traditional healthcare costs.

Sleep Dream Program - $1,100 (payment plans are available)

- Includes 1 virtual doctor visit, 1 home sleep study, 1 CPAP machine, and a virtual appointment for CPAP setup.
  Average Savings: Typically saves $2,000+ per year compared to standard pricing for CPAP machines and services.

Machine Madness Program - $900 (payment plans are available)

- Includes 1 CPAP machine, 1 mask, and a virtual appointment for CPAP setup.
  Average Savings: Typically saves $1,500+ per year compared to standard pricing for CPAP equipment and setup.

Pulmonary 12-Month Virtual Self Plan - $200 (payment plans are available)

- Includes up to 2 routine virtual or office visits, 2 sick visits, 1 spirometry test, and a discounted Pulmonary Function Test (PFT) for $100.
  Average Savings: Typically saves $1,000+ per year compared to standard pulmonary care costs.

Let Us Help You Sleep (Discounted or Free)

For those who earn less than $23,000 a year and don't have insurance:

- Free or discounted care, including routine office visits, sleep testing, a used CPAP machine, mask, and supplies.
  Average Savings: Potential savings of $2,500+ per year on sleep-related care.
-

Let Us Help You Breathe (Discounted or Free)

For those who earn less than $23,000 a year and don't have insurance:

- Free or discounted care, including routine office visits and pulmonary testing.
  Average Savings: Potential savings of $1,500+ per year on pulmonary care.

Eligibility for Free or Discounted Care
To qualify, you must be an established patient and provide last year's tax return, W-2, or Social Security Disability form for review.

For more information or to see if you qualify speak to one of our staff members or call 972-923-8923.

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