Northeastern Pulmonary Associates, LLC

Welcome!!!

Your physician has referred you to our office for a consultation. Please call us to schedule at 860-875-2444 for your new patient appointment if you have not made one already.

Enclosed you will find our New Patient Paperwork Packet. Includes our phone number, address, and directions to our office as well as all of our medical providers names. Please complete the paperwork to the best of your ability before your appointment. Completing paperwork prior to your appointment will most certainly shorten your appointment time here in the office. ***If you do not complete any of it, you will need to do so when you arrive, but you must arrive 15 minutes prior to your appointment time.*** *Arriving at your appointment time without the paperwork completed, will result in us rescheduling this appointment.* ***It takes far too long to do this paperwork when you arrive AT the scheduled time.***

If you wish to go to our website, you can meet our providers and staff there. You can also see what services we offer as well as make a payment, download test instructions and directions to our office. Visit: ***Https://NortheasternPulmonary.org*** *to view our website.*

*****All New Patient Appointments* ***MUST BE CONFIRMED BY THE PATIENT BY 3PM THE DAY PRIOR TO THEIR APPOINTMENT! FAILURE TO CALL BACK TO CONFIRM WILL RESULT IN CANCELLATION OF THIS APPOINTMENT!*** *We have too many NO SHOWS for our New Patient Appointments, which has prompted a change in how we schedule and confirm these hour-long appointments.* ***THEY MUST BE CONFIRMED.*** *If you do not speak with one of our office staff to confirm, please call the office back to speak with someone. Thank you for your understanding.*

Please be sure to bring all of your insurance cards and ID for your appointment. We look forward to meeting you!

~Northeastern Pulmonary Associates Staff~

Northeastern Pulmonary Associates, LLC

M. Saud Anwar, M.D, MPH FCCP Faustinus C. Onyirimba, M.D, FCCP
Saima Ansari, M.D Karen C. Halasan, M.D
Anasua Chakraborty, M.D
Milos Tomic, APRN

Your appointment is on _____, with Dr._____.
Please bring this completed paperwork, with your insurance cards(s) and photo I.D. Please come in 15 minutes before your appointment time so you can give everything to out receptionist.
Thank you and we look forward to helping you!!

*DIRECTIONS TO **VERNON** OFFICE*
27 Naek Road, Unit 2
Vernon, CT 06066

From the West:
Take route 84 East
Take exit 64/65 (Dual exit)
Take your 2nd right off exit onto Route 83 North (Talcottville Road)
Take your 3rd left onto Naek Road (approximately 1 mile)
Take left into second driveway (at first brick building) #27 Naek Road
Proceed to the end (corner of building) and park

From the East:
Take 84 West
Take exit 65
Turn left off the exit onto Route 30 West (Hartford Turnpike)
Continue to the next light and take right onto Dobson Road
Go to the light and take a right onto Route 83 (Talcottville Road)
Go approximately 1 mile and take your first left onto Naek Road
Take left into second driveway (at first brick building) #27 Naek Road
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If you are coming from Rockville Hospital area on Union Street:
You will travel West on Union & then Union will turn into Route 83 (Talcottville Road)
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27 Naek Road, Unit 2, Vernon, CT, 06066
Telephone (860) 875-2444 Fax (860)872 -2936

Northeastern Pulmonary Associates, LLC

Patient Information (Please Print)

Patient Name: _____ Home Phone: _____
Address: _____ Cell Phone: _____
City: _____ State: _____ Zip: _____ Work Phone: _____
Date of Birth: _____ Drivers License # _____
Social Security Number: _____ **(Mandatory)**

SEX: M F (Circle) Marital Status: S M D W Separated (Circle)

Emergency Contact: _____ Relationship to Patient: _____
Emergency Phone # _____
Primary Care Physician: _____ Pharmacy: _____
Referring Physician: _____ Pharmacy Phone# _____

INSURANCE INFORMATION

Primary Insurance
Name of Insurance Co: _____
ID# _____
Group# _____
Name of Insured: _____
Employer: _____
Relationship to Insured: Self Spouse Child
Other (please circle)

Secondary Insurance
Name of Insurance Co: _____
ID# _____
Group# _____
Name of Insured: _____
Employer: _____
Relationship to Insured: Self Spouse Child
Other (please circle)

ASSIGNMENT AND RELEASE

I, the undersigned, assign directly to Northeastern Pulmonary, all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment benefits. I authorize the use of this signature on all my Insurance submissions.

Patient Signature: _____ Date: _____

MEDICARE AUTHORIZATION

I request the payment of authorized Medicare benefits be made either to me or on my behalf to Northeastern Pulmonary for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize the release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the Insurer or agency shown. For Medicare assigned cases the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: _____ Date: _____

Northeastern Pulmonary Associates, LLC
Patient History

Date: _____ Physician: _____
Patient Name: _____ Age: _____
Date of Birth: _____ Sex: M F Race: _____

Reason for visit: _____
Source of Referral: _____
List of all physicians you see: _____
_____

Presenting Complaint(s):

1. _____
2. _____
3. _____
4. _____

History of Presenting Complaint(s):
Severity: _____
Timing: _____
Duration: _____
Quality: _____
Context: _____
Modifying Factors: _____
Location: _____
Associated Signs/Symptoms: _____
Other: _____

Past Medical History: _____
_____
_____
_____
_____
_____
_____

Please Circle Yes or No if you have any of the following medical problems:

Diabetes……..	YES	NO	Gastrointestinal Problems……..	YES	NO
Bleeding Disorder……..	YES	NO	Genitourinary Problem……..	YES	NO
Cancer……..	YES	NO	Cardiac Problems…….	YES	NO
Stroke……..	YES	NO	Infectious Diseases……..	YES	NO

Medications:

Medication	*Dosage*	*Frequency*	*Duration*

Allergies:

Drug/Agent	*Reaction Type*

Past Surgical History:

Social History:

Smoking: Age Started: _____ Age Ended: _____ Average/day: _____

Alcohol: Amount/day: _____ Other Drugs: _____ Amount: _____

Exercise: _____

Marital Status (circle) Married Divorced Separated Widowed Single

People Living In Household: _____

Age of House/Building: _____

Exposure to chemicals and dusts outside workplace: _____

Hobbies: _____

OCCUPATIONAL HISTORY:

Job Title and Duration of Services	*Company & Location*	*Exposures & Duration Day/week/yr. Protection*

Job Status: _____

Source of Income: _____

Family History: Circle appropriate and List Medical Problems

Father: Alive / Deceased	*Mother: Alive / Deceased*	*Siblings: Brothers____ Sisters ____*

Choice of Hospital for Admission: _____

Advanced Directives: _____

_____

_____

Power of Attorney: _____

_____

REVIEW OF SYSTEMS: Please circle YES or NO if you have any of the following

Constitutional

Good General Health	YES	NO
Recent Weight Change	YES	NO
Night Sweats/Fevers	YES	NO
Fatigue	YES	NO

Ears/Nose/Mouth/Throat

Nose Bleeds	YES	NO
Congestion	YES	NO
Post Nasal Drip	YES	NO
Sore Throat	YES	NO
Voice Change	YES	NO
Sinus Problems	YES	NO
Hearing Loss or Tinnitus	YES	NO
Other	YES	NO

Respiratory

Cough up Blood	YES	NO
Shortness of Breath	YES	NO
Wheezing	YES	NO
Dyspnea on Exertion	YES	NO
Cough	YES	NO

Cardiovascular

Chest Pain	YES	NO
Palpitations	YES	NO
Murmur	YES	NO
Swelling of Feet	YES	NO

Allergic/Immunologic

Indoor Allergies	YES	NO
Seasonal Allergies	YES	NO
Food Allergies	YES	NO
Medicine Allergies	YES	NO

Gastrointestinal

Nausea/Vomiting	YES	NO
GERD	YES	NO
Abdominal Pain	YES	NO
Rectal Bleeding	YES	NO
Black Tarry Stools	YES	NO

Genitourinary

Blood in Urine	YES	NO
Kidney Stones	YES	NO
Sexual Problems	YES	NO

Endocrine

Excessive Thirst/Urination	YES	NO
Thyroid Disease	YES	NO
Excessive Hair Growth	YES	NO
Excessive Eating	YES	NO
Feeling Cold/Hot	YES	NO

Musculoskeletal

Muscle Pain	YES	NO
Joint Pain	YES	NO
Stiffness/Swelling	YES	No
Difficulty Walking	YES	NO

Eyes

Glaucoma	YES	NO
Blurred/Double Vision	YES	NO
Watery Eyes	YES	NO

Integumentry (Skin/Breast)

Rashes/Itching	YES	NO
Breast Lump	YES	NO
Breast Pain/Discharge	YES	NO

Hematologic/Lymphatic

Excessive Bleeding	YES	NO
Enlarged Glands	YES	NO
Easy Bruising	YES	NO
Excessive Clotting	YES	NO

Neurological

Frequent Headaches	YES	NO
Convulsions/Seizures	YES	NO
Numbness/Tingling	YES	NO
Paralysis/Tremors	YES	NO

Psychiatric

Depression	YES	NO
Insomnia	YES	NO
Anxiety	YES	NO

PREVENTIVE PULMONARY MEDICINE

Smoking Cessation _____
Osteoporosis _____
Glucose _____
PPD (TB TEST) _____
Pneumovax _____
Flu Vaccine _____

Patient Statement: To the best of my knowledge, the above information is accurate and complete

Signed: _____ Date: _____

Physician Statement: I have reviewed the questionnaire with the patient:

Signed: _____ Date: _____

Fill up only if you are here for evaluation of sleep problems

Usual Bed time:	Weekdays	am	pm	
	Weekends	am	pm	
On average how long does it take you to fall asleep:			minutes	
Usual wakes up time:	Weekdays	am	pm	
	Weekends	am	pm	
On awakening do you feel	Refreshed	Non-refreshed	Gasping	
	Headache	Fatigue		
How many Caffeinated beverages do you drink in 1 day:			cups	

Have you ever had a sleep study	No Yes	If yes, have you even been prescribed CPAP:	No Yes	
Daytime somnolence	No Yes	Are you napping during the day?	No Yes	Duration
		Falls asleep during	Reading Driving Working	
Snoring	No Yes			
Stop breathing while asleep	No Yes			
Dryness of throat on waking up	No Yes			
Difficulty falling asleep	No Yes	What do you do when you cannot fall asleep	Get up: Watch TV in bed: Use cell phone: Lie in the dark: Others:	
Difficulty waking up in the morning	No Yes			
Repeated awakenings from sleep	No Yes	How many times on an average:	What wakes you up Snoring Nocturia Others Unknown reasons	
Do your legs feel achy/restless/ creeping-crawling in the evening	Yes No			
Unrefreshing naps	No Yes			

Fill up only if you are here for evaluation of sleep problems

Sudden muscle weakness in response to emotions such as laughter, anger or surprise	No Yes
Hallucinations or dreamlike images when falling asleep or waking up	No Yes
Inability to move while falling asleep or when waking up	No Yes
Bedwetting	No Yes
Grinding teeth during sleep	No Yes
I act on my dreams while asleep	No Yes
Sleep talking	No Yes
Sleepwalking	No Yes
Unwanted behaviors during sleep	No Yes Describe:
Using sleeping pills to induce sleep	No Yes
Vivid dreams	No Yes
I frequently dream during daytime naps	No Yes

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would effect you. Use the following scale to choose the most appropriate number for each situation:

0= No chance of Dozing
1= Slight Chance of Dozing
2= Moderate Chance of Dozing
3= High Chance of Dozing

SITUATION	CHANCE OF DOZING
Sitting and Reading	
Watching TV	
Sitting Inactive in a public place (e.g. theater, meeting, etc.)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in traffic	

Northeastern Pulmonary Associates, LLC

DIRECTIONS TO OUR OFFICE

27 Naek Road, Unit 2
Vernon, CT 06066
(860) 875-2444

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~No Show & Cancellation Policy~

We must have 48 hours (2 days) notice of Cancellation of appointment. If we do not have the required 48-hour cancellation notice (does not include weekends), you will be charged a "no show" fee of $150.00 for testing, Pulmonary Clearance & New Patients, $50.00 for follow-up appointments.

No Shows are also charged a fee of $50.00-$150.00 (depending on service type) for missed appointments

We currently have a waiting list of patients for appointments…… If you cannot make your appointment, please notify us so we can give someone else that appointment time

Thank you for your cooperation

~Referrals~

If your insurance requires referrals to see a specialist, it is *YOUR responsibility* to obtain a referral from your primary care physician. If you are seen and do not have a referral, you will be billed for our services. Please check your insurance card &/or call your health plan to see if you are required to obtain a referral to see a specialist.

*(** Some United Healthcare policies require referrals from your primary care physician**)*

~Office Copays~

Copays are due upon arrival for your scheduled appointment. You may pay your copay in cash, credit card or bank card. If you have any questions please see the receptionist.

Northeastern Pulmonary Associates, LLC
27 Naek Road, Unit 2, Vernon, CT 06066 Phone: (860) 875-2444 Fax (860) 875-1952

Authorization To Release Protected Health Information

Patient Name:_____ Date of Birth: _____

I authorize (Name of releasing physician):_____
To release from my entire medical record to include (Office notes, Results of diagnostic testing (ie; x-rays, EKG, Laboratory testing), past medical history & correspondence from other providers. Please also include the following:
(Circle): HIV Testing/Treatment Psychiatric Notes Drug/Alcohol Counseling/Testing
Genetic Counseling/Testing & _____

Please mail or fax records to: _____
_____
Protected Health Information to be used for Medical Treatment &/ or:_____

Signature: _____ Date: _____
(Patient or Guardian)
Witness: _____ Date: _____

HIV Related Information: "This information is disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical information is not sufficient for this purpose." Conn. Gen. Stat. 19a-583, 585

Drug and/or Alcohol: I may revoke this authorization at any time, except to the extent that action has been taken thereon. This authorization, unless expressly revoked earlier, **EXPIRES SIX MONTHS FROM THE DATE** or this request. PL9-282 Sec. 52-146

Psychiatric: The confidentiality of a psychiatric record is required under Connecticut General Statutes. This information shall not be transmitted to anyone else without written consent or other authorization as provided by CGS Sec. 52-146.

To The Patient: The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

You have the right to revoke this authorization, at anytime, as long as the release has not been completed. PL9=282 Sec. 52-146

This authorization, unless expressly revoked by earlier, **EXPIRES SIX MONTHS FROM THE DATE OF THIS REQUEST.** PL9-282 Sec. 52-146.
Per Northeastern Pulmonary Associates, LLC, HIPAA Policy 0003-The charge for copying of medical records is $0.65 per page plus first-class postage. If special mailing is required, an additional charge of $15.00 will be assessed.

Northeastern Pulmonary Associates, LLC

27 Naek Road, Unit 2, Vernon, CT 06066 Phone (860) 875-2444 Fax (860) 875-1952

Authorization to Share Protected Health Information with an Individual

Patient Name: _____ DOB: _____

Today's Date: _____

I authorize Northeastern Pulmonary Associates, LLC, to release any and all of my medical information to the following person(s):

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

Name: _____ Relationship: _____

Phone Number: _____

This information being released to the above individual(s) is solely for assistance in my treatment and my healthcare. I understand that this request will remain in effect until the expiration date or until I ask it to be removed/changed.

I understand I *have the right to revoke this authorization at anytime, as long as the release has not been completed. PL9=282 Sec.52-146*

This authorization ***EXPIRES SIX MONTHS FROM THE DATE OF THIS REQUEST****. PL9-282 Sec. 52-146*

Signature: _____ Date: _____
(Patient or Guardian)

Signature: _____ Date: _____
(Witness)

****Authorization EXPIRES on:** _____
(Date)

HIPPA Receipt and consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I _____, understand that as a part of my healthcare, Northeastern Pulmonary Associates, LLC. (NEPA, LLC) originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- ~ A basis for planning my care and treatment
- ~ A means of communication among the many health professionals who contribute to my care.
- ~ A source of information for applying my diagnosis and surgical information to my bill
- ~ A means by which a third-party payer can verify that services billed were actually provided.
- ~ A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a NOTICE OF PRIVACY PRACTICES that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- ~ The right to review the notice prior to signing this consent.
- ~ The right to object to the use of my health information for directory purposes
- ~ The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations/

I understand that NEPA, LLC reserves all right to change their notice of privacy practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should NEPA, LLC change their notice, they will send a copy of any revised notice to the address I have provided:
I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

_____

I understand that as a part of this organization's treatment, payment of healthcare Operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I have received a copy of NEPA's HIPPA privacy practices today and I understand and accept / decline the terms of this consent:

Patient Signature: _____
Date Signed: _____

IMPORTANT INFO
New Patient Appointments*

You must speak with the office to confirm your new patient appointment by 3pm the day before. Failure to call will result in a cancelled appointment.

If an appointment is on a Monday, the patient must confirm by 3pm the Friday before.
We do call all patients to confirm at least 2-3 days prior to scheduled appointments. We will leave a message if no answer.
It is your responsibility to call us back to confirm if you were left a message or did not get a message (sometimes a voice mailbox is full and we can't leave a message).

Thank you & we look forward to seeing you!