Atlanta Pulmonary & Sleep Solutions

Tarsem L. Gupta, M.D., F.C.C.P.

COMPREHENSIVE PATIENT HISTORY

PATIENT'S NAME: _____ **AGE:** _____ **DATE:** ___/___/___

What is the reason for your visit today? _____

Describe the following:

Location: _____ How long have you had this problem? _____

How severe is this problem? **Circle one:** Mild Moderate Severe

How often are you having this problem? _____

What caused the problem? _____

Does anything else occur with this problem? _____

List previous hospitalizations/surgeries/serious injuries When?

_____ _____

_____ _____

_____ _____

_____ _____

List Medication Allergies

1. _____
2. _____

List Current Medications

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Past Social History: (Circle what applies)

Use of Alcohol: Never Rarely Moderate Daily

Use of Tobacco: Never Former Current packs per day _____

Excessive exposure at home or work to: Fumes Dust Solvents Noise

Have you ever had the following? (Please circle)

Cancer	Diabetes	Hypertension	Venereal Disease
Arthritis/Gout	Stroke	Heart trouble	Hereditary Defects
Bleeding Tendency	Acute Infections	Convulsions	

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	____	_____	_____
Mother	____	_____	_____
Sibling(s)	____	_____	_____
	____	_____	_____
	____	_____	_____

Atlanta Pulmonary & Sleep Solutions
245 Village Center Pkwy, Ste 100, Stockbridge, GA 30281
Phone: 770.506.7171. Fax: 770.506.8406

Tarsem L. Gupta M.D., F.C.C.P.

Patient Information Sheet

DATE: ___/___/_____

Patient: _____
(Last) (First) (M.I)

Mailing Address: _____

_____

Residence (if different than above) _____

Home Phone #: _____ Cell # _____

Last 4 SSN: _____

Date of Birth: _____ Age: _____

SEX: Male / Female

MARITAL STATUS
Single Married Widowed Divorced

Name of Spouse: _____

Employer: _____

Address: _____

_____

Phone: _____ Ext. _____

Occupation: _____

Spouse's Employer: _____

Address: _____

_____

Phone: _____ Ext. _____

Occupation: _____

Nearest Relative (not living with you): _____ Relationship: _____

Address: _____

Phone #: _____ Work # _____

Emergency Contact (other than Relative): _____ Relationship: _____

Phone #: _____ Work#: _____

Were you referred to our office? ____Yes_____No If Yes, by Whom: _____

Reason for Referral: _____

If No, how did you find out about our office: _____

Signature: _____

Have you recently experienced any of the following?

CONSTITUTIONAL
Good general health lately ☐ No ☐ Yes
Recent weight change ☐ No ☐ Yes
Fevers ☐ No ☐ Yes
Fatigue ☐ No ☐ Yes
Headaches ☐ No ☐ Yes

EYES
Eye disease or injury ☐ No ☐ Yes
Wear glasses/contact lens ☐ No ☐ Yes
Blurry or double vision ☐ No ☐ Yes
Glaucoma ☐ No ☐ Yes

ENT
Hearing loss ☐ No ☐ Yes
Ringing in the ears ☐ No ☐ Yes
Earaches or drainage ☐ No ☐ Yes
Sinus problems ☐ No ☐ Yes
Nose bleeds ☐ No ☐ Yes
Mouth sores ☐ No ☐ Yes
Bleeding gums ☐ No ☐ Yes
Bad breath or bad taste ☐ No ☐ Yes
Sore throat or voice changes ☐ No ☐ Yes
Swollen glands in neck ☐ No ☐ Yes

CARDIOVASCULAR
Heart trouble ☐ No ☐ Yes
Chest pains ☐ No ☐ Yes
Sudden heartbeat changes ☐ No ☐ Yes
Swelling of feet, ankles or hands ☐ No ☐ Yes

RESPIRATORY
Frequent coughing ☐ No ☐ Yes
Spitting up blood ☐ No ☐ Yes
Shortness of breath ☐ No ☐ Yes
Asthma or wheezing ☐ No ☐ Yes

GASTROINTESTINAL
Loss of appetite ☐ No ☐ Yes
Change in bowel movements ☐ No ☐ Yes
Nausea or vomiting ☐ No ☐ Yes
Frequent diarrhea ☐ No ☐ Yes
Painful bowel movements or constipation ☐ No ☐ Yes
Blood in stool ☐ No ☐ Yes
Stomach pain ☐ No ☐ Yes

GENITOURINARY
Frequent urination ☐ No ☐ Yes
Burning or painful urination ☐ No ☐ Yes
Blood in urine ☐ No ☐ Yes
Change of force of strain when urinating ☐ No ☐ Yes
Incontinence or dribbling ☐ No ☐ Yes
Kidney stones ☐ No ☐ Yes
Male-testicle pain ☐ No ☐ Yes
Female- pain with periods ☐ No ☐ Yes
Female- irregular periods ☐ No ☐ Yes
Female- vaginal discharge ☐ No ☐ Yes
Female- # pregnancies ___ # miscarriages ___
Female- date of last PAP smear_____
Findings of PAP smear ☐ Normal ☐ Abnormal

MUSCULOSKELETAL
Joint pain ☐ No ☐ Yes
Joint stiffness ☐ No ☐ Yes
Weakness of muscles or joints ☐ No ☐ Yes
Muscle pain or cramps ☐ No ☐ Yes
Back pain ☐ No ☐ Yes
Cold extremities ☐ No ☐ Yes
Difficulty in walking ☐ No ☐ Yes

SKIN
Rash or itching ☐ No ☐ Yes
Change in skin color ☐ No ☐ Yes
Change in hair or nails ☐ No ☐ Yes
Varicose veins ☐ No ☐ Yes
Breast pain ☐ No ☐ Yes
Breast lump ☐ No ☐ Yes
Breast discharge ☐ No ☐ Yes

NEUROLOGICAL
Frequent or recurring headaches ☐ No ☐ Yes
Light headed or dizzy ☐ No ☐ Yes
Convulsions or seizures ☐ No ☐ Yes
Numbness or tingling ☐ No ☐ Yes
Tremors ☐ No ☐ Yes
Paralysis ☐ No ☐ Yes
Stroke ☐ No ☐ Yes

PSYCHIATRIC
Memory Loss or confusion ☐ No ☐ Yes
Nervousness ☐ No ☐ Yes
Depression ☐ No ☐ Yes
Sleep Problems ☐ No ☐ Yes

ENDOCRINE
Glandular or hormone problem ☐ No ☐ Yes
Thyroid disease ☐ No ☐ Yes
Excessive thirst or urination ☐ No ☐ Yes
Heat or cold intolerance ☐ No ☐ Yes
Dry skin ☐ No ☐ Yes
Change in hat or glove size ☐ No ☐ Yes

HEMATOLOGIC/LYMPHATIC
Slow to heal after cuts ☐ No ☐ Yes
Easily bruise or bleed ☐ No ☐ Yes
Anemia ☐ No ☐ Yes
Phlebitis ☐ No ☐ Yes
Past transfusion ☐ No ☐ Yes
Enlarged glands ☐ No ☐ Yes

Check if applies:

☐ History was filled out by someone other than the patient.

Print Name and relationship:

_____

Patient Signature:

_____

Payment Policy

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

1. **Insurance.** Knowing your insurance benefits is your responsibility. Please contact your insurance company with specific questions you have regarding your coverage. As a courtesy to our patients, the Front Office staff will verify benefits and attempt to obtain precertification and authorization if necessary. However, all patients are responsible for monitoring the number of visits as they relate to plan benefit limitations and or authorization limits. Exceptions to this policy are only when patient financial responsibility is limited statutory regulation of workers compensation claims, Medicare, Medicaid fee schedules.
2. **Copayments and Deductibles.** All Copayments and deductibles must be paid at the time of service. Copayments and deductibles are a part of the contract with your insurance company. Failure to collect copayments and deductibles can be considered fraud. Please help us uphold the law by paying your copayments and deductibles as indicated.
3. **Non-covered services.** Please be aware that some of the services that you may receive may be non-covered or not considered reasonable or medically necessary by your insurer. In the event of non-payment for any date of service by your insurer, you are expected to pay the balance on the account.
4. **Proof of insurance.** All patients must complete our patient sign in sheet before seeing the doctor. We must obtain a copy of a current valid insurance card to provide proof of insurance. If you fail to provide the correct insurance information in a timely manner, you may be responsible for the balance on your account.
5. **Claim Submission.** Our Accounts Receivable Department will submit your claims and assist you in any reasonable way to 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 your account is your responsibility whether or not your insurance company pays your claim. If they have not paid your claim within 60 days, the balance will be billed to you. Your Insurance benefit is a contract between you and your insurance carrier; we are not a party to that contract.
6. **Coverage changes.** If your insurance changes at any time, you must provide the new information prior to your next appointment. You must notify us so that we can make the appropriate changes to help you receive your maximum benefits.

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

Print Patient Name_____

Signature of the patient or responsible party

_____ Date_____

Tarsem L. Gupta
245 Village Center Pkwy STE 100
Stockbridge, GA 30281

Authorization to Release Medical Records

Patient's Name & DOB_____

I hereby authorize Atlanta Pulmonary and Sleep Solutions to release the medical information contained in my chart to my insurance carrier for the purpose of conducting chart reviews, as necessary.
Signature of Patient (Guardian)_____Date _____

Please list any persons that Atlanta Pulmonary and Sleep Solutions is allowed to discuss your protected health information with. This includes, but is not limited to your treatment, health care options, test results, appointment reminders, and medical bills. Please include your Emergency Contact listed on the first page.
Name _____ Relationship _____
Phone Number _____
Name _____ Relationship _____
Phone Number _____
Name _____ Relationship _____
Phone Number _____

By signing this authorization, I authorize Atlanta Pulmonary and Sleep Solutions to use and/or disclose protected health information (PHI) about me to the parties listed above. I understand that I can revoke or amend this authorization at any time.

_____
Patient/Guardian Signature Date

Referral Authorizations

Most managed care insurance companies, Health Maintenance Organizations (HMOs) or Point of Service plans (POSs) require a referral or authorization from your primary care physician for you to see a specialist.

It is your responsibility to be familiar with your insurance coverage and know whether or not your insurance carrier requires you to have a referral authorization. If your insurance carrier does require a referral authorization from your primary care physician, please let your primary care physician and staff know. If your insurance carrier requires a primary care physician referral and one was not obtained, you may be responsible for payment of services rendered

_____
Patient/Guardian Signature Date

Atlanta Pulmonary & Sleep Solutions
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Notice of Privacy Practices

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your individually identifiable Health Information. Please review this carefully.

A. Our Commitment to your Privacy. Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
Atlanta Pulmonary & Sleep Solutions, 245 Village Center Parkway, Ste 100 • Stockbridge, GA 30281 • Phone: 770.506.7171

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS
The following categories describe the different ways in which we may use and disclose your IIHI:

1. **Treatment.** Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice-including, but not limited to, our doctors and nurses-may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
2. **Payment.** Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items.
3. **Health Care Operations.** Our Practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

OPTIONAL:
4. **Appointment Reminders.** Our practice may use and disclose your IIHI to contact you and remind you of an appointment.

OPTIONAL:
5. **Treatment Options.** Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL:
6. **Health-Related Benefits and Services.** Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL:
7. **Release of Information to Family/Friends.** Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment for a cold. In this example, the babysitter may have access to this child's medical information.
8. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state, or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES. The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records, such as births and deaths
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled.
   - Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance
2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings.** Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.
4. **Law Enforcement.** We may release IIHI if asked to do so by a law enforcement official:
   - Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
   - Concerning a death we believe has resulted from criminal conduct
   - Regarding criminal conduct at our offices

(continued on other side)

- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victims(s) of the crime, or the description, identity or location of the perpetrator.

OPTIONAL:

5. **Deceased Patients.** Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

OPTIONAL:

6. **Organ and Tissue Donation.** Our practice may release your IIHI to organization that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL:

7. **Research.** Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when: (a) our use or disclosure was approved by an Institutional Review Board or a Privacy Board; (b) we obtain the oral or written agreement of a researcher that (i) the information being sought is necessary for the research study; (ii) the use or disclosure of your IIHI is being used only for the research and (iii) the researcher will not remove any of your IIHI from our practice; or (c) the IIHI sought by the researcher only related to decedents and the researcher agrees either orally or in writing that the use or disclosure is necessary for the research and, if we request it, to provide us with proof of death prior to access of the IIHI of the decedents.
8. **Serious Threats to Health or safety.** Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.
9. **Military.** Our practice may disclose your IIHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
10. **National Security.** Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.
11. **Inmates.** Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.
12. **Workers' Compensation.** Our practice may release your IIHI for workers' compensation and similar programs.

E. **YOUR RIGHTS REGARDING YOUR IIHI.** You have the following rights regarding the IIHI that we maintain about you:

1. **Confidential Communications.** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Atlanta Pulmonary & Sleep Solutions, **245 Village Center Parkway, Ste 100 • Stockbridge, GA 30281** and specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.
2. **Requesting Restrictions.** You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your IIHI, you must make your request in writing to: Atlanta Pulmonary & Sleep Solutions, **245 Village Center Parkway, Ste 100 • Stockbridge, GA 30281.** Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.
3. **Inspection and Copies.** You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to: Atlanta Pulmonary & Sleep Solutions, **245 Village Center Parkway, Ste 100 • Stockbridge, GA 30281** in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.
4. **Amendment.** You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to: Atlanta Pulmonary & Sleep Solutions, **245 Village Center Parkway, Ste 100 • Stockbridge, GA 30281.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.
5. **Accounting of Disclosures.** All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your IIHI for non-treatment or operations purposes. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to: Atlanta Pulmonary & Sleep Solutions, **245 Village Center Parkway, Ste 100 • Stockbridge, GA 30281.** All requests for an "accounting of disclosures" must state a time period, which may not be longer then six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list you request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.
6. **Right to a Paper Copy of This Notice.** You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact Atlanta Pulmonary & Sleep Solutions, **245 Village Center Parkway, Ste 100 • Stockbridge, GA 30281.**
7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Atlanta Pulmonary & Sleep Solutions, **245 Village Center Parkway, Ste 100 • Stockbridge, GA 30281.** All complaints must be submitted in writing. You will not be penalized for filing a complaint.
8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact: Atlanta Pulmonary & Sleep Solutions, **245 Village Center Parkway, Ste 100 • Stockbridge, GA 30281 • Phone: 770.506.7171.**

I acknowledge that I have received the Notice of Privacy Practices. _____