RESPIRATORY MEDICAL GROUP, INC.
Michael L. Cohen, M.D.
Harry J. MacDannald, M.D.
Kristina Kramer, M.D.
Ka Ling (Karin) Cheung, M.D.
Fred Nachtwey, M.D.
J. Julian Zaka, M.D.

Date Today: ____________

130 La Casa Via
Bldg. 2 - Suite 208
Walnut Creek, CA. 94598

PH: (925) 944-0166
FAX: (925) 944-6355

Who referred you to this office? _____________ Who is your primary care physician? __________

Your Name ____ Birthdate ____/____/____
last first middle

Your Address ____
street city state zip code

( ) _____-_________ ____-____-______ ______________ _M_F __S__M__D__W
telephone social security driver's license sex marital status

Employer Name ____ ( ) ____-____________
telephone

Employer Address _______________________________________ _____________________
occupation

Spouse Name ___________________________________ Birthdate ___/___/______

Spouse Employer ________________________________ ( ) _____-____________
telephone

Employer Address _________________________________ _________________________
occupation

Spouse Social Security ___- ___- ______ Drivers License _________________

Emergency Notification

Name _______________________ ____________________ ( ) _____ - _____________
relationship telephone

Primary Insurance ____

Address ____ ( ) ____ - ______________
street city state zip code telephone

Subscriber Name _____________________________________ Birthdate ___/___/______

I.D. # _________________________ Group # _______________ Plan # _______________

Secondary Insurance ____

Address ____ ( ) ____ - ______________
street city state zip code telephone

Subscriber Name _____________________________________ Birthdate ___/___/______

I.D. # _________________________ Group # _______________ Plan # _______________

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PULMONARY ASSESSMENT CHECKLIST Date: ________

NAME (First) ___________________ (MI) _________________ (Last) ___________________________

Age: ____ Weight: _____ Date of Birth: ____________ Occupation: ________________________

Referring Doctor's Name: __________________Primary Care M.D.: _____________________________

Reason for Referral/Complaint: ____

Medication(s): Please include both prescribed and over-the counter medications:

Name:	Strength:	How Often:	Prescribing Doctor

Allergies: **Reaction:**

____

____

____

Medical History:

____

____

____

____

____

____

Name:________________________
Date: ________________________

SOCIAL HISTORY:

Marital Status: _____ Single _____ Married _____ Divorced _____Widowed

HABITS:

Do you smoke cigarettes now?	___ Yes ___ No
Have you smoked in the past?	___ Yes ___ No
If yes, how many	___ cigarettes per day ___ pack(s) per day
	___ pipe ___ cigars
When did you start?	Age/year ____________
When did you stop?	Age/year ____________
Do you drink alcohol?	___ Yes ___ No
If yes, how often	___ Daily ____ Weekly ____ Monthly
How much	____________________
Other substance use?	___ Yes ___ No
Exposure to toxins or irritants?	___ Yes ___ No
Recent travel out of the country?	___ Yes ___ No
If yes, where?	____________________________________

FAMILY HISTORY:

	Current age	Major Illnesses	If deceased, age and cause of death?
Mother:	__________	_____________	_________________________
Father:	__________	_____________	_________________________
Brother(s)/Sister(s):	__________	_____________	_________________________
Children:	__________	_____________	_________________________
	__________	_____________	_________________________
	__________	_____________	_________________________
	__________	_____________	_________________________

Circle the diseases that tend to run in the family:

High blood pressure, heart attacks, strokes, cancer, bleeding disorders, tuberculosis, others.

Name:________________________
Date: ________________________

REVIEW OF SYSTEMS:

Please circle any symptoms listed below that apply to you now.

CONSTITUTIONAL:
Fever
Night sweats
Chills
Fatigue
Weight gain
Weight loss
Weakness

EYES:
Blurred vision
Double vision
Eye injury
Discharge from eyes

EARS, NOSE & THROAT:
Hearing loss
Ringing in ears
Dizziness
Vertigo
Nosebleeds
Sinusitis
Sore throat/hoarseness

CARDIOVASCULAR:
Chest pain
Irregular heartbeat
Shortness of breath
Palpitations
Swelling of feet, ankles or hands
Leg circulation problems or leg pains
High or low blood pressure

RESPIRATORY:
Cough
Wheezing
Chest pain
Shortness of breath
Coughing up blood

GASTROINTESTINAL:
Loss of appetite
Diarrhea
Constipation
Blood in stools
Nausea
Vomiting
Reflux
Heartburn/indigestion
Trouble swallowing

GENITOURINARY:
Urinary frequency
Nighttime urination ____times
Blood in urine
Painful urination
Incontinence

MUSCULOSKELETAL:
Joint pain
Joint stiffness
Joint swelling
Back pain
Neck pain
Arthritis

SKIN/BREASTS:
Rash
Itching
Change in color
Skin cancer
Breast pain
Breast lump

NEUROLOGICAL:
Headache
Weakness
Seizures
Tingling
Tremors
Memory loss
Confusion
Trouble concentrating
Insomnia
Snoring

PSYCHIATRIC:
Anxiety
Depression
Panic attacks

HEMATOLOGIC/ LYMPHATIC:
Enlarged nodes or glands
Bleeding tendency
Anemia
Phlebitis

ENDOCRINE:
History of high/low blood sugar
Thyroid problems

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AUTHORIZATION TO USE OR DISCLOSE INFORMATION FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS

I hereby authorize to the use or disclosure of my individually identifiable health information ("protected health information") by Respiratory Medical Group in order to carry out treatment, payment or health care operations. A copy of Respiratory Medical Group's Notice of Privacy Practices for Protected Health Information is available for my reading for a more complete description of the potential uses and disclosures of such information. I have the right to review such notice prior to signing this consent form. I have the right to request a copy of the notice.

Respiratory Medical Group reserves the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If the facility does change the terms of its Notice of Privacy Practices, I may obtain a copy of the revised notice.

I retain the right to request that Respiratory Medical Group further restrict how my protected health information is used or disclosed to carry out treatment, payment or health care operations. Respiratory Medical Group is not required to agree to such requested restrictions; however, if the facility does agree to my requested restriction(s), such restrictions are then binding on Respiratory Medical Group.

I authorize the office staff to notify me by telephone of forthcoming appointments and give medical results unless I otherwise specify.

I HAVE READ AND UNDERSTAND THIS INFORMATION AND HAVE THE RIGHT TO REQUEST A COPY OF THIS AUTHORIZATION.

Date : _____________ Time: ___________ AM/PM

Patient or Person Signing on Patient's Behalf	Witness for Person Signing on Patient's Behalf
Please print name	Please print name

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FINANCIAL POLICY:

The above physicians are **all** sub-specialists certified by the American Board of Internal Medicine in both Internal Medicine and Pulmonary Diseases. Dr. Mac Dannald, Dr. Kramer, Dr. Cheung and Dr Zaka are Board Certified in Critical Care Medicine. Dr. Cohen, Dr. Cheung, Dr. Nachtwey,Dr MacDannald and Dr Zaka are also Board Certified in Sleep Medicine.

A consultation consists of history-taking, physical examination pertinent to your problems, and discussion regarding your problems. Time not actually spent with you consists of discussing your care with the referring physician, obtaining and reviewing your present x-rays and appropriate laboratory tests, discussing results and writing a report to your referring physician. The fee for a consultation or initial office visit ranges from $220 to $320. A follow up office visit ranges from $100 to $235. Tests performed in our office (such as oximetry and spirometry) will incur additional charges.

MEDICARE PATIENTS:

We are participating physicians in the Medicare program and submit all billings to Medicare. You are responsible for your annual deductible as well as the 20% portion of the bill not covered by Medicare.

HMO/PPO PATIENTS:

HMO patients are responsible for obtaining an authorization from the primary care physician prior to each visit. We cannot see you without this authorization. If you elect to be seen without authorization, the charges will be your financial responsibility if your claim is denied. If you are a member of an HMO/PPO, you may be required by your health plan to pay a co-payment. We cannot waive the co-payment amount. All co-payments are due and payable at the time of the visit.

PRIVATE INSURANCE PATIENTS:

Your insurance is a contract between you and your insurance company. The fee for service rendered in this office is a separate contract between you and the physician. It is our policy to be paid at the time of the visit. For your convenience, we accept Mastercard, Visa, personal checks, money orders and cash.

CANCELLATIONS/NO SHOWS:

If you cancel an appointment with less than 48 business hour notice, there is a $50 no-show fee. Failure to show up for an appointment will also result in a no-show fee. Repeat no-shows may be dismissed from the practice. Missed appointments create gaps in our schedule resulting in our inability to provide appropriate care to all patients.

CHARGES FOR COMPLETION OF FORMS, PHOTO COPYING OF MEDICAL RECORDS:

There is a charge for completion of forms and photo copying of medical records.

PAYMENT METHOD:

We accept cash, Mastercard and Visa. A $25 charge will be applied on all returned checks.

FINANCE CHARGE:

Any patient balance past 30 days will be assessed a service charge of 1.5% per month, as well as a $5/month handling fee.

NAME:____ DATE:___________

I acknowledge I have read the above financial policy

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION:

Occasionally we are asked to provide your medical information to other treating medical providers and insurance companies involved in determining payments or benefits. We ask that you sign below to assist us in expediting those requests.

I hereby authorize Respiratory Medical Group, Inc. to furnish medical providers and insurance companies with any and all information they may request to further my medical care or process payments or benefits.

SIGNED ____ DATE ________________________

ASSIGNMENT OF BENEFITS:

I hereby assign medical and/or surgical payments to include major medical benefits to which I am entitled, private insurance and any other health plan to RESPIRATORY MEDICAL GROUP, INC. for services provided by the physicians at Respiratory Medical Group, Inc.

I understand that if claims are denied due to eligibility status, etc., I will assume full responsibility for all charges incurred by all dependents and me. I understand that I am financially responsible for any non-covered benefits, deductibles, or any co-payments for services which have been provided to me.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

SIGNED ____ DATE ________________________