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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SLEEP ASSESSMENT CHECKLIST

Name (First): ___________________ (MI) ________ (Last) __________________________

Age: __ Weight: ___ Height: ____ Neck Size: __ inches Occupation: _______________

Doctor's Name: ______________________________ Date: __________________________

SLEEP AND WAKE BEHAVIOR

CHECK ONE BOX FOR EACH STATEMENT

		Never	Sometimes	Often
1.	I snore loudly			
2.	Do you awaken yourself with your snoring?			
3.	I sleep with someone else in the bedroom			
4.	Does the observer describe breathing irregularity or breathing cessation while sleeping?			
5.	I feel my heart pounding during the night			
6.	I sweat a lot during the night			
7.	I have a restless, disturbed sleep			
8.	I wake up with a headache			
9.	I wake up with a dry mouth			
10.	I have dreams			
11.	I grind my teeth			

ABOUT SLEEPING

12. What is your usual bedtime hour? _________

13. How long does it take for you to fall asleep? _____________

14. On the average, how many hours of sleep do you get each night? ___

15. What time do you usually have your final awakening? ________

CHECK ONE BOX FOR EACH STATEMENT

	Never	Sometimes	Often
16. I "sleep-in" in the morning (more than 1 hr. past my usual wake up time).			
17. I have a very hard time waking up			
18. I wake up confused or disoriented			
19. When I awaken, I still feel tired			
20. I feel as though I did not have a restful sleep			

ABOUT DAYTIME FUNCTIONING

	Never	Sometimes	Often
21. I have a reduced attention span			
22. I have trouble concentrating			
23. I struggle to stay awake when inactive such as reading, watching TV, or in meetings			
24. I have trouble with my memory			

25. How many naps do you take in a usual week? _____

26. Are the naps refreshing? Yes No

CHECK ONE BOX FOR EACH STATEMENT

		Never	Sometimes	Often
27.	I feel sleepy during the day			
28.	I feel drowsy when driving			
29.	I feel drowsy when stopping for a few minutes in traffic			
30.	I feel fatigued during the day			
31.	I feel sad or depressed			
32.	I feel weakness in my muscles when laughing, surprised, angry, excited, etc.			
33.	I have a low energy level			

FAMILY HISTORY:

34. Does anyone in your family have a sleep disorder? Yes No

Relationship to you: ______________________ ______________________ ______________________

Describe the problem: ______________________ ______________________ ______________________

ABNORMAL MOVEMENTS

35.	When in bed, I have creeping, crawling, aching/twisting feelings in my legs (feels like I constantly have to move them)			
36.	I experience pain or discomfort when in bed at night			
37.	I walk in my sleep			
38.	I fall out of bed while asleep			
39.	I wake up screaming, violent or confused.			

40. I have unusual movements while asleep as reported by my partner

INSOMNIA QUESTIONS

41. On the average, how long does it take you to fall asleep? _______

42. How many times do you wake up each night ? _____
Do you have trouble getting back to sleep? Yes No

43. I feel afraid I won't return to sleep after awakening

44. On a typical night, what is your longest period of wakefulness? __ hours __ min.

45. If you awaken during the night, is it usually during the: 1st half of the night
2nd half of the night

46. I wake up 1-2 hours before I have to get up

47. Do you drink caffeinated beverages within 2 hours of bedtime? If so, which?

	During a typical day	Within 2 hrs. before bedtime
A. Coffee: caffeinated	_________ cups	________ cups
decaffeinated	_________ cups	________ cups
B. Tea	_________ cups	________ cups
C. Soda caffeinated	_________ cans	________ cans

Do you drink alcohol within 2 hours of bedtime? If so, which?

D. Beer	_________ cans/oz.	________ cans/oz.
E. Wine	_________ glasses/oz.	______ glasses/oz.
F. Other alcoholic beverages	_________ glasses/oz.	______ glasses/oz.

48. Do you smoke tobacco?
A. Pack of cigarettes ________
B. Cigars ________
C. (Pipe) bowls ________

CHECK ONE BOX FOR EACH STATEMENT

49. How often do you use:	Never	Sometimes	Often
A. Marijuana			
B. Cocaine			
C. Hallucinogens (LSD, mescaline, Angel dust, etc.)			
D. Stimulants.			
E. Depressants			
F. Narcotics (heroin, morphine, opium, etc.			

50. Please list the name and dose (in mg.) of all medications that you take now or within the past 30 days.

Medications:	Dose:	What For?
____________________	__________	______________________
____________________	__________	______________________
____________________	__________	______________________
____________________	__________	______________________
____________________	__________	______________________

ALLERGIES? _____________ REACTION: ____________________

51. Please list the names of any pill for sleeping or to help you stay awake that you have taken in the past.

	Did it help?	
__________________________________	Yes	No
__________________________________	Yes	No

52. How many times each week do you participate in a sport or partake in some form of exercise? _____________

53. What is your personal interpretation as to why you have your particular sleep/wake problem?

____

____

HEALTH HISTORY

54. Has your weight changed recently? Yes No
If yes, explain: ____

____

55. Please check any problem or illness you have had:

Heart Disease	High Blood Pressure	Heart Attack	Low Blood
Fainting	Dizziness	Headaches	Tuberculosis
Blackouts	Hemophilia (bleeder)	Ulcers	Hernia
Prostate	Mental problems	Back Trouble	Gout
Seizures	Asthma	Allergies	Bronchitis
Cancer	Kidney Trouble	Bladder Trouble	Eye Trouble
Pneumonia	Hearing Trouble	Meningitis	Heartburn
Impotence	Depression	Arthritis	Venereal Disease
Muscle Cramps	Ringing of the ears		

SURGERIES AND HOSPITALIZATIONS

Please list any hospitalizations and/or surgeries you have had. PLACE THE LAST FIRST. Include where, what and when.

____

____

____

____

____

____

NASAL BREATHING

56. Do you breathe comfortably through your nose? Yes No

57. Do you have nasal allergies? Yes No

58. Do you use any nasal sprays? Yes No

59. Do you have a history of sinus problems, nasal polyps, or nasal surgery?

Yes No Describe ______________________________

THE EPWORTH SLEEPINESS SCALE

Name: ________________________ Today's Date: _________ Age: ___ Sex: ____

How likely are you to doze off or fall asleep in the following situations, compared to just feeling 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 have affected you. Use the following scale to choose the *most appropriate number* for each situation.

0 = would *never* doze 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 (meeting, theater)	
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 eating lunch without alcohol	
In a car while stopped for a few minutes in traffic	

Total Points ________

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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 ________________________