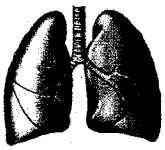

BAY AREA CHEST PHYSICIANS, P.A.

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JERAMY MOSBURG, D.O.

LUCAS A. MIKULIC, M.D.

DEBORAH D. MATTSON, PA-C

Welcome to Bay Area Chest Physicians

We are pleased you have chosen us for your medical needs. Enclosed is our New Patient Packet that provides information about our practice, privacy and financial policies. For additional information; be sure to visit our website at www.bayareachestphysicians.com.

Please prepare for your visit with us by completing the enclosed

- Patient Information Sheet
- Medical Data
- Patient Financial Policy

For your protection against identity theft; you will need to present a photo ID and your insurance cards at your first visit.

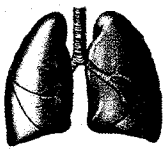
Again, we thank you for choosing Bay Area Chest Physicians. You can feel better knowing we are committed to providing you with the highest quality of care and service.

If you need to re-schedule or cancel an appointment, please contact our office at least 24 hours in advance (727)443-0611.

We look forward to meeting you.

Bay Area Chest Physicians

430 MORTON PLANT STREET, STE 405, CLEARWATER, FL 33756
Phone: (727) 443-0611 Fax: (727) 461-5493
www.BayAreaChest.com



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Medical Authorization

I am a patient of Bay Area Chest Physicians and currently under the medical care of Dr. _____. I give authorization to either release or gather my healthcare information from other healthcare providers.

This information, either released and/or obtained, will be utilized for the continuity of my medical care. I realize this information may also be used by my healthcare provider to receive reimbursement from my insurance company and/or companies.

Release to: _____

Fax # 727-466-9573

Permission to obtain from: _____

Fax #_____ Ph# _____

Information to be released: _____

_____

To Receiving Party: Prohibition of Re-Disclosure

This information has been disclosed to you from records whose confidentiality is protected by law. Any further re-disclosure is strictly prohibited unless the patient provides specific written consent for the subsequent disclosure of this information.

This single document does not have an expiration date.

Date of Birth: _____Social Security Number (last 4 digits) _____

_____

Patient Signature/Legal Guardian Date

_____

Print Patient Name

430 MORTON PLANT STREET, STE 405, CLEARWATER, FL 33756

Phone: (727) 443-0611 Fax: (727) 461-5493

www.BayAreaChest.com

Bay Area Chest Physicians

HIPAA Release Form

Name: _____

Today's Date : ____/_____/_____**Date of Birth:** _____/_____/_____

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse_____

☐ Child(ren)_____

☐ Other_____

☐ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Consent to Obtain External Prescription History

I, _____, whose signature appears below, authorize Bay Area Chest Physicians to view my external prescription history.

By signing this consent form you are agreeing that your provider at Bay Area Chest Physicians may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Print Patient Name _____Patient DOB _____

Signature of Patient or Guardian _____ Date _____

Relationship to Patient_____

Consent to Share My Health Information With the BayCare Electronic Health Exchange

The BayCare Electronic Health Exchange **(BayCare eHX)** is an exciting program designed to improve your health care and make office visits easier and more convenient. This authorization will allow all of your doctors participating in the BayCare eHX to enroll you in the BayCare eHX and to disclose your demographic, insurance and medical information (collectively, your **"health information"**) to the BayCare eHX so that it can be shared with other providers of health care, including doctors, nurses, health professionals, hospitals and other health care facilities. Only health care providers and authorized personnel that participate in the BayCare eHX, and others whose job it is to maintain, secure, monitor and evaluate the operation of the BayCare eHX, will be able to access your health information. The BayCare eHX will allow your providers access to your health information more quickly and accurately than with paper charts.

You may use this Consent Form to decide whether or not to allow the BayCare eHX to see and obtain access to your health information in this way. You can give consent or deny consent, and this form may be filled out now or at a later date. **Your choice will not affect your ability to get medical care or health insurance coverage. Your choice to give or to deny consent may not be the basis for denial of health services. However, to the extent you have denied consent, you understand that your health information will not be available to other providers on the BayCare eHX for your medical treatment.**

If you check the **"I GIVE CONSENT"** box below, you are saying "Yes, members of the BayCare eHX may see and get access to all of my health information through the BayCare eHX."

If you check the **"I DENY CONSENT"** box below, you are saying "No, members of the BayCare eHX may not be given access to my health information through the BayCare eHX for any purpose."

Please carefully read the "Details About Your Health Information" form before making your decision.

Your Consent Choices: You can fill out this form now or in the future. You have two choices:

☐ **YES, I GIVE CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

☐ **NO, I DENY CONSENT for my doctors to enroll me in the BayCare eHX and for the members of the BayCare eHX to access ALL of my health information as set forth in this Consent Form.**

_____ _____ _____

Printed Name of Patient/Representative Signature of Patient/Representative Date

AUTHORITY OF REPRESENTATIVE:

I, _____, do hereby state that I am authorized to sign this permission on behalf of the patient on the following basis: _____

_____

_____

Relationship to Patient: _____

BayCare
Health System

ELECTRONIC MEDICAL RECORDS

Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Bay Area Chest Physicians may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Bay Area Chest Physicians has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Bay Area Chest Physicians will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow Bay Area Chest Physicians to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Bay Area Chest Physicians has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Bay Area Chest Physicians 430 Morton Plant St Ste 405 Clearwater, Fl 33756 Attn: HIPAA Representative.

FORM Us

Bay Area Chest Physicians

Please fill out as completely as possible to help in your medical management.

Name_____ Referring Physician_____

Date_____ DOB_____ Primary Care Physician_____

Reason for Visit_____

CHECK ONE: Single ☐ Married ☐ Widowed ☐ Divorced ☐		Drug Allergies:
MEDICATIONS:	Dose:	
		Date of last Vaccine
		Influenza : ☐
		Pneumonia: ☐
		Smoking Hystory: Y / N
		Year Started:
		Year Stopped:
		Current Smoker Y / N ☐
		Recreational Drug use:
		Yes ☐ No ☐
		Exposure To:
		Asbestos Y / N ☐
		Coal Dust Y/ N ☐
		Other:

Recent Foreign Travel :

Family History:
Father:
Mother:
Siblings:
Children:
Other:

Medical History:		Year:
Pneumonia	☐ Y / N	
TB	☐ Y / N	
Bronchitis	☐ Y / N	
Asthma	☐ Y / N	
COPD	☐ Y / N	
Emphysema	☐ Y / N	
Lung Cancer	☐ Y / N	
Pulmnry HTN	☐ Y / N	
Hypertension	☐ Y / N	
Angina	☐ Y / N	
Heart Attack	☐ Y / N	
Heart Failure:	☐ Y / N	
High Choles	☐ Y / N	
Atrial Fib	☐ Y / N	
Blood Clots	☐ Y / N	
Pacemaker	☐ Y / N	
Irregular Heart Rate	☐ Y / N	
DVT	☐ Y / N	
Pulmonary Embolism	☐ Y / N	
SLE(Lupus)	☐ Y / N	
Arthritis: ☐ Osteo / Rheumatoid		

Digestive:	
GERD	☐ Y / N
Ulcer	☐ Y / N
G/I Bleed	☐ Y / N
Dysphagia	☐ Y / N
Endocrine:	
Diabetes	☐ Y / N
Insulin	☐ Y / N
Thyroid Dis.	☐ Y / N
Neurologic:	
Seizures	☐ Y / N
TIA	☐ Y / N
Stroke	☐ Y / N
Hematologic:	
Anemia	☐ Y / N
Bruising	☐ Y / N
Bleeding	☐ Y / N
Enlarged Lymph Nodes	☐ Y / N

Surgical History:

Circle if these apply to you:

General Symptoms: Unexplained wt loss/gain, fatigue, fever, chills, night sweats **/ HEENT:** Runny nose, nasal congestion,nose bleeding, sinus pain **/ Cardiac:** Palpitations, chest pain, short of breath lying flat, dizzy spells, fainting **/ Pulmonary:** Cough: dry or wet. Sputum: clear, purulent, or bloody, chest pain w/inhale **Neurology:** Seizure, TIA, Stroke, tremor, weakness, double visoin, unusual headaches. **/ Skin:** Rases **GI:** Nausea, vomiting, diarrhea, difficulty swallowing, GERD, peptic ulcer, rectal bleeding **Genito-urinary:** Urinary frequency, blood in urine, painful swelling, muscle aches and pains.

Cancer History:	Location / Type	Year

Sleep Evaluation: **fill out if you have a sleep problem** - Tired on waking, Daytime fatigue, poor sleep quality, morning headaches

Usual bedtime_____, Usual wake time_____, Dinner time_____, Nap _____,#of Caffinated drinks___,#of Nightly awakenings____

EPWORTH SLEEPINESS SCALE

NAME:_____

DATE: _____

How likely are you to doze off or fall asleep in the following situations in contrast to just feeling tired? 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 Television	_____
Sitting, inactive in a public place such as a theater or meeting	_____
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 a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Add all responses **TOTAL**	_____

SCORES

1 – 6	Getting enough sleep
7 – 8	Score is average
9 and up	Excessively sleepy – Seek the advice of a Sleep Specialist without delay.