# The Center for Respiratory and Sleep Disorders

You have an appointment with Dr. MacDonald on: _____

**FORMS:**
Print off new patient registration forms from **www.novi sleep.com.** It is essential that paperwork is received **prior** to your appointment. Once the forms are completed:

1. **Fax** the completed forms to us at **248-465-9285**
2. **Mail**-If your appointment is more than 5 days from now, mail them to us at:
   The Center for Respiratory and Sleep Disorders
   44000 W. 12 Mile Rd. Suite 113
   Novi, MI 48377
   Attn: forms
3. Drop the forms off at our office

**BRING ON YOUR APPOINTMENT DAY:**
1. A list of your medications, respiratory inhalers and supplements. Include the name, dose and frequency for each medication 2. Your completed forms and testing results 3. Picture ID and insurance card, 4. A referral (if required) from your primary care physician.

**TESTING:**
**Important: Contact your physician(s) and have the listed items below faxed to our office asap (248-465-9285) and/or bring them with you to your appointment:**

1. Pulmonary function test
2. Chest x-rays
3. CT scans/Pet scans
4. Echocardiogram
5. Stress test
6. Sleep studies
7. Medication list
8. Progress note(s) including recent hospitalizations

**X-RAYS/CT SCANS/PET SCANS from a Detroit Medical Center (DMC) or Providence/St. John facility:**
For testing (except sleep studies) done at a DMC or Providence/St. John facility, Dr. MacDonald can access the testing. It will not be necessary to bring them with you. *You **will** need to obtain any sleep studies.*

**X-RAYS/CT SCANS/PET SCANS *NOT* from a DMC or Providence/St. John facility:** Go to the facility where the images were taken. Inform the radiology staff you need the testing scanned onto a CD(s). Bring the CD(s) with you to your appointment.

**INSURANCE AND REFERRALS:**
It is the responsibility of patients to know their insurance coverage including any out of pocket expenses for services rendered. For those with inactive insurance coverage, no insurance or lack of a referral, full payment is required at time of the office visit. Visit www.novisleep.com for more information. **Any needed referrals from your primary care physician must be obtained by you prior to your appointment.**

Please contact our office at (248) 465-9253 should you have any questions. We look forward to meeting with you.

Thank you, Dr. Lawrence MacDonald and his staff

*All missed appointments and less than 24-hour cancellation notice are subject to a fee. See our website, www.novisleep.com for further information.*

Fill out completely, sign & date
**Form #1**

# The Center for Respiratory and Sleep Disorders

## Registration Information

Reason for Consultation _____

***Please list all physicians you see. Include: First name, last name and specialty. Example: "Dr. Jane Doe Cardiologist"***

Referring: First_____ Last_____ Specialty_____

Primary: First _____Last_____Specialty_____

Specialist: First _____Last_____ Specialty_____

Specialist: First _____Last _____ Specialty_____

Specialist: First _____Last _____Specialty_____

Patient Name: First _____ MI _____ Last _____

Date of Birth_____ Sex Male Female

Address _____

City _____ State _____ Zip _____

Primary Phone # _____ Cell Home

Alt Phone # _____ Cell Home

Marital Status: Married Single Divorced Domestic Partner Preferred Language _____

Ethnicity (Circle one): Hispanic Not Hispanic Declined/Not provided

Race: Caucasian/White African American/Black Native American Asian Declined/Not provided

Insurance _____ ID Number_____

Primary Insured_____ Primary Insured DOB_____

Email Address _____

Emergency Contact: First_____Last_____ Phone # _____

Relationship to patient _____

Pharmacy _____ Phone # _____

Address _____ City _____

Do you have a current home care company (DME)? Yes No

If yes, name of home care company: _____

I hereby assign all medical, to include major medical benefits to which I am entitled including Medicare and private insurance and any other health plans to: Michigan Respiratory and Sleep Physicians (corporate name for The Center for Respiratory and Sleep Physicians and Dr. Lawrence MacDonald). This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize Michigan Respiratory and Sleep Physicians to download my medication history and Rx benefits into my account from a Rx clearinghouse.

*Missed appointments & less than 24-hour cancellation notice are subject to a fee. See our website, www.novisleep.com for further information.*

**Patient Signature** _____ **Date** _____

**Form #2**

# The Center for Respiratory and Sleep Disorders

## Medication List (please print clearly)

Name: First_____ Last_____ DOB_____

| Medication Name | Dose | Frequency |
|---|---|---|
| IF NO MEDICATIONS, check box here: ☐ | | |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| 6. | | |
| 7. | | |
| 8. | | |
| 9. | | |
| 10. | | |
| 11. | | |
| Respiratory Inhalers- Name | Dose | Frequency |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| Allergies (Include drug, food and environmental) | Reaction | |
| IF NO KNOWN ALLERGIES, check box here: ☐ | | |
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | |
| 5. | | |
| Medical History | | |
| Pneumonia Vaccine | Date given: | |
| Flu Vaccine | Date given: | |
| Colonoscopy: *If applicable* | Date of procedure: | |
| Mammogram: *If applicable* | Date of procedure: | |
| Tobacco Use: *Please circle* | Never smoked | |
| Current smoker: Year started: | How much: | Years smoking: |
| Former smoker: Year started: Quit: | How much: | Years smoking: |

It is our goal to provide you with excellent care. Please include all prescription medications, inhalers, over the counter medication, herbal medication, and vitamins you are taking.

Form #3

# The Center for Respiratory and Sleep Disorders

Patient Name: First _____ Last _____

Date _____ Date of Birth: _____ Neck circumference_____

## Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast 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 (circle) | | | |
|---|---|---|---|---|
| Sitting and reading | 0 | 1 | 2 | 3 |
| Watching TV | 0 | 1 | 2 | 3 |
| Sitting inactive in a public place (like a theater or meeting) | 0 | 1 | 2 | 3 |
| As a passenger in a car for an hour without a break | 0 | 1 | 2 | 3 |
| Lying down to rest in the afternoon when circumstances permit | 0 | 1 | 2 | 3 |
| Sitting and talking to someone | 0 | 1 | 2 | 3 |
| Sitting quietly after lunch without alcohol | 0 | 1 | 2 | 3 |
| In a car, while stopped for a few minutes in traffic | 0 | 1 | 2 | 3 |

**Total** _____

## COPD Assessment Test (CAT)

For each item below, circle the number that best describes you currently. Be sure to only select one response.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| I never cough | 0 | 1 | 2 | 3 | 4 | 5 | I cough all the time |
| I have no phlegm (mucus) in my chest at all | 0 | 1 | 2 | 3 | 4 | 5 | My chest is completely full of phlegm (mucus) |
| My chest does not feel tight at all | 0 | 1 | 2 | 3 | 4 | 5 | My chest feels very tight |
| When I walk up a hill or one flight of stairs I am not breathless | 0 | 1 | 2 | 3 | 4 | 5 | When I walk up a hill or one flight of stairs I I am very breathless |
| I am not limited doing any activities at home | 0 | 1 | 2 | 3 | 4 | 5 | I am very limited doing activities at home |
| I am confident leaving my home condition | 0 | 1 | 2 | 3 | 4 | 5 | I am not at all confident leaving my home despite my lung because of my lung condition |
| I sleep soundly | 0 | 1 | 2 | 3 | 4 | 5 | I don't sleep soundly because of my lung condition |
| I have lots of energy | 0 | 1 | 2 | 3 | 4 | 5 | I have no energy at all |

**TOTAL SCORE:** _____

Form #4

# The Center for Respiratory and Sleep Disorders

## Authorization for Release of Information to Family Member or Friend: Without Power of Attorney

I, _____ (patient), hereby give the following person(s) authorization to obtain information regarding my:

_____ Confirm appointments and leave messages
_____ Lab work/ test results
_____ Medical records information

Person 1 _____ Relationship _____
Person 2 _____ Relationship _____
Person 3 _____ Relationship _____

Patient Signature _____ Date _____
Print Name _____

****This request valid for one year from date above****

## Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices maintained by my health care provider when I sought health care treatment. I understand that if I presented to my health care provider with an emergency condition or injury, the Notice of Privacy practices was provided as soon as reasonably practicable after the emergency condition or injury.

Date _____ Patient Signature _____

If this acknowledgment is signed on behalf of the patient, the person's authority to sign for the patient must be indicated.

Person signing on behalf of patient: Print Name_____

Date _____ _____ _____
Signature Legal Authority

Address: _____

***STAFF:*** *If the acknowledge is not signed by the patient or legal representative, document the reason for not obtaining the acknowledgement and the good faith efforts made to obtain the acknowledgement.*

_____

Staff Signature: _____ Date: _____

**Form #5**

# The Center for Respiratory and Sleep Disorders

Authorization for Another Facility/Office to Release Medical Information to The Center for Respiratory and Sleep Disorders

Patient Name_____ DOB_____

Patient Address_____

City _____ State _____ Zip _____

Phone Number _____

*I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the manager at the Center for Respiratory and Sleep Disorders. We may have already released the information based on your original authorization. We will not release any additional information after we receive your revocation. We will not condition treatment or payment based on this authorization or revocation unless otherwise allowed by law.*

SIGNATURE OF PATIENT_____

Print Name _____

DATE _____ Relationship to patient _____

***Patient: Please do not fill out below***

*****************OFFICE USE ONLY*****************

I authorize (facility/office) _____to release information contained in my medical record (including, if applicable, information about HIV infection or AIDS, substance abuse treatment and mental health services) to The Center for Respiratory and Sleep Disorders.

**Requested information:**

| | | |
|---|---|---|
| _____ Chest X-Rays | _____ Echocardiograms | _____Pulmonary Function Tests |
| _____ CT scans | _____ Sleep Studies | _____ Recent Hospitalizations |
| _____ Stress Tests | _____ Lab Results | _____ Demographic & Insurance info |

_____Progress Notes Dated: _____ Other: _____

Other: _____

Please **FAX RECORDS TO 248-465-9285**

If you have any questions please contact our office at **248-465-9253.**

# Notice of Privacy Practices

**This notice describes how medical information about you may be used and disclosed and also how you can get access to this information. Please review it carefully. This notice take affect on you initial date of service at our office and remains until we replace it.**

OUR PLEDGE REGARDING MEDICAL INFORMATION- The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

OUR LEGAL DUTY-Law requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the current notice.

We have the right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices: Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

USE AND DISCLOSURE FOR YOUR MEDICAL INFORMATION- This following section describes different ways that we use and disclose medical information. We have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below without specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the end of this notice.

**For treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, and other people who are taking care of you. We may also share medical information about you to other health care professionals to assist them in treating you.

**For payment:** We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third party payer. The information on or accompanying the bill may include your medical information.

**Notification:** We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission, if possible, before we share or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick-up medicine, x-rays or medical information about you.

**Disaster relief:** We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

**Court orders and judicial and administrative proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

**Public health activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems in order to enable recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

YOUR INDIVIDUAL RIGHTS- You have the right to:

1. Look at or get copies of certain parts of your medical information. You must make this request in writing by sending a letter to the contact person listed below.
2. Receive a list of times your medical information was shared for purposes other than treatment, payment and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in the case of an emergency.
4. Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you want changed. If we accept your request to change the information, we will make reasonable efforts to notify others, (including people you name) of the change and to include the changes in any future sharing of that information.

QUESTIONS AND COMPLAINTS-If you have any questions about this notice or if you think we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file a complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way, if you choose to file a complaint.

You may contact us at: The Center for Respiratory and Sleep Disorders-Attention-Manager 44000 W. 12 Mile Road, Suite 113 Novi, MI 48377