Chest Physician Consultants
Asaad Jandali MD, FCCP
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8840 Calumet Ave, Suite 206
Munster, IN 46321
Phone: (219) 836-7723
Fax: (219) 836-7726

Name: _____ Date of Birth_____
Home Phone: _____ Cell Phone: _____ Work: _____
Street Address: _____
City: _____ State: _____Zip: _____
Social Security: _____ Sex: _____ Marital Status: _____
Race: _____ Hispanic: _____ Non-Hispanic/Other: _____
Primary Language Spoke: _____
Email Address: _____
Preferred Method of Communication (**check one**) Email: _____ Call: _____SMS Text: _____
Preferred Pharmacy: (Name & Phone #) _____
Emergency Contact: _____
Relationship to Patient: _____ Phone: _____

*** Name of Physician or Person Who Referred You to Our Clinic***
Referred By: _____

Employer Name of the Insured: _____ Job Title: _____
Address: _____ Phone: _____

*** Please Give Cards to the Front Desk***

Primary Insurance: _____ Phone: _____
Insured Name: _____ Date Of Birth: _____
Policy/ID Number: _____ Group: _____
Relationship to the Insured: _____

Secondary Insurance: _____Phone: _____
Insured Name: _____ Date Of Birth: _____
Policy/ID Number: _____ Group: _____
Relationship to the Insured: _____

***** NO SHOW FEE**. We have a 24-hour cancellation policy. In the event you are unable to keep your scheduled appointment, please notify us as soon as possible so that we may fill that appointment slot. A $25.00 No-Show fee will be charged to your account for failure to notify us.
***** Afterhours Calls.** A $15 after hour service fee will be charged for all non-emergency phone calls to the physician between the hours of 6pm and 9 am, Monday through Friday, and anytime over the weekend. This fee is not billable to your insurance.

Patient Signature: _____ Date: _____

Last Name:_____ First:_____ Middle:_____

Today's Date:_____ Date of Birth:_____ Referring Physician:_____

CHIEF COMPLAINT: (Reason for visit today)_____

List Any Allergies

Dye	Y	N	Latex	Y	N
Iodine	Y	N	Shell Fish	Y	N

Medication Allergies:

_____

_____

_____

_____

List Any Past Surgeries

Type	Date (Year only)

Medications (Currently Taking)

Name	Amount	Times/Day

Patient's Medical History

			When Diagnosed (Year)
Cancer	Y	N	Type_____
Diabetes	Y	N	_____
Emphysema	Y	N	_____
Heart attack	Y	N	_____
Heart failure	Y	N	_____
Hypertension	Y	N	_____
Kidney stones	Y	N	_____
Other			_____
Pregnancy	Y	N	

Number of children_____

Vaginal delivery_____ C-section_____

Menses: every _____days ___Regular ___Irregular

Social History

Occupation:_____

Do You Smoke? Y N How Much?_____

Do You Drink Alcohol? Y N How Much?_____

Family History

			Family Member
Cancer (type)	Y	N	_____
Diabetes	Y	N	_____
Heart disease	Y	N	_____
Kidney stones	Y	N	_____
Stroke	Y	N	_____

CONSENT TO TREAT: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

INTL. _____

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INS BENEFITS: I authorize my physician to release information from my medical record to my insurance carrier(s), or government agency for the processing of claims for medical benefits. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my physician, on my behalf.

INTL. _____

MEDICARE CERTIFICATION: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my physician who treats me, to release information from my medical record to the Social Security Administration and/or the Medicare program or its intermediaries or carriers, or to the Professional Standards Review Organizations for processing of claims for medical benefits. I request that payment of authorization benefits be made directly to my physician treating me, on my behalf.

INTL. _____

FINANCIAL AGREEMENT: I understand all accounts are the full responsibility of the patient and/or the patient's responsible party/guarantor. My physician will assist patients in obtaining insurance benefits when those benefits are assigned to my physician. It is the patients responsibility to make sure insurance payments are processed and paid promptly to my physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

INTL. _____

PATIENT'S SIGNATURE _____ DATE _____

Parent/Guardian _____ DATE _____

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We at Chest Physician Consultants take your privacy rights very seriously and in an effort to communicate with you more effectively and keep your privacy information confidential to only (those you have chosen to receive your protected health information); we are asking that you complete the following form. This form lets you be the person to decide who we can release your information to and for what reason.

I, _____, have either received a paper copy or reviewed the office copy of Chest Physician Consultants privacy practices.

I would like to have on record the names and phone numbers of the following family members or friends to which you may discuss or leave information about my protected health information and /or financial matters.

Name: _____Relation: _____ Phone: _____

Name: _____Relation: _____ Phone: _____

Name: _____Relation: _____ Phone: _____

In addition to the above, how may we communicate with you regarding any health issues or concerns which may be confidential? (For example, Lab results, X-Rays, reminders of appointments, etc.)

May we leave messages on your phone? Yes_____ No_____

Can you be contacted at work? Yes_____ No_____ (if yes, please provide the number)

Post card or mail? Yes_____ No _____

Patients Signature: _____ Date: _____

Patient Privacy Notice

Chest Physician Consultants

Patient Information

Last Name: _____ **MI:**_____ **First Name:** _____

SSN: _____ **Date of Birth:** _____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

***Chest Physician Consultants* is required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties with respect to your protocol health information.**

Disclosure of your health care information:

Treatment

We may disclose your health care information to other health care professionals within our practice for the purpose of treatment, payment or health care operations.

Payment

We may disclose your health care information to your insurance care provider for the purpose of payment or health care operations.

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceedings.

Law Enforcement

We may disclose your health information to a law enforcement official for the purpose such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, or other law enforcement purposes.

Deceased Persons

We may disclose your health information to organizations involved to coroner's medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research

We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety

It may be necessary to disclose your health information to appropriate person in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefit purposes.

Your Health Information Rights

You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that *Chest Physician Consultants* is not required to agree to the restriction of your request.
You have the right to have your health information received or communication through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
You have the right to inspect and copy your health information.

You have a right to request that *Chest Physician Consultants* amend your protected health information. Please be advised, however *Chest Physician Consultants* is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
You have a right to receive an accounting of disclosures of your protected health information made by *Chest Physician Consultants.*
You have a right to a copy of this Notice of Privacy Practices at any time upon request.

Changes to this notice of privacy practices

Chest Physician Consultants reserves the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such amendment is made, *Chest Physician Consultants* is required by law to comply with this notice.

Chest Physician Consultants is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact us.

Complaints

Complaints about your Privacy Rights or how *Chest Physician Consultants* has handled your health information should be directed to us. You may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509 F HHH Building
Washington DC, Maryland 20201
This notice is effective of today's date listed below.

I have read the Privacy Notice and understand my rights contained in the notice. By way of signature, I provide *Chest Physician Consultants* with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

Last Name: _____ **First Name:** _____ **Date:**_____

Signature:_____

Screening Assessment

Patient Name:_____ Today's Date:____/____/_____

Date of Birth:____/____/_____ Patient Phone: (___) -_____-_____

Symptoms	Severity				Frequency		
	N/A	Mild	Moderate	Severe	Occasionally/Never	Seasonal	Most of the Year/Daily
Itchy Eyes	0	1	2	3	0	1	2
Watery Eyes	0	1	2	3	0	1	2
Red Eyes	0	1	2	3	0	1	2
Runny Nose	0	1	2	3	0	1	2
Itchy Nose	0	1	2	3	0	1	2
Stuffy Nose	0	1	2	3	0	1	2
Frequent Sneezing	0	1	2	3	0	1	2

Circle One

1. Have you ever been diagnosed with asthma, recurrent wheezing, or recurrent bronchitis?	Yes	No
2. Have you ever been diagnosed with atopic dermatitis, eczema, or recurrent sinusitis?	Yes	No
3. Do you take prescription or OTC medications to manage your allergy symptoms?	Yes	No

Circle each medication that you use to manage your allergy symptoms:

Allegra (Fexofenadine) Xyzal (Levocetirizine) Benadryl (Diphenhydramine) Zyrtec (Cetirizine)

Claritin (Loratadine) Singulair (Montelukast) Clarinex (Desloratadine) Other: _____

4. Do you take any steroidal or non-steroidal anti-inflammatory drugs?	Yes	No

Circle each medication that you use to treat inflammation:

Aleve (Naproxen) Aspirin Advil/Motrin (Ibuprofen) Prednisone Other: _____

5. Have you ever had a reaction to any foods in the past? If so, describe the event.	Yes	No

Circle the reaction(s) you experienced during the event(s):

Tingling/itchy mouth Hives/rash/eczema Swelling Wheezing/difficulty breathing

Abdominal pain/ diarrhea/nausea/vomiting Dizziness/lightheadedness/fainting

If the answer to question 5 was "No", please skip questions 6 and 7.

6. Do you have any family members that have been diagnosed or have suspected allergies? If so, list those family members and their diagnosed/suspected allergies.	Yes	No
7. Have you ever been tested for food allergies?	Yes	No

Patient/Guardian Signature: _____ **Date:** _____

Office Use Only:

Sum of severity of symptoms (0-21)	**Sum of frequency of symptoms (0-14)**	**Order 95004?**	
		Yes	No
Diagnosis (circle one) **J30.89** **J30.1** **J30.2** **Other** _____		**Circle Test(s)**	
Provider Signature:	**Date:**	Environmental	Food
		Environmental & Food	

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