<table>
<tr>
<td>
Vero Lung Center</td>
<td>John Suen, MD PA
3735 11th Circle, Suite 103
Vero Beach, FL 32960
PH: 772-770-4888
FAX: 772-770-0190</td>
<td>
Sleep Disorders Florida</td>
</tr>
</table>

Visit For: ( ) Pulmonary Care ( ) Sleep Medicine **Date:** ______________

Referred By: ( ) Dr. ____________________ PCP: ______________________ ( ) Self-Referral

Last Name: ________________________ **First Name:** ______________________ **MI:** ___

Date of Birth: __________ **Preferred Language:** __________ **Marital Status:** (M) (S) (D) (W)

Address: __________________________ **City:** _______________ **State:** _____ **ZIP:** ______

Home Phone: _______________________ **Cell Phone:** _________________________

Work Phone: _______________________ **Email:** ____________________ **Social Sec:** __________________

Sex: ( ) Male ( ) Female ( ) Transgender ( ) Prefer not to Disclose

Race: _______________________ **Of Hispanic Origin:** ( )Yes ( ) No ( ) Prefer not to Disclose

Spouse: _______________________ **Phone:** _________________________

Case of Emergency, Please Contact:

Name: _______________________ **Relationship:** ________________ **Phone:** __________________

Current Employer: ______________________________ **Address:** ______________________________

City: ____________ **State:** _________ **ZIP:** _________

Preferred Pharmacy (Local): ____________________ **Phone Number:** _________________

Preferred Pharmacy (Mail): ____________________ **Phone Number:** _________________

Insurance Information

(We will need a copy of your Insurance Card(s) and your Driver's License. If the subscriber on the Insurance Card is different, please list the name, date of birth, and social security number and billing address of the subscriber.)

Name of Subscriber: __________________________ **Date of Birth:** __________________

Social Security Number: ______-______-______ **Subscriber Phone:** ______________________

Address: __________________________ **City:** ______________ **State:** _______ **ZIP:** ________

Primary Method of Payment: ( ) Cash ( ) Check ( ) Credit Card

(WE ACCEPT ALL MAJOR CREDIT CARDS)

Care Team

Provider Type:	Name:	Phone Number:
Primary Care		

Medication List:

(If your list exceeds the space below, please bring an accurate list with you or attach with your documentation)

Medication Name:	Medication Dosage:	Medication Frequency:

Allergies:

(If your list exceeds the space below, please bring an accurate list with you or attach with your documentation)

Allergen:	Reaction:

Personal Medical History

(Circle All That Apply)

ADHD	**Crohn's Disease**	**Hiatal Hernia**	**Osteopenia/ Osteoporosis**
Alcoholism	**COPD/Emphysema**	**High Cholesterol**	**Parkinson's Disease**
Allergies, Seasonal	**Dementia**	**HIV**	**Peripheral Vascular Disease**
Anemia	**Depression**	**Hepatitis**	**Peptic Ulcer**
Anxiety	**Diabetes: I or II**	**Hypertension**	**Psoriasis**
Arrhythmia	**Diverticulitis**	**Irritable Bowel (IBS)**	**Pulmonary Embolism**
Arthritis	**DVT (Blood Clot)**	**Kidney Disease**	**Rheumatoid Arthritis**
Asthma	**GERD/ Acid Reflux**	**Kidney Stones**	**Seizure Disorder**
Bipolar	**Glaucoma**	**Liver Disease**	**Sleep Apnea**
Bladder Problems	**Headaches**	**Lupus**	**Stroke**
Bleeding Problems	**Heart Disease**	**Macular Degeneration**	**Thyroid Disorder**
Cancer:	**Heart Attack (MI)**	**Neuropathy**	**Ulcerative Colitis**

Other Medical Problems Not Listed Above: ______________________________

Past Surgical History

Surgery:	Date:

Social/Cultural History

Education Level: ( )Elementary ( )High School ( )Vocational ( )College ( )Graduate/Professional

Are there any vision problems that affect your communication? ( ) Yes ( ) No

Are there any hearing problems that affect your communication? ( ) Yes ( ) No

Are there any limitations to understanding or following instructions (either written or verbal)? ( ) Yes ( ) No

Current Living Situation: ( ) Single Family Household ( ) Multi-generational Household ( ) Homeless ( ) Shelter ( ) Skilled Nursing Facility ( ) Other: ___________

Smoking/Tobacco Use: ( ) Current ( ) Former ( ) Never

Type: ____________Amount/Day: ___________ Number of Years: ____________

Alcohol: ( ) Current ( ) Former ( ) Never Drinks/Week: _____________

Recreational Drug Use: ( ) Current ( ) Former ( ) Never Type: ___________________

Are there any personal problems or concerns at home, work, or school you would like to discuss? ( ) Yes ( ) No
If Yes: ____

Are there any cultural or religious concerns you have regarding the delivery of your care? ( ) Yes ( ) No
If Yes: ____

Occupation? *(If retired, what was your previous occupation?)*________________________________

Are there any financial issues that directly impact your ability to manage your health? ( ) Yes ( ) No
If Yes: ____

How often do you get the social and emotional support need?

( ) Always ( ) Usually ( ) Sometimes ( ) Rarely ( ) Never

Family History

Father: ( ) Living ( ) Deceased Age: __ If Deceased, Cause? ____________________________

Medical History: ____

Mother: ( ) Living ( ) Deceased Age: __ If Deceased, Cause? ____________________________

Medical History: ____

Siblings: ( ) Brother(s) ___ ( ) Sister(s) ___ Medical History: ___________________________

Child(ren): ______Son(s) ______Daughter(s) Medical History: ___________________________

Family History Unknown Secondary to Adoption? ( ) Yes ( ) No

Patient Signature: ______________________________Date: __________________________

Prescription Drug Policy

The law requires responsible usage of prescription drugs by providers and patients. If you accept a prescription from one of our providers, you are also accepting the responsibility to use the drug for yourself and only as prescribed. Our responsibility is to prescribe medications in an appropriate dosage and amount, with clear instructions. We will also inform you of the reasons we are prescribing the drug, the expected benefits from its use, and the major precautions and side effects.

Prescription drugs have potential for abuse and are regulated closely by state and federal agencies. Certain, more closely controlled drugs (narcotic pain medications and tranquilizers) require even more responsibility on your part. We will accept NO excuses for their loss, theft and will not order replacement. We expect you to notify our office if you change your Pharmacy so that the order at the first Pharmacy may be cancelled.

Many prescription drugs are appropriate for short-term use only. If and when we feel it is not in your best interest to continue on a medication, we will tell you. If we cannot agree about your continued use of a substance, then we will require additional consultation with other specialists to help decide on the correct course of action.

Our office also requires a 24–48-hour call-in policy for the refill of your prescriptions. When your medications aregetting low and you feel you will need a refill, please call our office with the name of your pharmacy and pharmacy phonenumber a minimum 48 hours prior. This will allow ample time to ask your treating provider and then call your medication in to your pharmacy. Please do not call the office again until we have been given the 48-hour time frame. Please reach out to your Pharmacy prior to calling to office to inquire if the prescription has been received. Prescriptions will NOT be refilled after 12:00pm (noon) on Friday or on weekends. These prescriptions will be sent on the next business day.

Failure to follow these policies will force our office to terminate our professional relationship and may require us to file a report with the Department of Professional Regulation (DPR). If you are in agreement with all the information that has been provided above, please sign your acceptance to abide by these policies.

______________________________ ____________________

Patient's or Patient's Guardian Signature **Date**

Release of Information

( ) I authorize the release of information including: diagnosis, records, examination rendered to me, and claimsinformation. 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.

Messages

Please call ( ) My Home Number ( ) My Work Number ( ) My Cell Number

If unable to reach me:

( ) You may leave a detailed message

( ) Leave a message asking for me to return your call

( ) Other ____ ____

The best time to reach me is (Day) ____________________between (Time) ____________________

Signed: ____ ____________________________________Date: ____________________________

Witness: ____ Date: ___________________________

AUTHORIZATION TO RELEASE OR USE INFORMATION FOR TREATMENT, PAYMENT, ORHEALTHCARE OPERATIONS

I hereby authorize the release or use of my individually identifiable heath information (protected heath information) and medical record information by John S. Suen, M.D. PA (the Practice) in order to carry out treatment, payment, or healthcare operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or health care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I acknowledge and agree that the Practice may disclose my protected health information and medical record information to the individuals who are either my family members, legal representatives, guardians, health care surrogates, or have power of attorney on my behalf: noted on the previous page.

IN NETWORK PAYMENT POLICIES

Dr. Suen accepts assignment on all Medicare patients. I understand that I am responsible for being aware of and meeting any deductibles. I understand that the 20% co-payment not covered by Medicare, or any co-payment not covered by private insurance, is expected on the day services are rendered. In case of financial hardship or difficulty, a financial arrangement must be made prior to initiation of treatment. Our office files your insurance as a courtesy twice. After the second try, the responsibility is yours,

Our office will file all the primary and secondary insurance claims for our patients. In most cases, we will receive payment from the insurance companies. However, in cases of the insurance company sending the payment to the patient, we expect the payment to be surrendered in its entirety. We ask that the patient endorse the check and forward to our office upon receipt as payment for services rendered by Dr. Suen. By signing below, you have indicated that you have read the aforementioned insurance disclosure and agree to comply with the policy set forth by ouroffice.

If your Provider is an IN-NETWORK provider for your insurance, YOUR CO-PAY MUST BE PAID AT THE TIME OF SERVICE AND ALL DEDUCTIBLES ARE DUE AT THE TIME OF THE VISIT.

Please note - Each insurance policy is different. It is **YOUR** responsibility to know your policy. If pre-authorization is needed, then it is **YOUR** responsibility to notify our staff so we may obtain authorization. If authorization is not obtained, it is **YOUR** responsibility to pay for all charges incurred. Remember, your insurance policy is a contract between you and your insurance company. It is **NOT** a contract between you and your doctor.

There is a $25.00 charge for NSF checks.

Signature: ______________________ Printed Name: ____________________ Date: ________

Vero Lung/ Sleep Disorders Center Florida

No Call/ No Show Policy

Your appointment is important to us and to your health. If you miss an appointment you may delay the treatment that you need. You may also have to wait longer than you would like for a new appointment date. We do not want to keep you waiting, but our health care providers are frequently booked at capacity and may not be able to reschedule you immediately.

If you must change your appointment, in consideration to others who are waiting to be seen here, please call us 24 hours in advance to cancel the appointment. **You may leave a voice message to cancel only during office hours**. Failure to do so will result in a charge of **$25** for office visits, **$200** for sleep studies. **This charge is not covered by insurance and is to be paid beforeanother appointment can be scheduled.**

Late Policy

Our goal is to be on time for your appointment, however, due to unforeseen circumstances we may occasionally run behind. If you arrive late for your appointment, this further increases delays to not only your care, but also other patients who have arrived on time and may be waiting. **(This applies to office appointments and testing.)**

If you are greater than 15 minutes late for your appointment, you may be asked to:

1. Wait to be fit in to an available time slot with one of our providers
2. Come back later in the day for an opening
3. Reschedule your appointment for another day

We greatly appreciate your understanding and cooperation with this policy.

My signature below indicates that I have read and understand the above policy.

Signature: ______________________________ Printed Name: _____________________ Date: ________

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** All Services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** All Services below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Pulmonary or Sleep Services at Dr. John Suen's office	Upon services being rendered accordingly, our office will bill your insurance. Any services that are denied, will be patient's responsibility. If you agree to this, please check option 1. If you do not check option 1, we are unable to render services to you.	To be determined by your Insurance

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** All Services listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: **Check only one box. We cannot choose a box for you.**
☐ **OPTION 1.** I want the **D** All Services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I want the **D.** All Services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
☐ **OPTION 3.** I don't want the **D.** All Services listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

Sleep Disorders Center Florida
Patient Questionnaire

Name: ______________________ **Date of Birth:** ____________

Height: ________ **Weight:** _________ **Neck size (inches):** __________

Referring Physician: ______________________ **Today's Date:** __________

Please check all that apply to you:

_______ Disturbed or restless sleep

_______ Frequent Unexplained Arousals

_______ Fragmented Sleep

_______ Non-Restorative Sleep (still feel tired upon waking after full night sleep)

_______ Excessive Daytime Sleepiness

_______ Fatigue

_______ Sleepiness interferes with social activities or work

_______ Disruptive/Loud Snoring

_______ Witnessed apneas during sleep (others witness you not breathing)

_______ Choking or gasping during sleep

_______ Speaking while sleeping

_______ Sleepwalking

_______ Snoring wakes you up

_______ Wake up and can't go back to sleep

_______ Unable to fall asleep/relax

_______ Experience dreaming shortly after falling asleep

_______ Sudden muscle loss or fainting feeling after experiencing strong emotions (laughing, crying, fear, anxiety, etc.)

_______ Fall asleep easily (in any situation)

_______ Fall asleep watching TV or reading

_______ Fall asleep having a conversation

_______ Experience leg pain, cramps, creeping/crawling/itching sensation in arms or legs when trying to fall asleep

_______ Experience twitching/movement of limbs while asleep (or partner complains of these)

_______ Awaken with heart pounding

_______ Awaken with sore/dry throat

_______ Other sleep complaints not listed:

____

____

____

____

Questionnaire Continued...

Have you ever had a sleep study? YES NO When? ____________________________

Where? ____

Have you ever been on CPAP or BiPAP? Y N Do you use CPAP or BiPAP currently? Y N

CPAP or BiPAP Pressure (if known) ______________

Why are you not using CPAP or BiPAP (if applicable)? ______________________________

What is your preferred bedtime? ______________ What time do you go to bed? ______________

What time do you wake up? ________________ How long does it take to fall asleep? ____________

How many hours do you think you sleep at night? ________

How often do you use the restroom at night? ___________times

Do you work shifts? YES NO If so, please explain: ______________________________

Is your sleep different on weekends than weekdays? YES NO

If so, please explain: ____

Do you take naps during the day? YES NO How many? ________ How long each? ____________

Do you take sleep aids? YES NO Name/dose______________________________________

Where do you sleep? Traditional Bed Adjustable Bed Recliner

If using a recliner or adjustable bed, give reason why. ______________________________

Do you require assistance getting in and out of bed? Y N

Do you have a caregiver to stay with you if you need assistance? Y N

Do you have any medical conditions that may affect your study or your ability to take a study that we need to be aware of? (i.e. tape or latex allergies, open wounds, recent surgery, acid reflux, etc.)

____

Do you have a pacemaker or internal defibrillator? Y N

Do you sleep with supplemental oxygen? Y N LPM: ______________

Do you have any of the following medical conditions? (please check any and all that apply)

_____ Lung Disease _____ Heart Disease _____ Mental Disorders

_____Depression _____ Drug addiction _____ Alcohol abuse

_____ Liver /kidney disease _____ Neurologic disorder _____ Diabetes

_____ Hypertension _____ Blood disorders _____ Chronic pain

______ CHF (Congestive Heart Failure) ______ COPD (Coronary Obstructive Pulmonary Disorder)

______ Asthma

The Epworth Sleepiness Scale

Name: ______________________________ **Date of Birth:** ____________

Height: ________ **Weight:** __________ **Neck size (inches):**__________

Sex: Male Female (circle one) **Today's Date:** ____________

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*
Sitting and reading	________
Watching TV	________
Sitting inactive in a public place	________
As a passenger in a car for an hour without a break	________
Lying down in the afternoon when circumstances permit	________
Sitting and talking to someone	________
Sitting quietly after lunch without alcohol	________
In a car, while stopped for a few minutes in traffic	________
Total:	________

SLEEP DISORDERS CENTER FLORIDA

3735 11TH CIRCLE, SUITE 103, VERO BEACH, FLORIDA 32960

PERMISSION TO PHOTOGRAPH AND/OR RECORD AUDIO AND VIDEO

I, ______________________________________

Patient/Guardian

Hereby authorize Sleep Disorders Center Florida, or their representative, to take photographs(s) and/or record audio and video

of ____

Name of Patient

I understand that such photograph(s), audio recording(s) and/or video recordings will be used for clinical (the sleep study) or training purposes (training Sleep Technologists) or in the event of legal action. The sleep center and trustees of Sleep Disorders Center Florida and its duly appointed representatives are hereby released without recourse from any liability arising from obtaining and using such photograph(s), audio recording(s) and/or video recordings.

The undersigned also hereby transfers and assigns to the Sleep Disorders Center Florida the right to copy the materials in whole or in part (to assist in diagnosing a sleep disorder).

No use of the material for employee training purposes (Sleep Technologists) will identify me by name.

______________________________ ______________________________

Signature (patient or guardian) Print Name

______________________________ ______________________________

Relationship to Patient Date