A MEMBER OF BAPTIST MEMORIAL MEDICAL GROUP

MEMPHIS LUNG

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Laura Smith, DNP, ACNPC-AG
Hamzha Aysheh, DNP, AGACNP-BC

APPOINTMENT DATE: _____ **CHECK-IN TIME:** _____

LOCATION: ☐ **2120 Exeter Rd, Suite 250, Germantown, TN 38138**
PH: 901-767-5864 **FAX:** 901-767-6591
(Located above OrthoSouth, next to Trader Joes, in the Baptist Medical Group building)

☐ **363 Southcrest Cir, Suite 201, Southaven, MS 38671**
PH: 662-349-0488 **FAX:** 662-349-5974

PLEASE ARRIVE AT THE CHECK-IN TIME LISTED ABOVE, BUT DO NOT ARRIVE MORE THAN 30 MINUTES PRIOR.

Below is a checklist of items that you need to bring to your upcoming appointment. ***Please be sure to bring each item, as this will save time when you arrive.***

- ☐ **Insurance cards and Photo ID**
- ☐ **Records from your referring physician (if they have not been faxed to us)**
- ☐ **Paperwork from this packet (PLEASE FILL OUT BEFORE APPOINTMENT)**
- ☐ **Any pertinent records for your visit including any hospitalizations or ER visits in the past six (6) months**
- ☐ **ALL outpatient testing records for any tests that you have had within the past two (2) years; includes CT scans of your chest, PET scans, Chest X-Rays, Lung Scans, Swallow Tests, Echocardiograms, Right Heart Caths, etc.** ***(For any imaging, we must have the images on a disc and we must also have a copy of the report.)***

You MUST bring this paperwork filled out entirely in order to be seen.

*IMPORTANT NOTICE!

When entering the Memphis Lung Physicians Foundation offices, please refrain from wearing perfumes, colognes, fragrance lotions, fragrance creams, essential oils, etc. that have a strong smell. These fragrances can and will trigger asthma attacks and/or COPD exacerbations for some patients and employees. Thank you for your cooperation with this.

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MEMPHIS LUNG

Late Arrival, Late Cancellation, and No Call/No Show Policy

Our goal at Memphis Lung Physicians Foundation is to provide exceptional individualized medical care. "Late Arrivals", "Late Cancellations", and "No Shows" create significant barriers for individuals who need access to medical care in a timely manner. As a courtesy, Memphis Lung Physicians Foundation issues reminder phone calls at least 48 hours in advance of our patient's appointments, furthering the expectation that patients arrive on time and/or cancel/reschedule their appointments in adequate time to allow for other patients to be seen. Communication regarding late arrivals and cancellations is of the utmost priority.

NOTICE: Effective April 1, 2023, the following policy will be enforced at all Memphis Lung Physicians Foundation facilities.

Late Arrival

If you arrive ***greater than 15 minutes after your scheduled check-in time without notifying our staff and receiving approval***, Memphis Lung Physicians Foundation reserves the right to reschedule your appointment for a different date and time.

Late Cancellation

We require that you notify the clinic of a cancellation 24 hours in advance of your scheduled appointment. ***Failure to cancel your appointment 24 hours in advance of your scheduled arrival time will result in a $25.00 Late Cancellation fee for each late cancellation.*** If it is determined that you habitually fail to provide adequate notice of your appointment cancellation, Memphis Lung Physicians Foundation will provide you with written notice.

No Call / No Show Appointments

If you fail to appear for a scheduled appointment, Memphis Lung Physicians Foundation follows the guidelines below:

1st and 2nd Missed Appointment: You will receive written notice regarding your No Call/No Show appointment and you will also incur a $25.00 "No Show Fee" for each occurrence.

3rd Missed Appointment: You will receive ***final*** written notice regarding your refusal to comply with the Memphis Lung Physicians Foundation No Show policy. As of your third No Show appointment, you will be referred back to your primary care provider and no additional appointments will be scheduled for you at Memphis Lung Physicians Foundation until a thorough review of your file has been completed by upper practice management and your provider(s).

It is expected that you satisfy any outstanding Late Cancellation or No Show fee balance incurred at Memphis Lung Physicians Foundation prior to check in at your next scheduled appointment. Please be mindful that these incurred fees are not reimbursable by your insurance company; all fees are billed directly to you, the patient.

By signing below, you acknowledge that you have received and read the guidelines above and that you agree to pay any incurred fees due to your inability to cancel a scheduled appointment within the required time period.

Printed Name	Signature	Date

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Authorizations & Acknowledgments

Patient Name: _____ DOB: _____
First, MI, Last

Acknowledgment of Notice of Privacy Practices

Initial Here _____ I acknowledge that a copy of the Notice of Privacy Practices was provided to me.

General Consent to Treatment and Test

Initial Here _____ I am voluntarily seeking medical treatment. I consent to examination by the physician, nurse practitioner, nurse, and other health care professionals at this clinic. I also consent to any medical procedures, x-ray, laboratory tests, or other health care services ordered by the health care team. I understand that I may refuse specific treatments or procedures by informing the health care team.

Release of Information

Initial Here _____ I authorize Memphis Lung Physicians Foundation, A Foundation of Baptist Medical Group, to release any medical information necessary to process payment of my claim.

Assignment of Insurance Benefits and Acceptance of Financial Responsibility

Initial Here _____ I authorize payment directly to Memphis Lung Physicians Foundation, a Foundation of Baptist Medical Group, for their fees. I understand and agree that if any part of my account is not paid by insurance, I am financially responsible. I also understand that I may qualify for financial assistance for services provided by MLPF or BMG and that I may request an application to apply for financial assistance. I further understand that the determination of whether I qualify for financial assistance is dependent upon my timely submittal of appropriate financial documentation and my failure to provide any such documentation could affect my ability to qualify for financial assistance.

Communications Regarding My Account

Initial Here _____ I agree that the facility, Medical Financial Services, Inc. or any other collection or servicing agency or agencies retained by the facility or my physicians (together referred to hereafter as "collectors") to collect any money that I owe to the facility may contact me by telephone or text message at any number given by me or that is or becomes associated with me or my account from sources other than me, including but not limited to, cellular/wireless telephone numbers which may result in my incurring fees for the call or text message. I understand, acknowledge, and agree that the collectors may contact me by automatic dialing devices and through pre-recorded messages, artificial voice messages or voice mail messages. I further agree that the collectors may contact me using e-mail at any e-mail address I provide to the facility or is otherwise associated with my account.

Destruction of X-ray Images/Graphic Data (MS Patients Only)

Initial Here _____ I hereby authorize the entity to retire x-ray images and other graphic data which may be generated during my care (treatment, testing, or otherwise) four years after the time generated if a proper report is in the medical record.

_____
Signature of patient/parent/guardian/person authorized to sign for patient

Date: _____

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AUTHORIZATION TO LEAVE MESSAGES

Patient Last Name_____ First Name _____ Middle Initial_____ Suffix_____(Jr/Sr/II etc.)

Address_____City_____State_____Zip _____

Date of Birth_____/_____/_____

Which of the following communications means are appropriate/acceptable for BMG to communicate with you: (please check all that apply)

- ☐ Home phone # _____ ☐ Okay to leave a message? ☐ Yes ☐ No
- ☐ Cell phone # _____ ☐ Okay to leave a message? ☐ Yes ☐ No
- ☐ Work phone # _____ ☐ Okay to leave a message? ☐ Yes ☐ No

Which method of communication is preferred? ☐ No contact ☐ Mail ☐ Phone ☐ Email ☐ Mychart

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With whom may we share information about your health? Please list below.

Note: In order for BMG to disclose your Private Health Information, the representative listed must be able to provide (2) two of the (3) identifiers listed below:

1. **Last 4 digits patient's social security number**
2. **Patient's date of birth**
3. **Patient's zip code**

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Name	Relationship to You	Telephone Number	May Discuss Diagnosis/Treatment		May Discuss Billing Info	
			Yes	No	Yes	No
			Yes	No	Yes	No
			Yes	No	Yes	No
			Yes	No	Yes	No

Do you have a legal document that states who will make decisions if you are unable? ☐ Yes ☐ No

If yes, Name_____Relationship to Patient _____

Check one: ☐ Healthcare Proxy/Agent ☐ General Power of Attorney ☐ Healthcare Power of Attorney

you would like information about appointing a healthcare proxy/agent, please let us know.

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to discuss and use the patient's healthcare information.

Patient/Legal Representative Signature:_____ Date: _____

OFFICE USE ONLY – Document should be Scanned under Ambulatory Auth and Consent Doc type

Memphis Lung Physicians Foundation
Medication Sheet

Patient Name _____

Patient DOB _____

Name of Pharmacy _____

Pharmacy Phone # _____

Allergies (Include all allergies, such as drug, food, skin, etc.): _____

_____

_____

To ensure that your medication list is complete, please include all breathing medications, nebulized medications, inhalers, vitamins, herbs, and over-the-counter medications and/or supplements.

Medication Name	**Dosage/Strength/MG/McG**	**Frequency** (Times Per Day/Wk/Mo)

SCORE

Memphis Lung Physicians Foundation

Today's Date: _____

Patient Name: _____

Date of Birth: _____

The 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 estimate how they would affect you.

Use the following scale to choose ***the most appropriate number*** for each situation:

0 = would ***never*** doze
1 = ***slight*** change of dozing
2 = ***moderate*** chance of dozing
3 = ***high*** chance of dozing

Situation	Chance of Dozing (# from above)
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting, ***inactive***, in a public place (e.g. a theater or meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after a lunch ***without alcohol***	_____
8. In a car, while stopped for a few minutes in traffic	_____

Memphis Lung Physicians Foundation
Insomnia Severity Index

The Insomnia Severity Index has seven questions. The seven answers are added up to get a total score. When you have your total score, look at the 'Guidelines for Scoring/Interpretation' below to see where your sleep difficulty fits.

For each question, please CIRCLE the number that best describes your answer.
Please rate the CURRENT (i.e. LAST 2 WEEKS) SEVERITY of your insomnia problem(s).

Insomnia Problem	None	Mild	Moderate	Severe	Very Severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problems waking up too early	0	1	2	3	4

4. How SATISFIED/DISSATISFIED are you with your CURRENT sleep pattern?

Very Satisfied	Satisfied	Moderately Satisfied	Dissatisfied	Very Dissatisfied
0	1	2	3	4

5. How NOTICEABLE to others do you think your sleep problem is in terms of impairing the quality of your life?

Not at all	A Little	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

6. How WORRIED/DISTRESSED are you about your current sleep problem?

Not at all Worried	A Little	Somewhat	Much	Very Much Worried
0	1	2	3	4

7. To what extent do you consider your sleep problem to INTERFERE with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood, etc.) CURRENTLY?

Not at all	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

Guidelines for Scoring/Interpretation:

Add the scores for all seven items (questions 1 + 2 + 3 + 4 + 5 +6 + 7) =__your total score Total score categories:

0–7 = No clinically significant insomnia
8–14 = Subthreshold insomnia
15–21 = Clinical insomnia (moderate severity)
22–28 = Clinical insomnia (severe)

Memphis Lung Physicians Foundation

Stop-Bang Questionnaire

Name _____

Patient to complete:

1. Do you snore loudly? (Louder than talking - OR - loud enough to be heard through closed doors) Yes ( ) No ( )

2. Do you often feel tired, fatigued, or sleepy during the daytime? Yes ( ) No ( )

3. Has anyone observed you to stop breathing during your sleep? Yes ( ) No ( )

4. Do you have or are you being treated for high blood pressure? Yes ( ) No ( )

NURSE TO COMPLETE

Height _____in Weight_____lbs BMI _____ ? > 35

Age_____ yrs ? > 50

Neck Circumference _____ in ? M > 17 ; F > 16

Gender _____ ? M

Stop-Bang Score _____

SLEEP PATTERN:

How long have you had your sleep problem? _____Weeks/Months/Years

On average, how long does it take you to fall asleep? _____Minutes/Hours

What time do you usually go to bed? _____

What time do you usually get up? _____

On average, how often do you wake up during the night? _____Times/night

On average, how long do you actually sleep at night? _____Minutes/Hours

Do you take naps? Yes _____ No _____ How Long? _____Minutes/Hours

Do you take any sleep medications? Yes ___ No __ List: _____

New Patient Sleep Questionnaire

Patient Name:_____ **Birth Date:**_____

Referring Physician: _____ **Date:**_____

Reason for Visit: _____

GENERAL SLEEP

How long have you had your sleep problem?

Do you snore?	Yes	No	Describe:
Do you stop breathing in your sleep?	Yes	No	Describe:
Do you wake up frequently overnight (more than 2 times)?	Yes	No	Describe:
Do you feel tired and non-refreshed when you wake up after your sleep period?	Yes	No	Describe:
Previously diagnosed with sleep apnea?	Yes	No	When/where:
Are you currently on CPAP/Bi-Level therapy?	Yes	No	Pressure setting:
Are you having trouble with CPAP/Bi-Level therapy?	Yes	No	Describe:
Are you under any stress, or feel depressed or anxious?	Yes	No	Describe:

Do you wake-up with any of the following?	Headache	Dry mouth	Sore throat	Other:

SLEEP PATTERN

** Please answer these questions for an average day/night **

What time do you usually go to bed?

How long does it take you to fall asleep?

How often do you wake-up during the night? | How long does it take you to fall back to sleep? (minutes)

What time do you wake-up in the morning? | What time do you get out of bed?

What is the total time that you spend sleeping overnight?

Do you take naps?	Yes	No	How many?
Do you keep the same sleep schedule on weekends/holidays/vacations?	Yes	No	Describe:
Have you ever done shift work?	Yes	No	Describe:

Describe your usual bedtime routine:

SLEEP BEHAVIORS

Any factors that you can identify that contribute to your sleep difficulty? (i.e.: Pain, disturbances in the environment, etc.)

What position do you sleep in?(circle)	Back	Side	Stomach	Toss and Turn

Do you take any medications to help you sleep?	Yes	No	Describe:
How much caffeine do you drink per day? (cups)		What time is your last cup?	
Does your mind race when you lay down to fall asleep?	Yes	No	Describe:
Have you experienced drowsy driving or fallen asleep while operating a motor vehicle?	Yes	No	Describe:

Do you engage in any of the following activities that may keep you from falling asleep , such as: (Circle)

Clock watching?	YES	NO	Stick to a sleep schedule?	YES	NO
Watching TV?	YES	NO	Get enough morning daylight?	YES	NO
Computer usage?	YES	NO	Exercise regularly?	YES	NO
Phone usage?	YES	NO	Avoid daytime napping?	YES	NO
Reading?	YES	NO	Any post-lunch caffeine?	YES	NO
Listening to music?	YES	NO	Any nighttime nicotine?	YES	NO
Alcohol consumption?	YES	NO	Wind down before bedtime?	YES	NO
Stay in bed if unable to fall asleep within 30 minutes?	YES	NO	Keep room quiet, dark, comfortable?	YES	NO

Have you gained weight recently?	Yes	No	How much? Over how long?

Any factors that you can identify that contribute to your sleep difficulty? (i.e.: indigestion, pain, noise, etc.)

OTHER SLEEP SYMPTOMS

Restless Legs Symptoms: When sitting quietly for prolonged periods or when lying down to go to sleep do you suffer from:

A strong urge or desire to move the limbs, often associated with abnormal sensations?	YES	NO
Symptoms are worse or present only during rest and get partially or temporarily better with activity?	YES	NO
Nighttime worsening of symptoms?	YES	NO

Do you suffer from frequent nightmares?	Yes	No	How often?
Do you grind your teeth?	Yes	No	Describe:
Any history of sleep walking?	Yes	No	Describe:
Any history of sleep eating?	Yes	No	Describe:
Are you aware of any unusual behavior or activity such as muscle twitches, leg kicking, acting out dreams during sleep?	Yes	No	Describe:
When you first wake up, do you ever feel like your mind is awake, but your body is paralyzed?	Yes	No	Describe:
Do you have hallucinations or vivid dreams upon falling asleep or awakening from sleep?	Yes	No	Describe:
Do you experience muscle weakness with strong emotions?	Yes	No	Describe:
Have you ever fallen asleep at inappropriate times? (i.e. during a conversation)	Yes	No	Describe:
Do you have chronic nasal congestion? Or seasonal allergies?	Yes	No	Medications:
Any history of nasal trauma or been told that you have a deviated septum?	Yes	No	Describe:
Have you had a tonsillectomy?	Yes	No	Describe:

Memphis Lung Physicians Foundation
2120 Exeter Rd., Suite 250
Germantown, TN 38138

Review of Systems

Patient Name: _____ DOB: _____ Age: _____ Gender: M / F

*Please check any symptoms you are experiencing that are **related to your complaint today:**

Allergic/Immunologic	Ears/Nose/Mouth/Throat	Genitourinary	Men Only
Frequent Sneezing	Bleeding Gums	Pain with Urinating	Pain / Lump in Testicle(s)
Hives	Difficulty Hearing	Blood in Urine	Penile Itching, Burning or Discharge
Itching	Dizziness	Difficulty Urinating	
Runny Nose	Dry Mouth	Incomplete Emptying	Problems Stopping or Starting Urine Stream
Sinus Pressure	Ear Pain	Urinary Frequency	
Cardiovascular	Frequent Infections	Loss of Urinary Control	Waking up to Urinate at Night
Chest Pressure/Pain	Frequent Nosebleeds	**Hematologic / Lymphatic**	
Chest Pain on Exertion	Hoarseness	Easy Bruising / Bleeding	Sexual Problems / Concerns
Irregular Heart Beats	Mouth Breathing	Swollen Glands	
Lightheaded	Mouth Ulcers	**Integumentary (Skin)**	History of Sexually Transmitted Diseases
Swelling (Edema)	Nose/Sinus Problems	Changes in Moles	
Shortness of Breath When Lying Down	Ringing in Ears	Dry Skin	**Women Only**
	Endocrine	Eczema	Bleeding Between Periods
Shortness of Breath When Walking	Increased Thirst / Urination	Growth / Lesions	
		Itching	Heavy Periods
Constitutional	Heat / Cold Intolerance	Jaundice (Yellow skin or eyes)	Extreme Menstrual Pain
Exercise Intolerance	**Gastrointestinal**		Vaginal Itching, Burning, or Discharge
Fatigue	Abdominal Pain	Rash	
Fever	Black / Tarry Stool	**Respiratory**	Waking up to Urinate at Night
Weight Gain (_____ lbs)	Blood in Stool	Cough	
Weight Loss (_____ lbs)	Change in Appetite	Coughing up Blood	Hot Flashes
Travel within 10 Days Where:	Frequent Indigestion	Shortness of Breath	Breast Lump
	Hemorrhoids	Sleep Apnea	Breast Pain
Eyes	Trouble Swallowing	Snoring	Nipple Discharge
Dry Eyes	Vomiting	Wheezing	No Periods
Eye Irritation	Constipation	Difficulty Breathing	Painful Intercourse
Vision Changes	Diarrhea	**Neurological**	History of Sexually Transmitted Diseases
Psychiatric	Nausea	Dizziness	
Anxiety / Stress	**Musculoskeletal**	Fainting	
Depression	Back Pain	Headaches / Migraines	
Do Not Feel Safe in Relationship	Joint Pain	Memory Loss	
	Muscle Aches	Numbness	
Mania	Muscle Weakness	Restless Legs	
Sleep Problems		Seizures	
		Weakness	