A MEMBER OF BAPTIST MEMORIAL MEDICAL GROUP

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Lindsay Barton, DNP, ACNPC-AG

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

☐ **1500 W. Poplar Ave, Suite 309, Collierville, TN 38017**
PH: 901-767-5864 **FAX:** 901-767-6591
(Located inside Baptist Collierville Hospital, in the physician's office building, 3rd floor)

☐ **76 Capital Way Cove, Suite B, Atoka, TN 38004**
PH: 901-767-5864 **FAX:** 901-767-6591

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 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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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

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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)

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