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UPSTATE LUNG
& Critical Care Specialists, P.C

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Anthony Raynor, PC-C
May Yin Suen, PA

NEW PAYMENT POLICY

EFFECTIVE JANUARY 1, 2013,
Upstate and Critical Care Specialists, PC

Payment policy changes:

ALL COPAYS WILL BE COLLECTED
AT THE TIME OF VISIT PRIOR TO BEING SEEN BY PHYSICIAN.

Thank you in advanced for your cooperation, if you would like more information about this topic, Please contact Upstate Lung and Critical Care Specialists, PC Insurance Department @ 864-573-6320 or toll free 866-573-6320

151 Harold Fleming Court, SC 29303 • (864) 573-6320 • Fax (864) 573-6323
Gaffney (864) 487-9931 • Union (864) 427-0278 • Greenville (864) 329-0540

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Dear Patient:

Thank you for choosing Upstate Lung and Critical Care Specialists, PC for your healthcare needs.

Please fill out **all** enclosed forms as completely and accurately as possible. **If you are not able to complete the forms yourself, please have someone complete them for you in order to avoid possibly having to reschedule the appointment.** (In these instances, nursing facilities should ensure the patient's paperwork is complete before sending the patient for their appointment.)
All forms must be signed and dated in the appropriate places. If anything does not apply to you, write N/A.

You **MUST** bring the following with you to this appointment:

1. **The enclosed forms filled out as completely as possible.**
2. **All medications that you are currently taking.**
3. **Your most recent x-rays and/or CT scan.**
4. **All insurance cards as well as a photo ID.**
5. **Your insurance co-pay.**

If you have any questions, please contact our office at:

Spartanburg	(864) 573-6320 or toll free (866) 573-6320
Gaffney	(864) 487-9931 or toll free (866) 573-6320
Union	(864) 427-0278 or toll free (866) 573-6320
Greenville	(864) 329-0540 or toll free (866) 573-6320

****

Date/Time of Appointment: _____@_____

To see Doctor:

Gregory J. Feldman, MD	**San Yin Wan, MD**
Joseph A. Boscia, MD	**Chandar Abboy, MD**
David R. Erb, MD	**Farhan Siddiqui, MD**
Luis I. De La Cruz, MD	**Christian E. Castillo, MD**

Office Location:

Spartanburg – 151 Harold Fleming Court, Spartanburg SC 29303
Gaffney - 1529 N. Limestone St,, Gaffney SC 29340
Union - 1005 Thompson Blvd,, Union SC 29379
Greenville – 220 Roper Mountain Rd Ext, Greenville SC 29615

YOU MUST ARRIVE 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME **WITH THE ENCLOSED FORMS COMPLETED**. BE SURE TO BRING ALL OTHER ITEMS AS REQUESTED ABOVE. THANK YOU.

PATIENT INFORMATION

NAME: _____ CHART: _____

ADDRESS: _____
(Street) (City) (State/Zip)

DATE OF BIRTH: ___/__/_____ AGE: _____ SEX: M F MARTIAL STATUS: S M D W

SOCIAL SECURITY: ____/___/_____ TELEPHONE HOME: (____)_____ CELL: (___) _____

EMPLOYER: _____ ADDRESS: _____ TELEPHONE(___)_____

SEND APPOINTMENT REMINDERS BY: _____ HOME PHONE _____ CELL PHONE _____EMAIL

SPOUSE'S NAME: _____ EMPLOYER: _____

Are you covered under spouse's insurance? Y N If so, spouse's social security# ___/___/_____ DOB ___/___/_____

Referring/Primary Care Physician: _____

Emergency Contact: _____

(Outside of Household) (Name) (Relationship) (Telephone)

Ethnicity: _____Hispanic or Latino _____ Not Hispanic or Latino

Race: _____ American Indian or Alaska Native _____ Asian _____ Black or African American

_____ Native Hawaiian _____ Other Pacific Islander _____ White

Primary Language: _____ English _____Spanish _____ Russian _____ Other

PRIMARY INSURANCE CARRIER

Policy Number _____

Group Number _____

SECONDARY INSURANCE CARRIER

Policy Number _____

Group Number _____

Policy Holder Name _____ Social Security # ____/___/_____ DOB ___/___/_____

LONG TERM INSURANCE AUTHORIZATION

I request that payment of authorized benefits be made on my behalf to Upstate Lung and Critical Care Specialists, P.C., for any services furnished to me by that physician. I authorize any holder of medical information about me to release to HealthCare Financing Administration, and/or my other insurance companies any information needed to determine benefits payable. I understand that I am responsible for any amounts approved but not covered by my insurance.

_____

Patient Signature/ Date

Authorization- Compound

This authorization form permits:

Physicians Office: Upstate Lung Critical Care Specialists
Address: 1005 Thompson Blvd., Union, SC 29379
to use or disclose protected health information listed in the Description section below to the Entity or Person listed in the Receiving Entity section for the following patient:

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

Address: _____

City/State/Zip: _____

Receiving Entity: Please check the boxes for those entities or persons you wish to get the described information about you.	**Description of information to be given to checked Entity or Person.**
Voice Mail Home **#(____)_____-_____**	— **Appointment time** — **Results of lab test or x-ray** — **Other**
Voice Mail Business **#(____)_____-_____**	— **Appointment time** — **Results of lab test or x-ray** — **Other**
Voice Mail Cell Phone **#(____)_____-_____**	— **Appointment time** — **Results of lab test or x-ray** — **Other**
Employer: _____ **School:** _____	— **Appointment or Absentee information** — **Return to Work or School information**
Spouse (Provide Name) _____	— **Family billing information** — **Financial information** — **Medical information-please list** _____
Parent (Provide Name) _____	— **Family billing information** — **Financial information** — **Medical information-please list** _____
Other (Provide Name) _____ **Relationship:** _____	— **Financial information** — **Medical information-please list** _____
Other (Provide Name) _____ **Relationship:** _____	— **Financial information** — **Medical information-please list** _____

Authorization- Compound

Purpose

The purpose of this authorization is to meet the patient's request for information disclosures and uses.

Expiration date or event: This authorization shall be enforce until revoked by the patient.

Verification method or code: This practice will verify the identity of any entity requesting protected health information. To verify identify of the patient you must provide the patients account number.

Your Account Number is _____

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Rights of the Patient

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. Patient will be responsible for 100% of charges, payable time of service and filing own insurance.

I understand that I have the right to revoke this authorization at any time by sending a written notification to the address listed above. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

_____ Date _____

Signature of Patient or Personal Representative (as defined by HIPAA)

Description of Personal Representative's Authority (attach necessary documentation)

_____

Office Use Only:

Receiving Employee_____ Date Received_____

— **Copy given to patient**

Rev 12/21/2010

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NOTICE TO ALL PATIENTS

Effective 07/01/2007, under our new financial management policy, the following practices and polices will be implemented and enforced in our office:

- **A fee of $10.00 will be charged per prescription for all call in request.** This fee is not covered by insurance and is the patient's responsibility. **Please note:** We will only refill prescriptions that were originally prescribed for you by this practice. We **cannot** refill any prescription that was originally written by another physician.

- **A fee of $20.00 will be charged for all missed appointments that are not canceled or rescheduled at least 24 hours in advance.** This fee is not covered by insurance and is the patient's responsibility.

- **A fee of $20.00 will be charged for appointments made in the morning to be seen on that same day that are not kept.** This fee is not covered by insurance and is the patient's responsibility.

- **All co-pays, deductibles and patient percentages are due and payable in full at the time of service.** These amounts are determined and required by your insurance plan. If there is a problem with paying your required amount, please inform the receptionist prior to being seen by a doctor.

- ★★**All patients without insurance are expected to pay $50.00 at the time of your first visit.** A payment plan will be set up to pay off the remainder of the balance.★★

Your compliance with these policies is appreciated.

Thank you,
Upstate Lung and Critical Care Specialists, P.C.

****

By my signature I state that I have read and understand the above policy.

Patient Signature _____ Date _____

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name: _____
Soc Sec #: _____ Date of Birth: _____
Patient's Address: _____
City, State and Zip Code: _____
Home Phone: _____

At the request of the individual, I _____, do hereby authorize
_____ to release medical records.

___HISTORY & PHYSICAL ___LABORATORY REPORTS ___OTHER _____
___PROGRESS NOTES ___RADIOLOGY REPORTS _____
___OPERATIVE NOTES ___EMERGENCY REPORTS _____

INFORMATION RELEASE TO: _____
Name of referring doctor/other company, agency or facility/person

_____
Full Address (Street, city and zip code)

PURPOSE OF DISCLOSURE:

___REFERRAL TO SPECIALIST ___INSURANCE ___WORKERS COMP ___CHANGE OF DOCTOR
___LEGAL INVESTIGATION ___DISABILITY DETERMINATION ___PERSONAL ___OTHERS_____

I hereby authorize disclosure of the health information for the above named patient. I authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation.
I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____
Signature of Individual or guardian or Personal Rep of patient's estate Date

NOTE: Federal and state laws permit a fee to be charged for the copying of patient records. Smart Document Solutions has been contracted to provide the service of medical records request. Currently, the charge is $.65 (1-30 pgs) $.50 (31-40 pgs) $.15 (41+) plus actual postage for Patient Personal Requests. Prices are subject to change without notice. Smart Document Solutions

In consideration of our patient's breathing problems, please **do not wear** perfumes, colognes or any other heavily fragranced product to our office.

Thank You.

Upstate Lung and Critical Care Specialists, P.C.
HEALTH HISTORY
(Confidential)

Name: _____ Today's Date: _____

Age: ____ Birthdate: _____ Sex: M F Date of last physical examination: _____

Primary care/referring physician: _____

Reason for this visit: _____

PULMONARY HISTORY

Do you have a chronic cough? ❑ No ❑ Yes If yes, how long have you had it? _____
Do you cough anything up? ❑ No ❑ Yes What color is it? _____
Have you ever coughed up blood? ❑ No ❑ Yes If yes, when? _____

Do you get short of breath if you walk or climb steps? ❑ No ❑ Yes At rest? ❑ No ❑ Yes At other times? ❑ No ❑ Yes
If yes, when? _____

Do you ever notice yourself wheezing? ❑ No ❑ Yes If yes, what makes the wheezing worse? _____

When was your last chest x-ray? ❑ No ❑ Yes Where? _____

Have you ever had a skin test for TB (Tuberculosis)? ❑ No ❑ Yes If yes, when? _____

Have you ever been exposed to TB? ❑ No ❑ Yes If yes, when? _____
Have you had a skin test since being exposed? ❑ No ❑ Yes If yes, what kind? _____

Immunization History
Flu vaccine _____ (date)
Pneumonia vaccine _____ (date)

Do you have any other medical concerns that you would like to discuss with your doctor? ❑ No ❑ Yes (Please list)

_____
_____
_____
_____

PAST MEDICAL HISTORY

❑ AIDS
❑ Alcoholism
❑ Anemia
❑ Anxiety
❑ Arthritis
❑ Asthma
❑ Bleeding disorders
❑ Bronchitis
❑ Cancer: Type: _____
❑ Depression
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Goiter
❑ Gout
❑ Heart disease
❑ Hepatitis: Type: _____
❑ High blood pressure
❑ High cholesterol
❑ HIV positive
❑ Kidney disease
❑ Liver disease

PRIOR SURGERIES

	Year		Year
❑ Appendectomy	_____	❑ Prostate surgery	_____
❑ Coronary bypass surgery	_____	❑ Mastectomy	_____
❑ Cholecystectomy	_____	❑ Pacemaker placement	_____
❑ Colon resection	_____	❑ Other: _____	_____
❑ Hernia repair	_____	_____	_____
❑ Hysterectomy	_____	_____	_____
❑ Tonsillectomy	_____	_____	_____

SOCIAL HISTORY

Are you a smoker? ❑ No ❑ Yes If yes, how many packs per day? _____ How many years? _____
If no, have you ever smoked in the past? ❑ No ❑ Yes If yes, how many years did you smoke? _____
How many packs per day? _____ How long have you been quit? _____
Does anyone else in your home smoke? ❑ No ❑ Yes

Alcohol use? ❑ No ❑ Yes Amount: _____
Caffeine? ❑ No ❑ Yes Amount: _____
Street drugs: ❑ No ❑ Yes Amount: _____

Marital status: _____

Occupation: _____

FAMILY HISTORY

Father living? ❑ Yes ❑ No Cause of death: _____ Age: _____
Mother living? ❑ Yes ❑ No Cause of death: _____ Age: _____
Siblings living? ❑ Yes ❑ No Cause of death: _____ Age: _____

	Mother	Father	Siblings
Asthma	❑	❑	❑
COPD	❑	❑	❑
OSA	❑	❑	❑
Depression	❑	❑	❑
Heart disease	❑	❑	❑
Hypertension	❑	❑	❑
Narcolepsy	❑	❑	❑
Stroke	❑	❑	❑
Cancer	❑ _____	❑ _____	❑ _____
Diabetes	❑	❑	❑
Other	❑ _____	❑ _____	❑ _____

Any additional family pulmonary problems? ❑ No ❑ Yes (Please list) _____

ALLERGIES

Do you have any **MEDICATION** allergies? ❑ No ❑ Yes (Please list) _____

Do you have allergies to any other substances (latex, etc.)? ❑ No ❑ Yes (Please list) _____

MEDICATIONS (Please bring to appointment)

List all medications you are currently taking including inhalers and over the counter medicines:

Name of Medication	Strength	Times Per Day	Name of Medication	Strength	Times Per Day

Use back of this sheet if additional space is needed.

SYMPTOMS REVIEW: Check (✓) symptoms you currently have or have had in the past year.

CONSTITUTIONAL
- ❑ Chills
- ❑ Dizziness
- ❑ Fainting
- ❑ Fatigue
- ❑ Fever
- ❑ Forgetfulness
- ❑ Headache
- ❑ Insomnia
- ❑ Loss of sleep
- ❑ Malaise
- ❑ Night sweats
- ❑ Weight gain
- ❑ Weight loss

EYES
- ❑ Blurred vision
- ❑ Double vision
- ❑ Eye discharge
- ❑ Eye pain
- ❑ Light sensitivity
- ❑ Redness
- ❑ Vision flashes
- ❑ Vision halos
- ❑ Vision loss

EAR, NOSE, THROAT
- ❑ Bleeding gums
- ❑ Difficulty swallowing
- ❑ Earache
- ❑ Ear discharge
- ❑ Hay fever
- ❑ Hoarseness
- ❑ Loss of hearing
- ❑ Nosebleeds
- ❑ Ringing in ears
- ❑ Sinus problems

CARDIOVASCULAR
- ❑ Blood clots
- ❑ Chest pain
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ Rapid heart beat
- ❑ Swelling of ankles

PULMONARY
- ❑ Chronic cough
- ❑ Cough
  - ❑ Non-productive
  - ❑ Productive
- ❑ Coughing up blood
- ❑ Excessive sleepiness
- ❑ Loud snoring
- ❑ Short of breath
- ❑ Wheezing

GASTROINTESTINAL
- ❑ Abdominal pain
- ❑ Acid indigestion
- ❑ Bloating
- ❑ Bowel changes
- ❑ Constipation
- ❑ Diarrhea
- ❑ Gas
- ❑ Hemorrhoids
- ❑ Nausea
- ❑ Poor appetite
- ❑ Rectal bleeding
- ❑ Vomiting

GENITO-URINARY
- ❑ Blood in urine
- ❑ Excessive urine amount
- ❑ Frequent urination
  - ❑ at night
- ❑ Frequent infections
- ❑ Hesitancy
- ❑ Incontinence
- ❑ Pain or burning

MEN ONLY
- ❑ Breast lump
- ❑ Erection difficulties
- ❑ Prostate difficulties

WOMEN ONLY
- ❑ Bleeding between periods
- ❑ Breast lump
- ❑ Hot flashes

MUSCULOSKELETAL

Neck
- ❑ Pain
- ❑ Stiffness

Back
- ❑ Arthritis
- ❑ Limitation of activity
- ❑ Limitation of movement

Ribs
- ❑ Pain
- ❑ Tenderness

Joints
- ❑ Arthritis

Muscles
- ❑ Cramps at rest
- ❑ Cramps with exertion
- ❑ Limitation of activity
- ❑ Limitation of movement
- ❑ Weakness

NEUROLOGICAL
- ❑ Blackouts
- ❑ Change in behavior
- ❑ Disorientation
- ❑ Loss of consciousness
- ❑ Numbness
- ❑ Paralysis
- ❑ Seizures
- ❑ Speech problems
- ❑ Tremors
- ❑ Unsteadiness
- ❑ Vertigo
- ❑ Weakness

ENDOCRINE
- ❑ Cold intolerance
- ❑ Excessive hunger
- ❑ Excessive sweating
- ❑ Excessive thirst
- ❑ Heat intolerance
- ❑ Recent weight change

Signature

Date