

ASSOCIATES IN PULMONARY AND CRITICAL CARE MEDICINE, PA

DR. ALAN VARRAUX, Director
Pulmonary, Sleep, and Critical Care Medicine

Nurse Practitioners: TERESA KARCSMAR, ARNP

60 WEST COLUMBIA STREET, SUITE F, ORLANDO, FL 32806
PHONE (407) 841-1290 Fax (407)-581-9583

Date _____

Dear _____:

Thank you for choosing our medical practice. We know that choosing a new practice and meeting different doctors or nurse practitioners can be stressful in addition to experiencing ill health or abnormal test results. Receiving experienced medical care is vital to maintaining or restoring good health and peace of mind. We will strive to provide you with the finest medical care available and work with you to provide diagnosis and a treatment plan. For your health and well-being it is important that we communicate our mutual concerns.

Enclosed are forms outlining your medical and health history. Please provide information to the best of your ability regarding your condition. Bring these completed forms to your first visit where we can review them. You can give them to the receptionist to put on your medical record.

YOUR APPOINTMENT IS SCHEDULED FOR: Mon Tues Wed Thur Fri _____
AT _____ AM PM

YOU ARE BEING SEEN AT: _____ DOWNTOWN OFFICE, 60 W. COLUMBIA ST., SUITE F, ORLANDO
_____ 245 WEST ROUTE 50, CLERMONT (across from Autozone)
_____ 1151 BLACKWOOD AVE STE 150 DOCOE, FL

YOU HAVE YOUR APPOINTMENT WITH: _____ ALAN R. VARRAUX, MD
_____ NURSE PRACTITIONER. TERESA KARCSMAR

Some of our patients have severe breathing problems, including asthma and emphysema, and may experience worsening symptoms when out of their home. We respectfully request that you **REFRAIN FROM WEARING ANY PERFUMES/COLOGNES** on any day that you visit any of our offices. Make sure your clothing is free of perfume worn on a different day. If the scent is strong, you may respectfully be asked to reschedule your appointment.

Please remember to **BRING COPIES** any recent medical tests results, including labs, x-rays, or CT scans. Also bring all of your oral, inhaled, or topical medications with you, or a **complete list of everything you take** or use to treat or prevent a condition. Please include any over-the-counter medications or vitamins you may take. We also need to make a copy of a **PHOTO IDENTIFICATION CARD, SUCH AS YOUR DRIVER'S LICENSE**. It is also best for you, to bring a relative or helping friend, as two sets of ears are better than one when it comes to providing respiratory care.

Our physician and practitioners care for many critically ill patients and those with complicated and life-threatening conditions on a daily basis. For that reason there may unforeseen delays at the appointed time of your visit. If you are unable to wait at that time, we would be happy to reschedule your appointment, if you wish. We also limit the number of patients we can see in any one day, and cannot accommodate walk-in visits. It is advisable to keep in close contact with your primary physician as we consult on your case. **We cannot take- over the medical care that is provided by or that should be provided by your primary care provider, family practice or internal medicine doctor.**

Please direct any urgent calls to the medical assistant help desk for recommendation. **All phone calls are directed through our Downtown Office where your chart is on file.** Our office accepts calls between 9:00 am and 4:00 pm, except on Friday when the office closes at noon. Depending on available staffing and the volume of calls, you may be asked to leave a message on our answering voice mail system. Please leave a detailed message and every attempt will be made to return your call in the order it was received or dependent on the urgency.

The following is a list of OFFICE POLICIES that should help you know what to expect from your encounters with our practice and staff.

If you are in need of refills of the medications to treat your respiratory condition, please ask your pharmacy to fax a refill request in writing to our office. Our staff will then note your last office visit, and if you have been to the office within the last six months and have a future office visit on the schedule, then refills will be issued on previously prescribed medication. If you need a refill on your blood pressure meds, diabetes meds, or any other medication not related to a respiratory problem, please contact your primary care doctor or appropriate specialist. Do not wait until you have no medication left to get approval for refills. If you need scripts for 3 month supply mail order, please let your practitioner know, so that these can be written at the time of your office visit.

Many of our out-patient diagnostic tests are scheduled through VIP Scheduling service and you may need to call them for any questions regarding authorization and timing for radiologic tests. Their phone number appears at the top of x-ray requisition form. They will tell you how you need to prepare for each radiologic test.

If you are having a problem with your oxygen supplement, nebulizer, or c-pap supplies, please report that problem to your durable medical equipment company. Their representatives will contact our office if they need assistance in handling that problem.

Pulmonary Function Tests (breathing tests) are currently performed in our Downtown Office. If you cannot schedule this test in our Downtown Office, you will be given a requisition with which you can schedule your own test at the local hospital. Ask the technician to give you a copy of your breathing test results at the completion of your test, so that we can review those results with you at the next appointment.

If blood tests are ordered, please bring that requisition to whichever independent lab or hospital lab that your insurance pays for. Quest Diagnostics and Lab Corp are 2 of the larger labs in town. Generally you do not need an appointment to have your blood drawn. Please note whether or not you need to be fasting before go to the lab.

If you cannot or will not have tests that are recommended by the doctor or practitioner; or if you do not follow the recommended plan of care, such as using oxygen supplement when it has been determined that you do not keep your oxygen blood levels above 88%, you may be subject to discharge from our practice by way of registered letter. In certain circumstances, we may be able to continue your care, but you will be asked to sign a waiver of medical responsibility and that you understand what risks you take.

If you cannot keep a scheduled appointment, and do not call our office to cancel/reschedule that visit, at least 24 hours before a scheduled appointment, your account will be charged a \$25.00 chart handling fee. This is not reimbursed by your insurance. You will not be allowed to be seen again unless this fee is paid.

If you have the type of insurance, usually an HMO, that requires a written referral to see a specialist, you are responsible for bringing that referral or referral renewal from your primary care provider to the office visit. It is your responsibility to obtain your referral. **You are to bring your referral to the office visit or you will not be seen.**

If you are having surgery that requires pulmonary surgical clearance, you must make an appointment in our Downtown Office, to undergo a quick breathing test and examination before written pre-surgical pulmonary clearance is issued to your surgeon. If your other medical care providers need a copy of our consult notes or test results, please allow at least 2 business days for that transfer of information to occur. You may also need to sign an information release form.

We look forward to meeting you at your initial consultation and visit.

Sincerely,
The Staff in the Office of Dr. Alan Varraux
Associates in Pulmonary and Critical Care Medicine



ASSOCIATES OF PULMONARY &
CRITICAL CARE MEDICINE, P.A.

PATIENT INFORMATION SHEET

Please Print

PATIENT NAME (Last, First, MI) _____ Marital Status (Circle) _____ Sex Male Female
M D W S

Local Address _____ Lot / Apt # _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Date of Birth _____ Age _____ Social Security Number _____
() ()

Driver License Number _____ State _____ Employer _____

Employer Address _____ City _____ State _____ Zip _____

Out of Town Address (If any) _____ City, State _____ Zip _____ Phone _____
()

SPOUSE INFORMATION Spouse's Name (Last, First, MI) _____ Date of Birth _____ Social Security Number _____

Mailing Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Employer _____
() ()

Employer Address _____ City _____ State _____ Zip _____

Nearest Relation/Friend Not Living in Household _____ Relationship _____ Phone _____
()

Address _____ City _____ State _____ Zip _____

EMERGENCY CONTACT _____ Relationship to Patient _____ Phone _____
()

Address _____ City _____ State _____ Zip _____

• INSURANCE POLICY #1 * PLEASE PROVIDE INSURANCE CARD FOR COPYING _____ Effective Date _____
Name of Insurance Company _____ Policy Number _____

Mailing Address _____ City _____ State _____ Zip _____ Phone _____
()

Name of Insured (Name on ID Card) _____ Insured's Date of Birth _____ Insured's Social Security Number _____

Relationship of Insured to Patient _____ Group Name _____ Group Number _____

• INSURANCE POLICY #2 _____ Effective Date _____
Name of Insurance Company _____ Policy Number _____

Mailing Address _____ City _____ State _____ Zip _____ Phone _____
()

Name of Insured (Name on ID Card) _____ Insured's Date of Birth _____ Insured's Social Security Number _____

Relationship of Insured to Patient _____ Group Name _____ Group Number _____

ASSIGNMENT OF BENEFITS / RELEASE OF INFORMATION

I hereby assign all insurance benefits to which I am entitled including Medicare, Medicaid, private insurance, major medical benefits and any other health plans to the assigned physician. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information including HIV, substance abuse or psychiatric information which may be found in the record and is necessary to secure payment.

PATIENT or RESPONSIBLE PARTY _____ Date: _____

I was referred here by: Another physician – Dr. _____ Insurance Company Directory
 Friend / Relative Name _____ Other _____

ASSOCIATES IN PULMONARY & CRITICAL CARE MEDICINE, P.A.

60 West Columbia Street, Suite F, P.O. Box 560364, Orlando, FL 32806-0364 Telephone (407) 841-1290

INITIAL HISTORY AND PHYSICAL on _____, 200____.

Name _____ Age _____ (Asian, Black, Caucasian, Latin, _____) (Male or Female)

Born in _____ Has lived in _____ Now lives in Florida since _____

Lives (alone, with spouse, adult children, other family members, caregivers, _____)

Is Referred by _____ Primary Doctor/NP/PA _____

Is now (retired, disabled from working, working full-time, working part-time, has never worked, _____)

CHIEF COMPLAINT (Reason for pulmonary consultation; what breathing or chest problems do you have):

HISTORY OF THE PRESENT ILLNESS (When did it begin, what happened first, other symptoms, what helped, etc.):

PAST SURGERY (sinus, tonsils, chest, cardiac, abdominal, pelvic, vascular, etc.)

Year

Surgical Procedure

Surgeon MD

Hospital Name and Location

1 _____

2 _____

3 _____

PAST and ONGOING MEDICAL PROBLEMS or CHRONIC CONDITIONS:

Age or Date of Onset

Diagnosis

Treating Physician

1 _____

2 _____

3 _____

4 _____

5 _____

FALLS, INJURIES, ACCIDENTS or MAJOR TRAUMA; especially involving chest or ribs :

Year	Type of Injury	Treating Physician	Hospital Name and Location
1			
2			

RECENT EMERGENCY VISITS OR MEDICAL HOSPITALIZATIONS: for breathing problems, pneumonia, etc.:

Year	Diagnosis	Treating Physician	Hospital Name and Location
1			
2			

LAST VACCINES: FLU _____ PNEUMONIA _____ TB TEST & result _____ BCG(only if foreign born) _____

ALLERGIES OR SEVERE REACTIONS TO MEDICATIONS:

Year	Name of Medication or Type of Drug	Type of Reaction
1		
2		
3		

CURRENT MEDICATION LIST (Prescriptions and Inhalers and Over-the-Counter, Vitamin, or Herbal Products):

Name of Medication	Strength/Dosage/Mg	Frequency of Use	Reason for Use
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

TOBACCO USE: Patient _____ never smoked _____ is trying to quit smoking _____ chews tobacco

Patient now smokes 1/4 1/2 1 1-1/2 2 2-1/2 3+ _____ packs per day for the last _____ years, since age _____.

Former smoker for _____ years total, having smoked on average _____ packs per day, but quit smoking _____ years ago.

Patient has tried quit smoking aides _____ nicotine patch, gum, inhaler _____ Zyban _____ hypnosis _____ acupuncture

BEER WINE LIQUOR USE: Doesn't drink ___ Quit drinking ___ Drinks occasionally ___ Drinks regularly ___

CAFFEINE: Patient drinks ___ caffeinated beverages per day. (cups of coffee, tea, sodas)

DIET: Patient's diet is restricted for ___ calories ___ fat ___ sugars ___ salt ___ diabetes ___ protein ___

EXERCISE: Patient exercises for ___ minutes per day on ___ days per week by _____

HOBBIES: _____

JOBS/OCCUPATIONS:

Patient was in the military for ___ years, in (army, navy, marines, air force). Job was _____

Past jobs included: _____

Current job: _____

Spouse's Job or Military Service during marriage: _____

OCCUPATIONAL/ ENVIRONMENTAL EXPOSURES: (Check all that you are or have been routinely exposed to)

- ___ 2nd hand smoke ___ Cleaning agents ___ Birds ___ Concrete/Mortar ___ Chemical Fumes
- ___ Perfumes/Powders ___ Fire Smoke ___ Dust ___ Wool/Cotton ___ Sick Building
- ___ Sprays/Paints ___ Extreme Temps ___ Pollens ___ Feather Bedding ___ Asbestos Handling
- ___ Fertilizer ___ Dogs ___ Cut grass ___ Carpet in BR ___ Metal Grinding
- ___ Pesticides ___ Cats ___ Molds ___ Welding work ___ Wood Cutting

FAMILY: Living/Died	Age/or Age at Death	Smokes/ed	Illnesses	Cause of Death
Mother _____				
Father _____				
Brothers _____				
Sisters _____				
Children _____				
Spouse _____				

RECENT DIAGNOSTIC PROCEDURES WITHIN LAST 3 YEARS AND LOCATION OF RECORDS:

- ___ Chest x-ray _____ ___ Spirometry _____ ___ Full Breathing Test _____
- ___ Chest CT Scan _____ ___ Sinus CT _____ ___ Echocardiogram _____
- ___ Cardiac Cath _____ ___ Endoscopy _____ ___ Colonoscopy _____
- ___ Mammogram _____ ___ Blood Tests _____ ___ Ultrasound _____
- ___ Bronchoscopy _____ ___ Allergy Test _____

ASSOCIATES OF PULMONARY & CRITICAL CARE MEDICINE

Notice of Privacy Practices

Associates of Pulmonary & Critical Care Medicine (APCCM), is committed to protecting your privacy. As a healthcare provider, we know your trust in us is of central importance. This policy discloses our information use policies and practices in detail. Please read it to learn more about the ways we protect the information we collect, and to find out how you can limit the information about you that is shared. If APCCM changes its information practices, we will provide you notice of material changes.

STRICT SECURITY MEASURES

APCCM takes the security of information very seriously and has established security standards and procedures to prevent unauthorized access to patient information. We maintain physical, electronic and procedural safeguards that comply with federal and state standards to guard patient information.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care you receive.

We may use or disclose identifiable health information about you without your authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We provide information when otherwise required by law such as for law enforcement in specific circumstances. In any other situation, we will ask for your written authorization to disclose information. You can later revoke that authorization to stop any further uses or disclosures. We may change our policy at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area and in each examination room. You can also request a copy of our notice at any time. For more information about our privacy practices, contact us at the number listed below.

INDIVIDUAL RIGHTS

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. If you request copies, we will charge you \$1.00 per page for the first 25 pages and \$0.50 for each additional page. You also have the right to receive a list of instances where we have disclosed health information about you for other reasons other than treatment, payment or related administrative purposes. If you believe that information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergencies. We will consider your request but are not legally required to accept it.

COMPLAINTS

If you are concerned that we have violated your privacy rights or you disagree with a decision we made about access or correction to your records, you may contact us at the number listed below. You may also send a written complaint to the US Department of Health and Human Services, you will not suffer any retaliation.

OUR LEGAL DUTY

We are required by law to protect the privacy of your information, provide this notice of our information practices, and follow the information practices that are described in this notice.

If you have any questions or complaints, please contact:

Associates of Pulmonary & Critical Care Medicine
Attn: Privacy Officer
60 West Columbia Street
Suite F
Orlando, FL 32806
(407)-841-1290

Sign _____

Date _____