PULMONARY
ASSOCIATES, PC
Pulmonary critical care and sleep medicine

719-471-1069 PH
719-577-4828 FX
1725 E. Boulder Street #204
Colorado Springs, CO 80909

WELCOME TO PULMONARY ASSOCIATES!

All of us at Pulmonary Associates look forward to your visit.

WE HAVE ENCLOSED A MEDICAL HISTORY AND MEDICATION LIST FOR YOU TO FILL OUT. PLEASE COMPLETE THEM AND PLEASE BRING THE COMPLETED MEDICAL HISTORY AND THE COMPLETED MEDICATION FORMS WITH YOU TO YOUR APPOINTMENT.

ALSO PLEASE OBTAIN:

- A chest x-ray or CT scan of your chest performed within the last 3 months. Bring either the x-ray film or CD to the appointment, not just the report. DO NOT RELY ON ANYONE TO SEND IT FOR YOU. Call us if this test needs to be ordered to be done. **Remember; if you are coming for a lung mass, pleural effusion, or any abnormal chest finding, the doctor cannot see it by just looking at you. Bring your x-ray or CT scan!**
- Office notes for your two most recent visits to your referring doctor.
- Other pertinent test results such as Pulmonary Function Tests, Echocardiogram, or Cardiac Catheterization
- A list of your medications including vitamins, inhalers, oxygen, and supplements so that we may verify the medications and the dosages that you take.
- Your insurance card(s)
- Your medication coverage card
- Your referral (if your insurance requires one) including: Effective date, Termination date, Authorization number, and Number of visits

NOTE: If you do not arrive for your initial visit and have not canceled at least 24 hours prior to it, we will not reschedule you and you may be subject to a no show penalty fee.

Kindly refrain from wearing perfume or cologne on the day of your visit.

Thank you for choosing us,

The Physicians & Staff of Pulmonary Associates

Timothy S. Rummel, MD Ronald Rains, MD Steven R. Mohnssen, MD Bruce Suckling, MD Sanjay Ratnakant, MD
Mario Fadila, MD Christopher Merrick, MD Suneel Kumar, MD Mehdi Shelhamer, DO

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Date ____ / ____ /_____

PLEASE PRINT

PATIENT INFORMATION		
Patient Name	Home #	Cell #
Address	Email	
City, State, Zip	Contact Preference: ❍ Home ❍ Cell ❍ Email	
SSN ______- ______ - ______	DOB (Month/Day/Year) _____ / _____ / _____	❍ Male ❍ Female
Marital Status: ❍ Single ❍ Married ❍ Widowed ❍ Divorced ❍ Other:		

EMPLOYER'S INFORMATION	
Employer	Occupation
Employer's address	Phone
City, State, Zip	

PRIMARY CARE PHYSICIAN	REFERRING PHYSICIAN
Name	Name
Address	Address
City, State, Zip	City, State, Zip

SPOUSE INFORMATION	
Spouse's Name	SSN _______- _______- _______
Employer	Phone

EMERGENCY CONTACT	
Name	Phone:
Address	City, State, Zip

If person responsible for payment is other than patient, please complete the following:	
Person Responsible	SSN _______- _______- _______
Relationship to patient	Occupation
Employer	Phone
Employer's address	
City, State, Zip	

INSURANCE: If you wish this office to file insurance, fill out the insurance section completely and sign below. If you have questions concerning your insurance, please see the billing office.		
REQUIRED TRICARE Sponsor's SSN ______- ______ - ______		
Primary insurance	ID#	Gp#
Name of Subscriber		Copay Amt.
Secondary insurance	ID#	Gp#
Name of Subscriber		Copay Amt.

I authorize the release of medical information from any other medical provider needed for treatment by Pulmonary Associates.	I authorize payment of medical benefits to Pulmonary Associates. I am also aware if my insurance does not cover services, I am responsible for all charges.
____	____
Patient's signature or guardian	Patient's signature

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At Pulmonary Associates, we are committed to insuring the privacy and confidentiality of your medical records. We comply with the Health Insurance Portability and Accessibility Act of 1996 (HIPAA).

In order to assist us in protecting your privacy, please complete the following:

Patient name________________________________ Date of Birth __________________

Home Phone________________________ Work Phone __________________________

Cell Phone_________________________

Who may we speak with, other than yourself, regarding your medical care:
(If more than one, please list all.)

Spouse ___ Child ___ Brother/Sister ___ Caregiver ___ Friend ___ Parent(s) ___ Guardian ___

Please list their full name(s):

_______________________________________ Phone _____________________

_______________________________________ Phone _____________________

_______________________________________ Phone _____________________

May we leave a message on your voice mail at home? Yes ___ No ___

May we leave a message on your cell phone? Yes ___ No ___

May we leave a message on your voice mail at work? Yes ___ No ___

May we mail medical information to your home? Yes ___ No ___

I have been made aware of the privacy policies of Pulmonary Associates and have received a copy of the Notice of Privacy Practices of pulmonary Associates (or one has been made available to me).

Signature__________________________________ Date _________________________

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Sleep Questionnaire

NAME:____ MR#: ______________ DATE: ________________

D.O.B: ___________ AGE: ___________ HEIGHT: ___________ WEIGHT: ___________ NECK SIZE: ___________

OCCUPATION:____

EPWORTH SLEEPINESS SCALE:
For each question, give the answer that shows your ability to stay awake in each situation:

	Would never doze	**Slight chance of dozing**	**Moderate chance of dozing**	**High chance of dozing**
Sitting and reading	0	1	2	3
Watching television	0	1	2	3
Sitting inactive in a public place	0	1	2	3
As a passenger in a car for one hour without a break	0	1	2	3
Lying down to rest in the afternoon	0	1	2	3
Sitting and talking to someone	0	1	2	3
Sitting quietly after lunch with no alcohol	0	1	2	3
In a car while stopped in traffic	0	1	2	3

TOTAL: ______________

BEHAVIOR DURING SLEEP:
Use the following scale to choose the most appropriate number for each situation:

0 = never during a usual night

1 = less than once a week

2 = 1 to 3 nights per week

3 = 4 to 7 nights a week

? = don't know or haven't been told

Patient name: ____ **DOB:** ____________________

During your usual sleep, you have noticed or have been told you do the following:

1.	Snore	0	1	2	3	?
2.	Snore loudly and bother others	0	1	2	3	?
3.	Snore so badly I wake myself up	0	1	2	3	?
4.	Choke, struggle for breath	0	1	2	3	?
5.	Stop breathing	0	1	2	3	?
6.	Toss and turn frequently	0	1	2	3	?
7.	Wake up with headache	0	1	2	3	?
8.	Crawling and Aching feeling in legs	0	1	2	3	?
9.	Kicking	0	1	2	3	?
10.	"Acting out" dreams	0	1	2	3	?
11.	Fall asleep driving	0	1	2	3	?

Symptom onset/duration _______ weeks, months, years

Sleep habits on work days:

Time to bed __________
Time you fall asleep __________
Time to awake in AM __________
Number of times wake up/night __________
How fast do you fall asleep? (minutes) __________
Hours in bed/24 hrs. __________
Naps per week __________
Length of naps __________

How do you feel after an average night of sleep?

- ❑ good most of the time
- ❑ varies
- ❑ usually drowsy and tired

On the average, how long do you stay in bed after waking in the morning? ____________
If you wake up, when do you usually wake up, and how long do you stay awake? ____________
Do you find it difficult to, "turn your mind off" when lying in bed? ____________
Do you have pain that may affect your sleep? ____________

My job involves shift work ❑ Yes ❑ No
My job involves frequent travel across time zones ❑ Yes ❑ No
Do you frequently use any of the following?

Alcohol ❑ Yes ❑ No
What type? ____________________________________
How much? ____________________________________
How often? ____________________________________

Caffeine ❑ Yes ❑ No
How much? ____________________________________
How often? ____________________________________

Prescription or other sleeping pills or aids ❑ Yes ❑ No

Patient name: ______________________________ **DOB:** ____________________

Do you have a history of the following?

Auto accidents due to excessive sleepiness?	❑ Yes	❑ No
Excessive leg movements during sleep?	❑ Yes	❑ No
Uncontrollable urge to move your legs during the day?	❑ Yes	❑ No
Sudden weakness in your legs or muscles while awake, especially during the expression of emotion (such as laughter, sorrow, anger, surprise, etc.)?	❑ Yes	❑ No
Felt paralyzed or unable to move when waking up or falling asleep?	❑ Ye	❑ No
Hallucinations or dreamlike images when not actually asleep but while falling asleep or awakening?	❑ Yes	❑ No
Nightmares, sleepwalking, teeth grinding, head Banging? (circle one)	❑ Yes	❑ No

Do you have a family history of sleep problems? ❑ Yes ❑ No

GENERAL MEDICAL REVIEW

Past Medical and Social History

Medical Illnesses

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________

Hospitalizations/ Surgeries

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________

Physicians (reason you're seeing them):______________________________

____

____

____

Allergies: ______________________________

Please list your medications and medication allergies on the Medication Flow Sheet.

Patient name: ____ **DOB:** ____________________

Do you or did you smoke cigarettes? ❑ Yes ❑ No
How many packs per day? _______ How many years? _______ When did you quit? ______________

How much alcohol do you drink per day? ___________________

Do you use or have you used illicit drugs? ❑ Yes ❑ No
If yes, which ones? ____

FAMILY HISTORY

Has any blood relative ever had the following? (please check all that apply)

Asthma	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No	Heart Disease	❑ Yes	❑ No
Emphysema	❑ Yes	❑ No	Allergies	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Lung Disease	❑ Yes	❑ No
Sleep Apnea	❑ Yes	❑ No	Narcolepsy	❑ Yes	❑ No

SYSTEMS REVIEW

General:
Do you feel you have problems with the following?

Fever	❑ Yes	❑ No	Night Sweats	❑ Yes	❑ No
Weight Loss	❑ Yes	❑ No	Weight Gain	❑ Yes	❑ No
How much? __________			How much? ___________		

Eyes, Ears, Nose and Throat:
Do you feel you have a problem with the following?

Vision	❑ Yes	❑ No	Cataracts	❑ Yes	❑ No
Glaucoma	❑ Yes	❑ No	Hoarseness	❑ Yes	❑ No
Nasal Congestion	❑ Yes	❑ No	Nose Bleeds	❑ Yes	❑ No
Hay Fever	❑ Yes	❑ No	Sore Throat	❑ Yes	❑ No
Sinus Infections	❑ Yes	❑ No			

How many colds do you have each year? ___________

Patient name: ____ **DOB:** ____________________

Cardiovascular:

Do you feel you have problems with the following?

Waking up at night short of breath	❑ Yes	❑ No
Shortness of breath for no apparent reason	❑ Yes	❑ No
Chest pain, heaviness, or tightness	❑ Yes	❑ No
Palpitations or fluttering of your heart	❑ Yes	❑ No
Swelling of the ankles or feet	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Leg Pain	❑ Yes	❑ No
Clots in veins or arteries	❑ Yes	❑ No
Fingers turning white when cold	❑ Yes	❑ No
Poor Circulation	❑ Yes	❑ No

Respiratory:

When was your last chest x-ray?____

Do you have a history of any of the following?

Pneumonia	❑ Yes	❑ No	Date ______________
Recurrent Bronchitis	❑ Yes	❑ No	Date ______________
Blood Clots	❑ Yes	❑ No	Date ______________
Asthma	❑ Yes	❑ No	Date ______________
Tuberculosis	❑ Yes	❑ No	Date ______________
Lung Cancer	❑ Yes	❑ No	Date ______________
Emphysema	❑ Yes	❑ No	Date ______________

Do you feel you have a problem with any of the following?

Cough	❑ Yes	❑ No	Phlegm	❑ Yes	❑ No
Chest Pain	❑ Yes	❑ No	Coughing up blood	❑ Yes	❑ No
Shortness of Breath	❑ Yes	❑ No	Asthma or Wheezing	❑ Yes	❑ No

Gastrointestinal:

Do you feel you have problems with any of the following?

Difficulty Swallowing	❑ Yes	❑ No	Heartburn	❑ Yes	❑ No
Food coming back up	❑ Yes	❑ No	Vomiting	❑ Yes	❑ No
Hiatal Hernia	❑ Yes	❑ No	Ulcer	❑ Yes	❑ No
Bleeding from stomach	❑ Yes	❑ No	Blood in stool	❑ Yes	❑ No
Constipation	❑ Yes	❑ No	Diarrhea	❑ Yes	❑ No
Abdominal pain	❑ Yes	❑ No			

Patient name: ____ **DOB:** _____________________

Genitourinary:

How often do you get up at night to urinate? _______ time(s)

Do you feel you have problems with any of the following?

Kidneys or bladder	❑ Yes	❑ No
Blood in urine	❑ Yes	❑ No
Prostate	❑ Yes	❑ No
Female organs	❑ Yes	❑ No

Musculoskeletal:

Do you feel you have problems with any of the following?

Arthritis or joints	❑ Yes	❑ No
Back, arm or leg pains	❑ Yes	❑ No
Muscle pain or cramps	❑ Yes	❑ No
Osteoporosis or weak pains	❑ Yes	❑ No

Skin:

Do you feel you have problems with any of the following?

Skin Rash	❑ Yes	❑ No
Skin Cancer	❑ Yes	❑ No

Neuropsych:

Do you feel you have problems with any of the following?

Headache	❑ Yes	❑ No	Tremor	❑ Yes	❑ No
Fatigue	❑ Yes	❑ No	Muscle Weakness	❑ Yes	❑ No
Depression	❑ Yes	❑ No	Dizziness	❑ Yes	❑ No
Anxiety	❑ Yes	❑ No	Fainting	❑ Yes	❑ No
Stroke	❑ Yes	❑ No			

Endocrine:

Do you feel you have problems with any of the following?

Diabetes	❑ Yes	❑ No
Thyroid Trouble	❑ Yes	❑ No

Hematologic/Lymphatic:

Do you feel you have problems with any of the following?

Anemia	❑ Yes	❑ No
Lymph Node Swelling	❑ Yes	❑ No
Bleeding	❑ Yes	❑ No

Patient name: ____ **DOB:** ____________________

MEDICATION FLOW SHEET

Medication Allergies: ____

____

____

Medication / dosages / reason taken			Date(s) Assessed								

Week #: ____________________ **Patient name:** ____ **DOB:** ____________________

SLEEP LOG

	SAMPLE							
DAY OF THE WEEK	*Monday*							
CALENDAR DATE	*3/25/96*							
1. Yesterday I napped from _______ to _______ (note time of all naps).	*1:30 - 2:45 pm*							
2. Last night I took _____ mg. of _____________ or _____ of alcohol as a sleep aid.	*Ambien 5 mg.*							
3. Last night I turned off the lights and attempted to fall asleep at _______ (AM or PM).	*11:30 pm*							
4. After turning off the lights it took me about _____ minutes to fall asleep.	*40 Min.*							
5. I woke from sleep _____ times. (Do not count your final awakening here)	*2 Times*							
6. My awakenings lasted _____ minutes. (List each awakening separately)	*25 Min.* *40 Min.*							
7. Today I woke up at _______ (AM or PM) **NOTE** this is your final awakening.	*6:30 am*							
8. Today I got out of bed for the day at __________ (AM or PM).	*7:15 am*							
9. I would rate the quality of last night's sleep as: 1 = very poor 4 = Good 2 = poor 5 = Excellent 3 = fair	*3*							
10. When I woke today I felt: 1 = not all rested 4 = rested 2 = slightly rested 5 = well rested 3 = somewhat rested	*2*							

Week #: ____________________ **Patient name:** ____ **DOB:** ____________________

SLEEP LOG

	SAMPLE							
DAY OF THE WEEK	*Monday*							
CALENDAR DATE	*3/25/96*							
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NOTICE OF PULMONARY ASSOCIATES FINANCIAL POLICY

$35 FEE FOR NO SHOWS OR CANCELLATIONS WITH LESS THAN 24 HOUR NOTICE:

We understand that there are times you must miss an appointment due to emergencies or other obligations. However, when you do not call to cancel your appointment in a timely manner, you may be preventing another patient who could have been scheduled in your slot from receiving the much needed care they may need. To avoid this fee please call to cancel appointments at least 24 hours in advance of your scheduled appointment.

Note: Patients with two or more unexcused no shows will be automatically discharged from the practice.

Note: Patients who are only scheduled for a Pulmonary Function Test (PFT) that no show will be subject to the No Show policy.

Note: Patients who are more than 15 minutes late for their scheduled appointment may be rescheduled to another day and time.

DELINQUENT ACCOUNTS:

Any outstanding Patient accounts sent to a third party collection agency will be sent to your doctor for review and could result in termination from the practice.

BILLING PRACTICES:

- Pulmonary Associates policy is to bill the patients insurance company for services rendered. Insurance is a contract between the patient and the insurance company and it is your responsibility to pay any fee's your insurance company assigns to you. Should the insurance company deny coverage due to non-covered benefits, or lack of referral, responsibility of payment will be assigned to the patient.
- If you do not have insurance, payment is due in full at time of service.
- All co-pays are due at the time of service.
- If your insurance plan requires a referral to be seen by a specialist, it is your responsibility to make sure a current referral has been obtained.
- It is the patient's responsibility to verify any treatment which takes place at the clinic or at an outside facility is in network with your benefits. If not, the patient will be responsible for any out of network charges that may be assessed. When referring out for any testing or procedures, Pulmonary Associates will do it's very best to refer the patient to a facility that is contracted with the patients insurance. However, with insurances continuously looking to narrow their networks, it is very difficult to know which facilities are in network with all insurances, and Pulmonary Associates cannot be liable for any out of network fees which may be assessed to the patient.

Please sign and date below to acknowledge receipt of Pulmonary Associates Financial Policy:

Patient Name: ______________________________________

Patient Signature: __________________________________ Date: ________________

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Notice of Privacy Practices for Protected Health Information

Pulmonary Associates

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY!

Effective date: July 2013

The Practice of Pulmonary Associates is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law, the Health Insurance Portability & Accountability Act of 1996 (HIPAA), to use and disclosure your PHI for the purposes of treatment, payment, and health care operations without your written authorization.

Examples of Uses of Your Health Information for Treatment Purposes are:

- Our nurse obtains treatment information about you and records it in a health record.
- During the course of your treatment, the physician determines he will need to consult with a specialist in another area. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition, or to remind you of medical appointments.

Example of a Use of Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company; the health insurance company requests information from us regarding medical care provided to you. We will provide this information to them.

Example of a Use of Your Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities such as quality assessment activities, to review employee activities, or to assist in the training of students. We may share information about you with our business associates, who perform these functions on our behalf, as necessary to obtain these services.

Other Examples:

- We may use or disclose your PHI to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use or disclose your PHI for activities such as sending you a newsletter about our practice and the services we offer. You may contact us to request that these materials not be sent to you.

Other uses and disclosure of your PHI will only be made with your authorization, unless otherwise permitted or required by law, as described below.

Your Health Information Rights

The health and billing records we maintain are the physical property of the office. The information in them, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information. We are not required to grant the request, but we will comply with any request that we agree to grant;
- Obtain a paper copy of the current Notice of Privacy Practices for Protected Health Information ("the Notice") by making a request at our office;
- Request that you be allowed to inspect and copy your health record and billing record – you may exercise this right by delivering the request to our office;
- Appeal a denial of access to your protected health information, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a request to our office. We may deny your request if you ask us to amend information that either was not created by us (unless the person or entity that created the information is no longer available to make the amendment), is not part of the health information kept

by the office, is not part of the information that you would be permitted to inspect and copy, or is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;

- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office;
- <u>Restrict information going to your health plan about an item or service for which you pay the Practice out-of-pocket and in full for the item or service.</u>
- Obtain an accounting of disclosures of your health information as required to be maintained by law. An accounting will not include uses and disclosures of information for treatment, payment, or operations; disclosures or uses made to you or made at your request; uses or disclosures made pursuant to an authorization signed by you; uses or disclosures made in a facility directory or to family members or friends relevant to that person's involvement in your care or in payment for such care; or, uses or disclosures to notify family or others responsible for your care of your location, condition, or your death.
- Revoke authorizations that you made previously to use or disclose information by delivering a written revocation to our office (except to the extent action has already been taken based on a previous authorization).

If you would like to exercise any of the above rights, please contact our office at (719) 471-1069 during regular business hours, or in writing. The Privacy Officer will inform you of the steps needed to exercise your rights under HIPAA.

<u>Our Responsibilities</u>

The office is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice ('Notice') as to our duties and privacy practices regarding the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods to communicate health information with you and not disclose PHI to your health plan if you request that we do not, and pay for the item/service out-of-pocket and in full. You must request this Patient Right in writing.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and to enact new provisions regarding the PHI we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy, visiting our website, or by visiting our office and picking up a copy.

<u>To Request Information or File a Complaint</u>

If you have questions, would like additional information, or would like to report a problem regarding the handling of your information, you may contact the Privacy Officer. If you believe your privacy rights have been violated, you may file a complaint by delivering it in writing to the Practice's Privacy Officer. You may also file a complaint with the Secretary of Health and Human Services, Office for Civil Rights (OCR). The address for this office is: OCR - U.S. Department of Health and Human Services - 200 Independence Avenue S.W. - Room 509F, HHH Building - Washington, D.C. 20201. Information regarding the steps to file a complaint with the OCR can also be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- <u>We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office.</u>
- <u>We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.</u>

<u>Other Uses and Disclosures of your PHI</u>

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object, or in an emergency.

Notification

- Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Research

- We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Disaster Relief

- We may use and disclose your protected health information to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation through Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- As authorized by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

Abuse & Neglect

- We may disclose your PHI to public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.

Enforcement

- We may disclose your PHI for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings

- We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

Serious Threat

- To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions

- We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary for them to carry out their duties.

Other Uses

- Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization. You may revoke any authorization at any time, as previously provided in this Notice under "Your Health Information Rights."

Website

- If we maintain a website that provides information about our entity, you will be able to access our Notice electronically on our website.

719-471-1069 PH
719-577-4828 FX

1725 E. Boulder Street #204
Colorado Springs, CO 80909

PATIENT SIGNATURE SECTION:

Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I have received the attached (above) Notice of Privacy Practices (“The Notice”) for the practice of Pulmonary Associates

____
Print Name

______________________________________ _______________
Patient (or Patient Representative*) Signature Date

****If Patient Representative, legal documentation must be included to show authority to sign or receive information.*