STANLEY TU, M.D.

Patient Personal Information

Name:_____
Address:_____
City/State/Zip:_____
Social Security Number:_____
Date of Birth:____/____/____
Circle Gender: Female Male
Phone (Home): (____)_____
Phone (Work): (____)_____
Phone (Cell): (____)_____
Primary Language:_____
Need Interpreter: (Check One) Yes____ No____
Occupation/Student: _____
Employer/School:_____
Referred By:_____

Responsible Party Information

Name:_____
Address:_____
City/State/Zip:_____
Social Security Number:_____
Date of Birth:____/____/____
Phone (Circle Home/Work/Cell): (____)_____
Relationship to Patient:_____

Emergency Contact

Name:_____
Phone (Home/Work/Cell): (____)_____
Relationship to Patient:_____

Insurance Information

Insurance Carrier:_____
Insurance I.D. #:_____
Type (Circle One) HMO PPO POS Medicare Medi-Cal
Secondary Insurance:_____
Subscriber's Name:_____
Subscriber's Date of Birth:_____

Spouse Information

Name:_____
Address:_____
City/State/Zip:_____
Date of Birth:____/____/____
Phone (Circle Home/Work/Cell): (____)_____
Relationship to Patient:_____
Pharmacy:_____

Authorization

I authorize you to share my protected health information with any of the following persons. This includes allowing them to pick up lab information, prescriptions, other referral information from Foothill Pulmonary and Critical Care Consultants Medical Group, Inc., and to make and receive phone calls regarding my health and/or the billing related to the service provided to me by Foothill Pulmonary and Critical Care Consultants Medical Group, Inc.

☐ SPOUSE:_____
☐ CAREGIVER:_____
☐ CHILDREN:_____
☐ OTHER:_____

ASSIGNMENT OF BENEFITS

I hereby assign payment of authorized Medicare and any other medical and/or surgical benefits, to include major medical benefits to which I am entitled, to be made either for me or on my behalf to Foothill Pulmonary and Critical Care Consultants Medical Group, Inc. for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. "I certify that I am eligible for benefits under the pre-paid health benefit plan. In the event I am later found to be ineligible, or as consideration for being treated without proof of eligibility, I agree to pay for any and all services provided by Foothill Pulmonary and Critical Care Consultants Medical Group, Inc. at their fees then in effect."

SIGNATURE:_____ DATE:_____

HIPAA PRIVACY POLICY

Our notice of Privacy Practices advises how we may use and disclose protected health information about you. Our current notice is available in our lobby, or upon request. I agree to the uses and disclosures of my information for purposes of treatment, payment, and practice operations.

SIGNATURE:_____ DATE:_____

Foothill Pulmonary and Critical Care Consultants Medical Group INC.

NextGen Patient Portal Authorization

Patient Name: _____

Email (Print): _____

IN EVENT OF AN EMERGENCY, DIAL 911.
Do Not Use the Patient Portal for Urgent or Emergent Matters.

Purpose of this Form
Our Medical Office offers secure electronic access to your medical record and secure electronic communications between our office and you for those patients who wish to participate. Secure messaging can be a valuable communications tool, but certain precautions should be used to minimize risks. In order to manage these risks we have imposed some terms and conditions of participation. Your signature on this form will demonstrate that you have been informed of these risks and the conditions of participation and that you accept the risks and agree to the conditions of participation.

How the Secure Patient Portal Works
A secure web portal is a webpage that uses encryption (a form of electronic security) to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the Portal site. Using the connection channel between your computer and the Web site, you can read, view, or send information on or from your computer. It is automatically encrypted in transmission between the Web site and your computer.

How to Participate
You may compose, pick up, and reply to secure messages or view information sent to you through the Patient Portal. Once you have reviewed, agreed to, and signed our policies and procedures regarding use of the Patient Portal, we will assign you a username and password. You may then login to the Patient Portal by going to https://nextmd.com/

Protecting Your Private Health Information and Risks
This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, no transmission system is perfect. We will do our best to maintain electronic security. Keeping messages secure depends on two additional factors: the secure message must reach the correct email address, and only the correct individual (or someone authorized by that individual) must be able to have access to it. You are responsible for ensuring that we have your current email address and you agree to inform us immediately if it changes. Protect your username and password information as you would protect your banking information. Safeguard this information so that only you or someone you authorize has access to this information. If you believe someone has learned your password, you should immediately go to the Web site and change it. You agree not to share your username and password with unauthorized persons and to maintain that username and password in a secure place at all times. Access to the Patient Portal is a free service but we reserve the right to change this policy if needed. We strive to keep all of your protected health care information completely confidential. Please read our Notice of Privacy Practices for additional information on uses and disclosures.

Conditions of Participating in the Patient Portal
Access to the secure web portal is a service, and we may suspend or discontinue it at any time and for any reason. If we do suspend or discontinue this service we will notify you as promptly as we reasonably can. You agree to not hold Foothill Pulmonary and Critical Care Consultants Medical Group INC. or any of its staff or physicians liable for network or security infractions beyond their control. By signing this agreement, you acknowledge that you understand the policies and procedure, agree to comply with them and all of your questions have been answered to your satisfaction. If you do not understand, or do not agree to comply with our policies and procedures, do not sign this agreement and do not request a username and password. **If you have questions we will gladly provide more information.** *Policies & Procedures are subject to change without notice.*

(Optional) Please allow access to my Patient Portal information to:

_____ _____
Print Name **Relationship**

Patient/Patent/Guardian Acknowledgement

_____ _____
Patient Signature **Date**

FOOTHILL PULMONARY AND CRITICAL CARE CONSULTANTS MEDICAL GROUP, INC.

959 E. Walnut St., Suite 120
Pasadena, California 91106
(626) 795-5118

301 W. Huntington Dr., Suite 607
Arcadia, California 91007
(626) 445-4558

1818 Verdugo Blvd., Suite 207
Glendale, California 91208
(818) 790-1730

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Elton Katagihara, M.D.
Mark Kroe, M.D.
Carlos G. Makabali, M.D.
Rajiv Philip, M.D.

David R. Ratto, M.D.
Pratap Saraf, M.D.
Robert Siew, M.D.
Stanley Tu, M.D.

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices:*

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____

Name of Patient | Date of Birth | Signature of Patient/Parent/Guardian | Date

II. Designation of Certain Relatives, Close Friends and other Caregivers as my Personal Representative:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name:_____ Last four digits of his/her SSN (required):_____

Print Name:_____ Last four digits of his/her SSN (required):_____

Print Name:_____ Last four digits of his/her SSN (required):_____

_____

Name of Patient (Print) | Signature | Date

Witness: _____ Date: _____

CAIR California Immunization Registry

Immunization Registry Notice to Patients and Parents

Immunizations or 'shots' prevent serious diseases. Tuberculosis (TB) screening tests help to determine if you may have TB infection and can be required for school or work. Keeping track of shots/TB tests you have received can be hard. It's especially hard if more than one doctor gave them. Today, doctors use a secure computer system called an *immunization registry* to keep track of shots and TB tests. If you change doctors, your new doctor can use the registry to see the shot/TB test record. It's your right to choose if you want shot/TB test records shared in the *California Immunization Registry.*

How Does a Registry Help You?

- Keeps track of all shots and TB tests (skin tests/chest x-rays), so you don't miss any or get too many
- Sends reminders when you or your child need shots
- Gives you a copy of the shot/TB record from the doctor
- Can show proof about shots/TB tests needed to start child care, school, or a new job

How Does a Registry Help Your Health Care Team?

Doctors, nurses, health plans, and public health agencies use the registry to:

- See which shots/TB tests are needed
- Remind you about shots needed
- Prevent disease in your community
- Help with record-keeping

Can Schools or Other Programs See the Registry?

Yes, but this is limited. Schools, child care, and other agencies allowed under California law may:

- See which shots/TB tests children in their programs need
- Make sure children have all shots/TB tests needed to start child care or school

What Information Can Be Shared in a Registry?

- patient's name, sex, and birth date
- parents' or guardians' names
- limited information to identify patients
- details about a patient's shots/TB tests

What's entered in the registry is treated like other private medical information. Misuse of the registry can be punished by law. Under California law, only your doctor's office, health plan, or public health department may see your address and phone number.

Patient and Parent Rights

It's your legal right to ask:

- not to share your (or your child's) registry shot/TB test records with others besides your doctor*
- not to get shot appointment reminders from your doctor's office
- to look at a copy of your or your child's shot/TB test records
- who has seen the records or to have the doctor change any mistakes

If you DO want your or your child's records in the registry, do nothing. You're all done.

If you DO NOT want your doctor's office to share your immunization/TB test information with other registry users, tell your doctor or download a "*Decline or Start Sharing/Information Request Form*" from the CAIR website (http://cairweb.org/cair-forms/) and FAX or email it to the CAIR Help Desk at **1-888-436-8320** or CAIRHelpDesk@cdph.ca.gov.

For more information, contact the CAIR Help Desk at 800-578-7889 or CAIRHelpDesk@cdph.ca.gov

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* *By law, public health officials can also look at the registry in the case of a public health emergency.*

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959 E. Walnut Street, Suite 120, Pasadena, CA 91106
(626)795-5118

Dear Patient,

In order to serve you, our valued patient, in a more efficient manner, please be advised of the following office policies:

1. **Medication Refills:**

Please have your pharmacy contact our office 3 to 5 days prior to when your medications are expired or completed. Practice good healthy habits and call us with your medication requirements prior to completion of your prescription. This policy allows you to take your medication without any interruptions or compromise in your health and well-being.
Routine medication refills (*including all CPAP and BiPAP equipment*) require at least one yearly follow up exam with your physician.

PRESCRIPTION REFILLS ARE NOT PROCESSED ON SATURDAY OR SUNDAY OR AFTER HOURS. Please allow 48 hours for all refills to be processed. Patients *must* be seen within one year for any refills. We are not responsible for your prescription plan coverage. Please read your medical plans pharmacy policies.

2. **Laboratory/Diagnostic testing:**

All test results are reviewed by the ordering physician within 1 working day of receiving the results. Patients will only be notified of abnormal test results requiring treatment. Patients are always encouraged to contact our office during normal business hours (Monday through Friday 9 a.m. to 5 p.m.) to obtain verbal results from our nurse.

3. **Cancelled/Missed Appointments:**

A scheduled appointment means that time is reserved only for you. If an appointment is missed or cancelled with less than a 24 hour notice, Foothill Pulmonary reserves the right to bill the patient according to the scheduled fee or according to the rules of the patient's health plan. You will be billed unless another appointment is made.

4. Authorization/Eligibility:

Because of the contractual relationship between Foothill Pulmonary and all managed care insurance plans, I am aware that every visit requires pre-authorization prior to any procedures or lab tests, which may delay health care. Co-payments are expected to be paid at the time of service and are required for each visit.

AUTHORAZATION FORMS MUST BE PRESENTED AT THE TIME OF SERVICE OR YOU MAY BE REFUSED SERVICE OR BE RESPONSIBLE FOR THE BILL AT THE TIME OF SERVICE.

I understand I must be seen prior to the expiration date of the authorization, and must be eligible with the insurance at the time of service. I will notify the office of any change in my insurance, primary care physician, or demographic information. Failure to do so may delay the billing process and/or medical care.

5. Disability forms and other non-insurance forms:

Due to the complexity of completing certain disability forms and other non-insurance forms, effective August 21, 2008 office has instituted a charge of $35.00 per form to complete these forms. This includes but is not limited to SDI, FMLA, DMV, Electric or Gas Company, jury duty, and airline forms. If you have any questions about this fee, please speak with one of the office staff.

Please be advised, if 3 years have passed since your last visit you will be considered a new patient.

We provide this information because we would like you to be able to plan for your entire health care needs and not inappropriately rely on a limited purpose visit as if it were a comprehensive examination of your overall health.

Your on going partnership and working relationship with our office and staff allows us to better meet your medical needs. We appreciate, very much, your cooperation and adherence to our policies. We understand the need for personalized medical care and we strive to meet your needs.

Do you have any personal, religious, or cultural preferences which may effect or influence the way you want to be treated?

Yes_____ No_____

If you answered yes, please explain

_____

_____

I agree to allow the physicians of Foothill Pulmonary to render medical care to:

_____
Patient's Name

I have read and understand the above information and agree to all of the terms stated above.
My signature below represents my acceptance of these policies.

_____ _____
Patient's signature Date

ADULT PATIENT QUESTIONNAIRE

In order to best care for you, please fill out the following information. This form only needs to be completed once so we can enter the information in our electronic medical record. If you have already completed this form you do not need to fill it out again.

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

Name of physician/provider you are seeing today: _____

Medications

Are you currently taking any medications? ☐ No ☐ Yes, please list medication and dosage if known:

_____

_____

_____

Allergies

Are you allergic to anything? ☐ No ☐ Yes, please list drug(s) and reaction(s):

_____

_____

_____

Immunizations (approximate dates are fine)

Date of your last flu shot? _____ ☐ None

Date of your last pneumonia shot? _____ ☐ None

Date of your last tetanus shot? _____ ☐ None

Have you been diagnosed with any of the following conditions?

☐ Alcoholism	☐ Allergies	☐ Alpha -1- antitrypsin deficiency
☐ Anemia	☐ Angina Pectoris	☐ Anxiety
☐ Asbestosis	☐ Asthma	☐ Blood Clots
☐ Bronchitis	☐ COPD	☐ Congestive Heart Failure
☐ Coronary Artery Disease	☐ CVA	☐ Depression
☐ Diabetes	☐ Emphysema	☐ Empyema
☐ Fibromyalgia	☐ Goodpasture's Syndrome	☐ Histoplasmosis
☐ HIV	☐ Hyperlipidemia	☐ Hypertension
☐ Insomnia	☐ Lung Abscess	☐ Lung Cancer
☐ Myocardial Infarction	☐ Obesity	☐ Pneumonia
☐ Pulmonary Fibrosis	☐ Restless Legs Syndrome	☐ Sarcoidosis
☐ Sleep Apnea	☐ Sleep Walking	☐ Squamous Cell Lung Cancer
☐ Small Cell Lung Cancer	☐ Systemic Lupus Erythematosis	☐ Toxic Exposure
☐ Thyroid Disease	☐ Tuberculosis	

Patient Name: _____ **Date:** _____

Social History

☐ Detailed document
☐ Reviewed, no changes
☐ History unobtainable

Primary language spoken: _____ Language spoken at home: _____

Birthplace: _____ Hand dominance ☐ Right ☐ Left ☐ Ambidextrous

Education/Employment/Occupation/Military Experience

Education: _____ Degree obtained: _____ From what country: _____

Employment	Occupation	Restrictions	Employment Status	Retire Date

Occupational hazards

Military experience ☐ Yes ☐ No

Branch of military: _____ Current status: _____ Number of years served: _____

Stationed overseas ☐ Yes ☐ No Noise Exposure ☐ Yes ☐ No Biohazard exposure ☐ Yes ☐ No

Marital Status/Family/Social Support

Current marital status: _____ Previously widowed ☐ Yes ☐ No ____ Times

Previously divorced ☐ Yes ☐ No ____ Times

Who lives with you at your primary residence? _____

Who comprises your support network? _____

Tobacco

Do you use tobacco? ☐ Yes ☐ No ☐ Former

Tobacco type: _____ Number of years: _____ Tobacco per day: _____

Ever try to quit? ☐ Yes ☐ No Year quit: _____

Passive smoke exposure? ☐ Yes ☐ No

Alcohol

Do you drink alcohol? ☐ Yes ☐ No ☐ Former

Types: _____

Frequency: _____ Amount: _____ Last drink: _____

Do you use caffeine ☐ Yes ☐ No

Type of caffeine used: ☐ Coffee ☐ Tea ☐ Tables ☐ Energy Drinks ☐ Chocolate

Caffeine per day: _____