

Pulmonary Disease, Critical Care & Sleep Medicine

Farah Sagheer, M.D

Name: _____ Age: _____ DOB: ____/____/____

Phone: _____ Address: _____

Sex: Male Female Drug Allergies: _____

SS # _____ Pharmacy Name: _____ Address: _____

Primary care doctors name: _____ who referred you? _____

Briefly describe the reason for your visit today and what you hope to accomplish:

Please list all current medications with dosage or provide a list:

Past Medical History (Please check all that apply) DO NOT LEAVE BLANK:

- Congestive Heart Kidney Failure Depression Crohn's Disease
 Atrial Fibrillation Skin Cancer Anxiety Tuberculosis TIA
 Coronary artery disease Asthma Bipolar disorder Chronic Bronchitis
 Heart murmur Pneumonia Diabetes Arrhythmia Lung cancer
 COPD Hypothyroidism Hypertension (High blood pressure) Liver cirrhosis
 Emphysema Seizures Hepatitis Acid reflux Sleep apnea
 Fibromyalgia Hyperlipidemia (high cholesterol) Heart disease Anemia
 Rheumatoid Arthritis Diverticulosis Cancer/Type Palsy Stroke

Email for patient portal: _____

Summary of pulmonary history:

- **Concern of lung disease because of the following symptoms:**

- **Previously diagnosed with the following lung disease:**

Past surgical history: (Please supply dates and surgery location)

Family History:

Mother: Alive ___ or Deceased ___
___ Lung cancer ___ COPD/Emphysema
___ Heart disease ___ Diabetes Mellitus
___ Arthritis Other _____

Father: Alive ___ or Deceased ___
___ Lung cancer ___ COPD/Emphysema
___ Heart disease ___ Diabetes Mellitus
___ Arthritis Other _____

Epworth sleepiness scale: How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Use the following scale to choose the most appropriate number for each situation.

- | | |
|-------------------------------|---|
| 0 = Would never doze | Sitting and reading ___ |
| 1 = Slight chance of dozing | Watching TV ___ |
| 2 = Moderate chance of dozing | Sitting, inactive in a public place ___ |
| 3 = High change of dozing | As a passenger in a car for an hour without break ___ |
| | Lying down to rest in the afternoon when time permits ___ |
| | Sitting and talking with someone ___ |
| | Sitting quietly after lunch without alcohol ___ |
| | In a car, while stopped for a few minutes in traffic ___ |

Do you smoke? ___ Yes or ___ No **Have you ever smoked?** ___ Yes or ___ No **Year quit?** _____

Use marijuana ___ Yes or ___ No **How many years have you smoked?** _____

Review of symptoms (check all that apply)

General: Fatigue Headache Weight gain Weight loss

Allergy: Sneezing Rash Hives Watery eyes

Cardiovascular: Chest pain Palpitations Murmur

Pulmonary: Hemoptysis Wheezing Snoring Chest pain

Repertory: Shortness of breath Cough Sputum Chest pain

Gastrointestinal: Heartburn Nausea Vomiting Constipation Diarrhea
 vomiting blood Abdominal pain

Endocrine: Heat intolerance Cold intolerance Difficulty sleeping

Neurologic: Visual disturbances Blackouts Numbness

Psychiatric: Anxiety Depression

Musculoskeletal: Joint pain Back pain Arthralgia

Ophthalmological: Blurred vision

ENT: Difficulty swallowing Sore throat

**PATIENT AUTHORIZATION TO THE USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION FOR TREATMENT,
PAYMENT OR HEALTHCARE OPERATIONS:**

I wish to have the following restrictions to the use or disclosure of my health information:

You may release my PHI to family members & relationships:

_____ Phone Number: _____

_____ Phone Number: _____

_____ Phone Number: _____

_____ Phone Number: _____

_____ Phone Number: _____

You may leave a message on my answering device (Please circle): YES OR NO

I understand that as part of this organizations treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, Including disclosure via fax.

Signature of patient/ Legal Guardian: _____

Date: _____ Print Name: _____

PATIENT AUTHORIZATION TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I, _____ understand that as a part of my healthcare, Farah Sagheer, M.D originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results; diagnosis, treatment, and any plans for future care or treatment. I understand that this information serve as:

- *A basis for planning my care and treatment
- *A means for communication amount to many health professionals who contribute to my care
- *A source of information for applying my diagnosis and surgical information to my bill
- * A means by which third party payer can verify that services billed were actually provided
- * A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a notice of information practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- *The right to review the notice prior to signing this consent
- * The right to object to the use of my health information for directory purpose
- *The right to request requisitions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that Farah Sagheer, M.D. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance Theron. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by section 164.506 of the code of federal regulations. I further understand that Farah Sagheer, M.D. reserves the right to change their notice and practice prior implementation, in accordance with section 164.520 of the code of federal regulations. Should Farah Sagheer, M.D change their notice, the will send a copy of any revised notice to the address I've provided

Dear Valued Patient,

Thank you very much for choosing Farah Sagheer, M.D to participate in your healthcare. As a participant in your own healthcare, it is your responsibility to make sure that there is a clear and open method of communication from our office to you. It is your duty to make sure that this office always has a way to contact you to communicate test results and other important matters relating to your medical care. Along the way, we will recommend/perform diagnostic studies which we feel are important to your wellbeing. These diagnostic studies serve the purpose of diagnosing your ailment, defining treatment strategies and maintaining your health. As with all diagnostic studies we are at times unpleasantly surprised by the results. The results include cancer and other potentially deadly conditions, which if gone undiagnosed or if diagnosis is delayed can result in death or serious disability. Some of these studies will be at the time of an active issue, other times it will be recommendations for the future, maybe even ten years in the future. We pride ourselves in attempting to contact every single patient with reminders for follow up issues. Sometimes we are unable to contact you, or the results are not returned to our office. Ultimately, it is your responsibility to contact us if you do not hear within 14 days regarding your test results or if you do not receive a reminder notice for follow up diagnostic study.

By signing this letter, you acknowledge the imperfection in our system and agree to the following: **Please initial each line**

1. _____ Call our office 2 weeks after any diagnostic study
2. _____ Call our office again, for any issue if we do not return your call
3. _____ Immediately notify our office of a change of address or contact telephone number
4. _____ Keep a record of when your diagnostic studies are and notify our office if you cannot comply
5. _____ Keep a record of your future follow up needs, even if it is ten years in the future

Many thanks and we look forward to a mutually gratifying relationship:

Farah Sagheer, M.D

Patient printed name: _____ Witness name: _____

Patient signed name: _____ Witness signed name: _____

Date: _____

Date: _____

CONSENT FORM

I, the undersigned voluntarily give consent to my Access Healthcare Physicians, LLC medical professional to provide and perform such medical/diagnostic/minor surgical treatment(s) and/or services as deemed advisable and necessary for the diagnosis and or treatment of my conditions or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge the no guarantees have been made to me as a result of treatment or examination in the office.

Patient printed name: _____ Date: _____

Signature of patient: _____ Relationship to patient: _____

AUTHORIZATION AND ASSIGNMENT

I hereby authorize my Access Health Care Physicians, LLC practice location to release any medical information necessary to process all claims for reimbursement on my behalf. I authorize payment to be made directly to Access healthcare, LLC for services rendered. I also authorize payment of government benefits to the physician (entity) and any payments related to crossover medigap insurers. I request that payment of authorized secondary insurance be made either to me or on my behalf to the above named entity. I understand that I am financially responsible for all charges if they are not covered by my insurance. In the event or default, I agree to pay all costs of collections and reasonable attorney's fees. I certify that the information I have reported with regard to my insurance coverage is correct. I further agree that a photocopy of this agreement shall be considered effective and valid as the original.

Signature of patient/ legal representative:

Date:

Release of Information (ROI)

Patients Name: _____ Date of birth: ____/____/____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

REQUESTING RECORDS FROM:

Doctors/Facility name: _____

Doctors/Facility Address: _____ City: _____

State: _____ Zip code: _____

Doctors/Facility Phone number: _____

Doctors/Facility fax number: _____

SEND INFORMATION TO:

Name: Dr. Farah Sagheer Send by Mail Fax Secured fax

Address: 7128 Sagheer Street Brooksville Florida 34613

Phone: 352-345-4876 Fax number: 352-593-4156 Alt Fax: 352-345-4880

The information you may release subject to this signed release form is as follows:

History and physical Discharge note Pulmonary consult Cardiology consult
 Bronch Report Biopsy report CT chest Chest x-ray
 Echo results Pcp notes Last office note Others(Please specify)

I, _____ (Name), hereby grant permission for you to release confidential health information about me, by releasing a copy of my medical record or a summary or narrative of my protected health information, to the physician/person/facility.

Patient name: _____ Date: _____

Patient Signature: _____

