Welcome New Patient!

Thank you for choosing Integrative Pulmonary and Sleep Medicine. We specialize in comprehensive pulmonary, critical care, and sleep medicine, including convenient telehealth options when appropriate.

Please read through this entire packet carefully, complete the registration and questionnaires, and review the policies. At the end, you'll check boxes to confirm each section and sign **once** on the final page.

Bring: Insurance cards, photo ID, current medication list, and any recent test results (e.g., sleep studies, lung function tests).

We're here to support your health—questions? Call us at (248) 795-1047.

Patient Registration Form

Date: ______________________________

Patient Name: ______________________________ Preferred Name: ____________________
Date of Birth: ____ / ____ / ____ Age: ____ Gender: ____________________ Address: ____ City: ____________________ State: MI Zip: ________

Home Phone: ____________________ Cell: ____________________ Email: ____________________

Emergency Contact: Name ____________________ Relationship: ____________________
Phone: ____________________

Insurance Information Primary: Provider ____________________ Policy #: ____________________ Group #: ____________________ Secondary (if any): Provider ____________________ Policy #: ____________________ Group #: ____________________

Referring Physician: ____________________ Primary Care Physician: ____________________
Preferred Pharmacy: ____________________ Phone: ____________________

Reason for Visit: ____

(Office use only: ____________________ Date: ____________________)

HIPAA Privacy Practices Acknowledgment Summary

I acknowledge receiving and reviewing the Notice of Privacy Practices. It explains how my health information may be used/disclosed and my rights (e.g., access, amend, restrict, complain). I can ask questions anytime.

(Full Notice provided separately or attached.)

Consent to Treat Summary

I consent to medical evaluation, examinations, tests, treatments, and procedures as recommended by my providers, with risks, benefits, and alternatives discussed as needed.

Assignment of Benefits Summary

I assign insurance/Medicare benefits directly to the practice for services rendered. I authorize release of necessary information for billing/claims. I remain responsible for deductibles, copays, coinsurance, or non-covered services. (Medicare: lifetime assignment included if applicable.)

Financial Policy Summary

Financial Policy:

We strive to make your care as accessible and convenient as possible. Payment for any copays, deductibles, or non-covered services is due at the time of your visit. We accept major credit cards, cash, and checks, and we'll bill your insurance as a courtesy (please verify your coverage in advance to avoid unnecessary billing).

To help ensure timely access for all patients, we reserve the right to apply a $50 fee for no-shows or cancellations/reschedules with less than 24 hours' notice (without prior notification). We understand emergencies happen and will consider waiving the fee in those cases—please let us know if something unexpected arises.

Unpaid balances may be sent to collections after reasonable attempts to resolve.

Communication Consent Summary

I consent to receive appointment reminders, billing info, test results, and non-urgent health updates via text, email, phone (including voicemail), or patient portal. I understand these are convenient but not fully secure, and I can revoke consent anytime in writing.

Notice of Privacy Practices:

Integrative Pulmonary and Sleep Medicine

2490 South Rochester Road, Rochester Hills, MI 48307 Phone: (248) 795-1047 | Fax: (248) 795-1048 **Effective Date: May 1st, 2026.**

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.

Our Pledge Regarding Your Health Information We understand that medical information about you and your health is personal. We are committed to protecting the privacy of your protected health information (PHI). We are required by law (HIPAA Privacy Rule) to maintain the privacy of your PHI, provide this notice of our legal duties and privacy practices, and notify you following a breach of unsecured PHI.

How We May Use and Disclose Your Health Information We may use or disclose your PHI without your written authorization for the following purposes (examples, not exhaustive):

- **Treatment**: To provide, coordinate, or manage your health care (e.g., sharing with other providers involved in your care, such as referring specialists or hospitals).
- **Payment**: To bill and collect for services (e.g., submitting claims to your insurance, determining eligibility).
- **Health Care Operations**: For quality improvement, training, compliance, business management (e.g., reviewing records for accuracy, conducting audits).
- **Other Permitted Uses/Disclosures** (without authorization): As required by law (e.g., public health reporting, abuse/neglect, health oversight, judicial proceedings, coroners, workers' compensation, law enforcement in limited cases); for research (under strict protections); to avert serious threats to health/safety; to organ procurement organizations; for specialized government functions (e.g., military, national security).

Uses/Disclosures Requiring Your Authorization We will obtain your written authorization before using or disclosing your PHI for purposes not listed above, such as marketing (except certain communications), sale of PHI, or psychotherapy notes (if applicable). You may revoke authorization in writing at any time (except to the extent we have already acted in reliance).

Your Rights Regarding Your Health Information You have the right to:

- Receive a paper copy of this notice upon request.
- Inspect and obtain a copy of your PHI (with limited exceptions, e.g., psychotherapy notes).
- Request amendments to your PHI if inaccurate or incomplete.
- Request restrictions on uses/disclosures (we are not required to agree except for certain paid-out-of-pocket services).
- Receive confidential communications (e.g., alternative address/phone).

- Receive an accounting of disclosures (for up to 6 years prior).
- File a complaint if you believe your privacy rights were violated (with us or HHS Office for Civil Rights).

To exercise these rights, contact our Privacy Officer (see below).

Our Responsibilities We are required to:

- Maintain the privacy of your PHI.
- Provide this notice and abide by its terms.
- Notify you following a breach of unsecured PHI.
- Accommodate reasonable requests for confidential communications or restrictions.

We reserve the right to change our practices and update this notice. The revised notice will apply to all PHI we maintain. Current notice available upon request, in office, or on our website (if applicable).

Privacy Officer Contact For questions, to exercise rights, or to file a complaint: Privacy Officer Integrative Pulmonary and Sleep Medicine 2490 South Rochester Road, Rochester Hills, MI 48307 Phone: (248) 795-1047 | Email: Victorgordon@IPSM.onmicrosoft.com.

You may also contact the U.S. Department of Health and Human Services Office for Civil Rights: OCRComplaint@hhs.gov | (800) 368-1019 | www.hhs.gov/ocr/privacy/hipaa/complaints

Acknowledgment By signing our intake forms, you acknowledge receipt/review of this Notice. We will make good-faith efforts to obtain your acknowledgment.

Medical Records Release Summary

I authorize the practice to release or obtain my protected health information to/from other providers, facilities, insurers, or payers as needed for treatment, payment, or healthcare operations. Valid until revoked in writing.

Telehealth Consent Summary

I consent to receive care via telehealth (video/audio visits) when appropriate and recommended by my provider. I understand:

- Benefits: Convenient access from home, reduced travel, timely consultations.
- Limitations/Risks: No in-person physical exam; potential technical issues (audio/video quality, connectivity); privacy/security not as robust as in-office (though we use secure, HIPAA-compliant platforms); possible need to switch to in-person if issues arise.
- Alternatives: In-person visits are always available.
- Emergencies: Telehealth is not for urgent/emergency situations—call 911 or go to ER if needed.
- Rights: I can stop/withdraw consent anytime; ask questions; and/or file complaints.

I agree to follow instructions for setup and participation.

Pulmonary History Questionnaire

Patient Name: ______________________________ DOB: ____________________

Chief Complaint:
____

Past Medical History (check all that apply): □ Asthma □ COPD □ Pneumonia □ TB □ Lung Cancer □ Other: __________

Current Medications:
____
____

Allergies:
____

Smoking History: □ Never □ Current (____ packs/day x ____ years) □ Former (quit year ____)

Symptoms (frequency): Shortness of breath ____ Cough ____ Wheezing ____ Chest pain ____ Sputum ____ Fatigue ____

Family History of lung issues:
____

Sleep History Questionnaire

Main or Any Sleep Concern:
____

Typical Schedule: Weekdays bedtime _______ waketime ______ hrs ______

Weekends ___________________________________

Symptoms (check): □ Loud snoring □ Breathing pauses □ Daytime sleepiness □ Morning headaches □ Restless legs □ Night sweats

Prior Sleep Study? □ Yes (details: ____________________) □ No CPAP/BiPAP Use? □ Yes (compliance/issues: ____________________) □ No

Additional:
____

Consolidated Signature / Acknowledgment Page

Patient Name (print): ____________________________________DOB: _________________

Date: _________________

I have carefully read and understand all sections of this packet. By checking the boxes below and signing once, I confirm my acknowledgment and agreement where applicable:

☐ Patient Registration – All provided information is accurate and complete.

☐ HIPAA Privacy Acknowledgment – I received and reviewed the Notice of Privacy Practices.
☐ Consent to Treat – I consent to recommended evaluation and treatment.

☐ Assignment of Benefits – I assign benefits and authorize billing/release of information. ☐ Financial Policy – I understand and agree (including the reserved right to apply a $50 no-show/late cancellation fee with <24 hours' notice, with consideration for emergencies).

☐ Communication Consent – I consent to text/email/phone communications. ☐ Medical Records Release – I authorize release/obtain of records as described.

☐ Telehealth Consent – I consent to telehealth services when appropriate, understanding benefits, risks, limitations, and my rights.

☐ Pulmonary History Questionnaire – Information provided is accurate to the best of my knowledge.

☐ Sleep History Questionnaire – Information provided is accurate to the best of my knowledge.

I understand these are voluntary, I can ask questions at any time, and (except where limited by law) I may revoke consents in writing later. I am signing of my own free will.

Signature of Patient (or Legal Representative): __________________________________

Date: _________________

Printed Name: _____________________________

Relationship (if not self): _________________

Reason unable to sign (if applicable): ____

Staff Witness (optional): _____________________________ Date: _________________