Welcome to MEDCORPS Asthma & Pulmonary Specialists! It is our goal to assist you with all of your pulmonary and sleep apnea needs. We want to make your visit informative, productive and rewarding. During your consultation, we will review your medical history, perform a physical exam and discuss your goals. We encourage you to make a list of questions you may have.

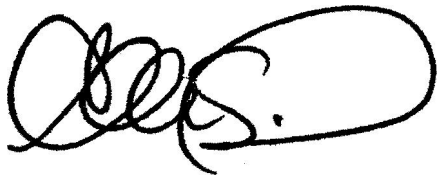
Before your appointment, please complete and return all paper work from our office, provide us with any previous chest x-ray, PFT, sleep study reports and any previous medical record from other providers that will help us assist you at your office visit.

- Please do not wear perfume, cologne or scented lotion to your appointment.

- Please do not smoke 4 hours prior to your appointment.

Please call at least 24 hours in advance to reschedule your appointment. Enclosed with this welcome letter is our office policies and forms that need to filled out and mailed back to our office prior to your appointment.

Thank you for choosing MEDCORPS Asthma & Pulmonary Specialists



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(856) 352-6572 - office (856) 352-6710 - fax

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(609) 778-2744 - office (609) 778-2579 - fax

222 New Rd Suite #201, Linwood, NJ 08221
(609) 788-8953 - office (609) 904-6929 - fax

MedCorps Asthma & Pulmonary Policies

Office Visit Policy

All patients will be required to present a valid driver's license or photo ID, their current medical insurance card and deductible and co-pay payments at every office visit. If your insurance requires authorization number or referral, please be sure your Primary Care Physician has obtained one for you or your appointment will be rescheduled. Patients without verifiable health insurance will be required to demonstrate a form of payment before being seen.

Refill Policy

At your scheduled office visit, the provider will discuss appropriate monitoring intervals for your medications and any blood work that is required.

Most medications will be given 5 refills. Please let us know if you would like a 90day supply.

Patients should have been seen as indicated by their provider before a refill is given, however a one-month courtesy prescription refill may be given as long as the patient understands they need to be seen and/or complete blood work before another refill will be issued.

We prefer the pharmacy fax refill requests to 856-352-6710.

Pre-authorization

Our office will complete any pre-authorization paperwork required by your insurance company in a timely manner. We will call you when we know your insurance company's decision regarding the medication, test or procedure.

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MedCorps Asthma & Pulmonary Policies Continued:

Cancellation Policy

Please call at least 24 hours before your office visit to cancel an appointment. You may be assessed a missed appointment fee if you cancel on the same day as your appointment or you miss an appointment completely. Missed appointment fee is $50.00

Insurance Claims/Billing

MedCorps Asthma and Pulmonary Specialist participates with most major insurance carriers. As a courtesy to our patients, we will file insurance claims for those insurances with which we participate. Please remember, any amount not covered by insurance is ultimately the patient's responsibility. We require that you bring your insurance card and photo ID to all visits.

Payment

Payment will be requested at the time of service for all services that are non-covered or determined to be the patient's responsibility, including co-payments and deductibles from care you received at a rehabilitation facility. Payment may be made by cash, check, MasterCard, or Visa. If you have a question regarding insurance, billing or our fees, please call the office.

Patient's name: _____

Patient's signature: _____

Today's date: _____

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MEDICATION LIST

Patient's Name: _____

Medications Used At Home

List any medications you are taking. Include both prescription and over-the -counter drugs, inhalers and nebulized medications, oxygen as well as any regularly.

Name of Medication	Dose {number of puffs or Pills	Frequency (number of times per day)
Medications you have at home for a breathing exacerbation (e.g. antibiotics, steroids)		

Oxygen therapy		liters per min		During the Day
Oxygen therapy		liters per min		At Night

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FAMILY HISTORY

Patient's Name: _____

Please Check All That Apply

DISEASE / CONDITIONS	Mother	Father	Sister	Brother	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad
Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Blood Clots	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
COPD	☐	☐	☐	☐	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐	☐	☐	☐	☐
Heart Problems	☐	☐	☐	☐	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐	☐	☐	☐	☐
Restless Leg Syndrome	☐	☐	☐	☐	☐	☐	☐	☐

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MEDICAL RECORDS RELEASE

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical records of the above named patient.

Patient information is needed for:

- ☐ Continuing Medical Care
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Military
- ☐ Personal Use
- ☐ School
- ☐ Social Security/Disability
- ☐ Other:

Information to be released or accessed:

- ☐ History & Physical
- ☐ Operative Reports
- ☐ Lab/Path Reports
- ☐ Consultation Report
- ☐ Discharge/Death Summary
- ☐ X-Ray Reports/Images
- ☐ Emergency Room Record
- ☐ Face Sheet
- ☐ Other

The above information may be released to:

MedCorps Asthma & Pulmonary
901 Route 168 Suite 108 Turnersville, NJ 08012
Office - 856-352-6572
Fax - 856-352-6710

MedCorps Asthma & Pulmonary
222 New Road Suite 201 Linwood, NJ 08221
Office - 609-788-8953
Fax - 609-904-6929

Requesting provider: _____

(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

Address {Street, City, State and Zip) Fax Number

I understand that my records are confidential and cannot be disdosed without my written consent, except when otherwise permitted by law. Information used or disclosed prior to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may indude but is not limited to history, diagnoses, and/or treatment of drug/alcohol abuse, mental illness, or communicable disease.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. This authorization will expire in 12 months from date of my signature, unless 1 revoke the authorization prior to that time.

Signature of Patient or Legally Authorized Representative Date:

Printed Name of Patient or Legally Authorized Representative Relationship to Patient

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The EPWORTH SLEEPINESS SCALE

(To access the risk of Obstructive Sleep Abnea)

Patient's Name: _____

Use the following scale to choose the most appropriate number for each situation.

0 - Would never doze
1 - Slight chance of dozing
2 - Moderate chance of dozing
3 - High chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	
Watching TV	
Sitting, inactive on a public place (e.g. a theater or meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
TOTAL	0

Score:	
00-10	Normal Range
10-12	Borderline
12-24	Abnormal

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