Welcome to Medcorps Asthma and Pulmonary Specialists.

You are scheduled to see the provider at:_____

Please arrive 20 minutes early to check in with receptionist and the nurse. Your appointment time is the time you see the provider, not the time you arrive.

We want to make your appointment informative and efficient. 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.
Before your appointment, please complete and return all paper work from our office, provide us with any previous diagnostic imaging, labs, PFT, or sleep study reports, and any previous medical records from other pulmonary providers.

We ask that you and anyone coming to the office with you, not to use perfume, cologne or scented lotion. We also ask that you and anyone coming with you to the office not smell of cigarette smoke. Please do not smoke 4 hours prior to your appointment.

Office Visit Policy

All patients will be required to present a 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.

Service Animal Policy

Trained service animals, whether accompanied by individuals with disabilities or by trainers of service animals, are permitted in Medcorps Asthma and Pulmonary Specialists Offices, in compliance with the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act of 1973 (Section 504) and applicable state law. We intend that the broadest access be provided to service animals and persons using service animals, and trainers of service animals, be afforded independent access to Medcorps Asthma and Pulmonary.
All service animals must always remain on a leash and be appropriately controlled.
Owners of service animals shall be liable for any harm caused by the animal to Medcorps Asthma and Pulmonary Specialists, its officers, agents, employees, patients, and visitors.
Pets or animals whose sole purpose to provide comfort or emotional support do not qualify as Service Animals under the American with Disabilities Act. Pets and comfort animals are not permitted.

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Refill Policy

A one-time, one-month courtesy supply of medications may be given to patients who miss an appointment or need a follow up appointment.
Please have your pharmacy fax refill requests to 856-352-6710.

Prior Authorizations

Our office will complete any prior authorization paperwork required by your insurance company. Authorizations can take up to 14 days after all information is submitted. Specialty medications can take longer. We do not recommend scheduling your test without the authorization. Starting the prior authorization yourself or having another doctors office start the prior authorization will significantly slow the process.

Cancellation Policy

Due to an overwhelming number of late cancellations and no show appointment events, Medcorps Asthma and Pulmonary Specialists is amending our policy to enable us to accommodate more patients on our wait list.

1. Medcorps Asthma and Pulmonary Specialists requires at least 48 hour notice to cancel your appointment.
2. 10 minutes late for your appointment is considered a no show.

- We may be able to accommodate late patients if time is available. This is determined on a case by case basis.
- $50 late fee will be assessed
    - Fee will be waived if patient is in hospital or ER, documentation is to be sent to our office.
    - Fee will not be waived for transportation issues, not getting day off from work, oversleeping, forgetting appointment, having another doctor appointment etc.
- Payment of late fee will be collected at the next appointment.
    - Failure to pay late fees will result in dismissal from practice
- Rescheduling a late cancel appointment does not negate the late cancel fee.
- Our office not being able to confirm your appointment does not negate the late cancel fee.

After 2 incidents of late cancellations and/ or no shows for new patient appointments you will not be rescheduled with any of our offices.

After 3 incidents of late cancellations and/ or no shows for follow up appointments, you will not be rescheduled with any of our offices.

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Dismissal from Medcorps Asthma and Pulmonary

Grounds for dismissal include but are not limited to yelling, cursing, threatening, staff or providers, failure to pay for services, failure to return equipment

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.

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 or hospital.

Payment may be made by cash, check, Master Card, or Visa. We realize that deductibles are very high, and we will gladly set up payment plans. If you have a question regarding insurance, billing or our fees, please call the office.

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COVID-19 Assumption of Risk, Release, and Waiver of Liability Agreement

RELEASE AND WAIVER. In consideration of my receiving pulmonary services from Medcorps Asthma and Pulmonary Specialists (the "Services"), I, being 18 years of age or older, do hereby forever release, waive, discharge, and covenant not to sue Medcorps Asthma and Pulmonary Specialists and its past, current, and future officers, directors, employees, members, volunteers, contractors, representatives, parents, owners, affiliates, agents, successors, and assigns (collectively, "Service Provider") from any and all damages, injuries, losses, liability, claims, causes of action, litigation, or demands, including but not limited to those for personal injury, sickness, or death, as well as property damages and expenses, of any nature whatsoever which may be incurred, directly or indirectly, now or in the future, in any way related to COVID-19 and in connection with my participation in the Services or any travel related thereto. I promise not to sue Service Provider for any of the foregoing.

ASSUMPTION OF RISKS. I understand that while Service Provider has undertaken reasonable steps to lessen the risk of transmission of COVID-19 in connection with the Services, Service Provider is not responsible in any manner for any risks related to COVID-19 in connection with the Services. I understand that the World Health Organization has classified the COVID-19 outbreak as a pandemic. I further understand that COVID-19 is a highly contagious and dangerous disease, and that contact with the virus that causes COVID-19 may result in significant personal injury or death. I am fully aware that participation in the Services (including any related travel) carries with it certain inherent risks related to COVID-19 transmission ("Inherent Risks") that cannot be eliminated regardless of the care taken to avoid such risks. Inherent Risks may include, but are not limited to, (1) the risk of coming into close contact with individuals or objects that may be carrying COVID-19; (2) the risk of transmitting or contracting COVID-19, directly or indirectly, to or from other individuals; and (3) injuries and complications ranging in severity from minor to catastrophic, including death, resulting directly or indirectly from COVID-19 or the treatment thereof. Further, I understand that the risks of COVID-19 are not fully understood, and that contact with, or transmission of, COVID-19 may result in risks including but not limited to loss, personal injury, sickness, death, damage, and expense, the exact nature of which are not currently ascertainable, and all of which are to be considered Inherent Risks. I hereby voluntarily accept and assume all risk of loss, personal injury, sickness, death, damage, and expense arising from such Inherent Risks. Furthermore, I represent and warrant that I do not suffer from any medical condition or disease that might in any way hinder or prevent me from receiving the Services, including, to my knowledge, COVID-19.

This COVID-19 Assumption of Risk, Release, and Waiver of Liability Agreement ("Agreement") shall be binding on my heirs, executors, administrators, successors, and assigns. I expressly agree that this Agreement is intended to be as broad and inclusive as is permitted by applicable laws, and that if any portion of this Agreement is found to be void or unenforceable, the remaining portions shall remain in full force and effect. This Agreement contains the entire understanding of the parties relating to the subject matter, and shall not be altered, modified, amended, waived or supplemented in any manner whatsoever except by a written agreement signed by both parties hereto or their duly authorized representatives. This Agreement may be executed, made and delivered electronically.

To the maximum extent permitted by applicable law, I (a) covenant and agree not to elect a trial by jury with respect to any issue arising out of this Agreement or the Services that is triable of right by a jury, and (b) waive any right to trial by jury with respect to such issue to the extent that any such right exists now or in the future. This waiver of right to trial by jury is given knowingly and voluntarily.

I have read and understood this Agreement and enter into it voluntarily in consideration of the opportunity to participate in the Services. I acknowledge I am giving up legal rights and/or remedies which may be available to me.

Signature: _____ Date: _____

Printed Name: _____

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All patients and designated support person will be required to answer screening questions, have temperature checked and sign release prior to being seen in office. Thank you for your cooperation.

1. Within the past 14 days, have you have been in close physical contact (6 feet or closer for at least 15 minutes) with a person who is known to have a laboratory-confirmed positive COVID-19 test.

◯ Yes Who _____ ◯ No

When _____

2. Have you or anyone you have been in close physical contact (6 feet or closer for at least 15 minutes)

been tested for COVID-19 and are awaiting results?

◯ Yes Who _____ ◯ No

When _____

3. Have you or anyone you have been in close physical contact (6 feet or closer for at least 15 minutes) had any symptoms consistent with COVID-19 over the previous 2 to 14 days??

Symptoms of COVID-19 include

Fever (>100.4) Chills Diarrhea Nausea Loss of sense of smell or taste Severe headache Sore throat New or Worsening Shortness of breath Difficulty breathing New or Worsening Cough Muscle or body aches Congestion or runny nose

◯ Yes Who _____ ◯ No

When _____

4. Have you traveled outside the State of New Jersey within the last 14 days?

◯ Yes (Please Clarify what state): _____ ◯ No

Print Name: _____ Date: _____

Signature_____

Date of Birth_____

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Name: _____ Date of Birth: _____

Primary Care Physician (PCP): _____

City/State: _____ Phone: _____

Pharmacy Name and town: _____

Blood work Lab name and town: _____

Diagnostic center you use for X-rays: _____

Who told you to see a lung doctor? _____

Why do you need to be seen by a lung doctor? _____

Smoking History

Do you smoke currently, or have you ever smoked? ◯ Current ◯ Former ◯ Never Smoker

If yes, how many packs/day? _____ How many years? _____ Date of last use: _____

EXPOSURE

What do you do for a living? _____

Were you/or have you ever been exposed to dust, chemicals or asbestos at your home, job or during military service? ◯ NO ◯ YES

If yes, please explain: _____

Are there pets in the house? ☐ Dogs ☐ Cats Other: _____

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MEDICATION LIST

Name: _____ Date of Birth _____

List all medications you are taking. Include both prescription and over-the -counter drugs, inhalers and nebulized medications, oxygen as well as any supplements you use 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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PATIENT HISTORY

Name: _____ Date of Birth _____

List any medical conditions and date of diagnosis and all past surgeries and dates of surgery.

_____

_____

_____

_____

_____

FAMILY HISTORY - 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
- ☐ Chronic Care Management
- ☐ Other: _____

Information to be released or accessed:

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

The above information may be released and disclosed to the following individuals or organizations:

☐ MedCorps Asthma & Pulmonary Offices - FAX:(844) 883-0058 or _____;

NAME: _____

ADDRESS: _____

PHONE#: _____

Who are we getting your records from? _____ Phone Number _____

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

I understand that my records are confidential and cannot be disclosed 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 include 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 I 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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Name: _____ Today's Date: _____

How is your COPD? Take the COPD assessment testTM (CAT)

This questionnaire will help you and your healthcare professional measure the impact COPD (Chronic Obstructive Pulmonary Disease) is having on your wellbeing and daily life. Your answers, and test score, can be used by you and your healthcare professional to help improve the management of your COPD and get the greatest benefit from treatment.

For each item below, place a mark (X) in the box that best describes you currently. Be sure to only select one response for each question

								SCORE
Example: I am very happy	0	X	2	3	4	5	I am very sad	
I never cough	0	1	2	3	4	5	I cough all the time	
I have no phlegm (mucus)	0	1	2	3	4	5	My chest is completely full of phlegm (mucus)	
My chest does not	0	1	2	3	4	5	My chest feels very tight	
When I walk up a hill or one flight of stairs I am not breathless	0	1	2	3	4	5	When I walk up a hill or one flight of stairs I am very breathless	
I am not limited doing	0	1	2	3	4	5	I am very limited doing activities at home	
I am confident leaving my home despite my lung condition	0	1	2	3	4	5	I am not at all confident leaving my home because of my lung condition	
I sleep soundly	0	1	2	3	4	5	I don't sleep soundly because of my lung condition	
I have lots of energy	0	1	2	3	4	5	I have no energy at all	

TOTAL SCORE

Name: _____ Today's Date: _____

Restless Leg Syndrome (RLS)

Restless Leg Syndrome (RLS) may include a strong urge to move your legs or arms that you may not be able to resist. This need is often accompanied by uncomfortable sensations that might be described as creeping, itching, pulling, creepy crawly, tugging or gnawing.

- Symptoms may start or worsen when you are resting. The longer you rest, the more frequent and intense your symptoms will likely become.
- Symptoms may improve when you move your legs or arms. Relief can be complete or partial, but generally starts very soon after starting an activity. Relief persists as long as you keep moving.
- Symptoms may worsen in the evening, especially when you are lying down. Activities that bother you at night do not bother you during the day.
- Symptoms cannot solely be attributed to a medical or behavioral disorder (e.g., arthritis, leg cramps, vein disorders, habitual foot tapping).
- Symptoms may cause significant stress on you relationships, work, family, education or other areas of life by impacting your sleep, energy/vitality, daily activities or mood

Please answer questions describing your Restless Leg Syndrome Symptoms (RLS) for the past 4 weeks

Overall, how would you rate the RLS discomfort in your legs or arms?

☐ Very severe ☐ Severe ☐ Moderate ☐ Mild ☐ None

Overall, how would you rate the need to move around because of your RLS symptoms?

☐ Very severe ☐ Severe ☐ Moderate ☐ Mild ☐ None

Overall, how much relief of your RLS arm or leg discomfort do you get from moving around?

☐ None ☐ Slight ☐ Moderate ☐ Either complete or almost complete relief

Overall, how severe is your sleep disturbance from your RLS symptoms?

☐ Very severe ☐ Severe ☐ Moderate ☐ Mild ☐ None

How severe is your tiredness or sleepiness from your RLS symptoms?

☐ Very severe ☐ Severe ☐ Moderate ☐ Mild ☐ None

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Name: _____ Today's Date: _____

The Epworth Sleepiness Scale

How Sleepy Are You? How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing =0
- Slight chance of dozing =1
- Moderate chance of dozing =2
- High chance of dozing =3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Chance of Dozing	**Situation**
	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 SCORE

Interpretation:

- 0-7: It is unlikely that you are abnormally sleepy.
- 8-9: You have an average amount of daytime sleepiness.
- 10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.
- 16-24: You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. Sleep 1991; 14(6):540-5.

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Name: _____ Today's Date: _____

ASTHMA CONTROL TEST

In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school or at home?

- ☐ All the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ A little of the time
- ☐ None of the time

During the past 4 weeks, how often have you had shortness of breath?

- ☐ More than once a day
- ☐ Once a day
- ☐ 3 to 6 times a day
- ☐ Once or twice a week
- ☐ Not at all

During the past 4 weeks, how often did y ur asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning.

- ☐ 4 or more nights a week
- ☐ 2 or 3 nights a week
- ☐ Once a week
- ☐ Once or twice
- ☐ Not at all

During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?

- ☐ 3 or more times per day
- ☐ 1 to 2 times per day
- ☐ 2 to 3 per week
- ☐ Once a week or less
- ☐ Not at all

4.How would you rate your asthma control during the past 4 weeks?

- ☐ Not controlled at all
- ☐ Poorly controlled
- ☐ Somewhat controlled
- ☐ Well controlled
- ☐ Completely controlled

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