SLEEP DISORDERS CENTER

MEDICAL & SURGICAL WEIGHT MANAGEMENT

PULMONARY REHABILITATION

1345 King Street
Bellingham, WA 98229-6223
T: (360) 676-1696
F: (360) 676-6636
www.northstarmedicalspecialists.com

Informed Consent for Services

Patient Name: ___________________________________

Consent For Treatment: I voluntarily consent to evaluation, treatment, diagnostic, testing and therapy, which my physician and or his/her designees determine to be necessary. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result to examination or treatment in this facility.

Use of Medical Records in Research: I authorize the use of my medical records for medical or scientific research. I may disagree with the use of my medical records for this purpose by crossing through this paragraph and initialing in the left margin.

Consent for Personnel in Training: I am aware that patients at this facility may be attended by medical, nursing, and other health care personnel in training, who may be present during patient care as part of their education.

Consent for Release of Information: I consent to the release of information about my medical condition to any health care provider involved with my current treatment. I understand that facility personnel may release the fact that I am presently a patient here, without disclosing confidential information, so that I may receive phone calls.

Insurance Consent: I request that payment of authorized benefits be made to NorthStar Medical Specialists and the facility's participating physicians, for any services furnished to me. I authorize this facility to release to Medicare, and or accident or health insurer, medical or financial information as needed for claims processing, fraud investigation, or quality of care review, and studies. I understand that I may revoke this consent for release of information at any time by notifying the facility in writing, but such revocation will not apply to information previously released.

Pre-certification/prior authorization agreement: I understand that I am responsible to comply with the rules and requirements of my insurance company reading pre-certification and prior authorization requirements.

Guarantee of account: I agree to pay NorthStar Associates, PLLC for all charges not covered by any third party payor.

Grievance procedure: I acknowledge that the Operations Director makes themselves readily available to discuss my concerns or questions I may have. I acknowledge that if I have a grievance of any kind, I have the right to utilize the Section 504 Grievance Procedure, posted in the facility lobby.

_______________________________   __________________   __________________

Patient Signature (or legal representative)   Relationship to patient   Date

Reason patient is unable to sign consent: ___(minor) ___(physical or mental disability) ___(other)

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Patient Registration

Patient's full name:____________________________ Social Security Number:___________________

Mailing Address:____Apt#:____ Birthdate:___/___/___

City/State/Zip:________________________________ Email: ____________________________

Home Phone#:_______________ Work Phone#:________________ Sex:______ Age:_______

Language: __________________ Race: ____________________ Ethnicity: ______________________

In case of emergency, contact:______________________________Phone#:______________________

Relationship to patient: ________________________ Spouse's Employer: ________________________

Referring physician:___________________________Primary care physician:______________________

Reason for referral: ____

How did you hear about NorthStar Medical? (circle one below)

Doctor referral / Friend/family referral / Newspaper / Radio / Other ___________________________

Name of Primary Insurance Company:____

Subscriber's name:___________________________________ Date of Birth:______________________

Subscriber's relationship to patient:__________________________

Subscriber's #:_____________________________________ Group #:___________________________

Name of Secondary Insurance Company:____

Subscriber's name:____Date of Birth:__________________

Subscriber's relationship to patient:__________________________

Subscriber's #:_____________________________________ Group #:__________________________

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Living Situation

___House ___Apartment ___Mobile home

___Condo ___Assisted living

Level: ___Single ___Multi Level

Entrance: ___Incline ___Stair(s) #__

Household members:______________________________

Relationship & names:______________________________

Household pets:______________________________

Type & names:______________________________

Usual household duties I perform: ___Cooking ___Grocery shopping

___Cleaning ___Yard work

___Laundry ___Finances

My major source(s) of support: (names & relationship______________________________

Transportation

___Currently Drive ___Use public transportation

___Rely on family ___Is a real problem for me ___Rely on friends

Occupational History

Current or former occupation:______________________________

Retirement/disability date:______________________________

Occupational exposure: ___Welding ___Pottery ___Asbestos

___Mines/foundry ___Gas/fumes ___Quarry

___Sandblasting ___Chemicals ___Dust

Medical History

___Asthma ___Tuberculosis ___Arthritis

___Chronic bronchitis ___Cancer ___Collasped lung

___Emphysema ___Diabetes ___Sarcodosis

___Bronchiectasis ___Sinus problems ___Pneumonia

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___Cystic fibrosis ___Circulatory Problems ___Heart Disease
___Osteoporosis ___High blood pressure ___Pulmonary fibrosis
___Fractures (specify)____

Allergy History

I have seen an allergist. ___Yes ___No
Was a skin test performed? ___Yes ___No
I am allergic to the following:
Foods:____
Medications:____
Environmental: ___Dust ___Grass
___Mold
___Pollens Others:____________________

I have the most difficulty when exposed to the following irritants:
___Smog ___Humidity ___Rapid change in temperature
___Dust ___Wind ___Perfumes/colognes
___Solvents ___Tobacco smoke

Vaccine History

I receive the flu vaccine annually. ___Yes ___No
If yes, date received:____
If not, why:____
I have received the pneumonia vaccine. ___Yes ___No
If not, why:____
If yes, date received:____

Smoking History

___I have never smoked
___I have smoked in the past but do not smoke now
Year started:_________Year quit:_________
Number of packs smoked per day:_________

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___I am currently a smoker

Number of packs smoked per day:________

Exposure to secondhand smoke: ___None ___Home ___Work ___Social situations

Pulmonary Health History

Cough: ___Yes ___No

___AM ___PM ___Nighttime ___Around the clock

Mucus: Normal color:____________________ ___Thick ___Thin ___Moderate

Amount per day: ___1/2tsp. ___1tsp. ___1/4tbsp.

___1/2cup ___1cup ___>1cup

When: ___AM ___PM ___Nighttime ___Around the clock

I use the following to help raise my mucus:

___Drink warm liquids ___Inhalers

___Aerosol Treatments ___Chest percussion

___Postural drainage ___Increase my fluids

I cough up blood. ___Yes ___No If yes, when:__________________________

I have taken steroid pills.___Yes ___No

Length of time:____________ Late date:_________ Highest dose_____________

I experience the following:

___Chest pain ___Ankle swelling ___Dizziness/unsteadiness

___Angina ___Hoarseness ___Wheezing

___Fatigue ___Weight change Know triggers factors:_______________

I have been on a ventilator in an intensive care unit. ___Yes ___No

If yes, when:__________________________

What I remember most about that experience is:_________________________________

____

____

I see my lung doctor every (please give time frame):____________________________

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Pulmonary Infections

Number per year:______________________________

Antibiotic usually taken:______________________________

I know I have an infection when.______________________________

____

Pulmonary Hospitalizations

Number in past year:__________ Number in previous year:__________

Emergency Room Visits for Pulmonary Reasons

Number in past year:__________ Number in previous year:__________

Shortness of Breath

I have experienced shortness of breath since:______________________________

My breathing is most difficult: ___Early AM ___AM ___PM ___Bedtime

Shortness of Breath continued…

I do the following to decrease or avoid being short of breath:

___Stop and rest ___Check my peak flow ___Use a fan or air conditioner

___Use inhalers ___Use aerosol machine ___Remove away from irritant

___Open window ___Use pursed-lip breathing ___Avoid tobacco smoke

___Limit my activity ___Avoid exposure to irritant ___Use diaphragm breathing

___Practice relaxation techniques

___Check the air pollution forecast

Dietary History

Current height:______ft.______in. Current weight:____________

I have recently had a change in my weight. ___Yes ___No

Gained____________pounds Lost______________pounds

Over this period of time:______________________________

I can attribute this weight change to:______________________________

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I follow the following type of diet:

___No special diet ___Low saturated fat ___Other_______________________

___Low sodium (salt) ___Caloric restriction

___Low cholesterol ___Diabetic

My appetite is: ___Good ___Fair ___poor

I drink this amount of each of these a day:

Water_____________ Soda______________ Coffee____________

Tea_______________ Wine______________ Hard Liquor________

Milk_______________ Juice______________ Beer______________

I have difficulty with: Chewing ___Yes ___No

Swallowing ___Yes ___No

Digesting ___Yes ___No

I take vitamins: ___Yes ___No

If yes, please list:____

Sleeping History

Usual Bedtime:________________________ Usual time of waking:________________________

Naps taken during the day: ___YES ___No

If yes, number of naps and length of time:_______________________________________

Medication

Medication name/strength	Amount and how often on a daily basis	Purpose of medication	Response
Example			
Albuterol	2 puffs 4 times a day	Improve breathing	Yes or No

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Activities of Daily Living

Use this shortness of breath scale to answer the following questions:

Scale: 0 = None; 1 = Minimal; 2= Moderate; 3=Great; 4 = Unable to do

___Eating
___Simple personal care
(washing face, combing hair, ect.)
___Taking full bath or shower
___Picking up or straightening up
___Dressing
___Sweeping or vacuuming
___Shopping

___Walking your own pace on a level surface
___Walking around your house
___Walking 1 block
___Walking with others your age
___Walking up a slight hill
___Walking up stairs
___Laundry
___Cooking and doing dishes

Activity/Exercise History

I do have an exercise regimen or exercise program. ___Yes ___No

The following things limit my ability to remain active:

___Shortness of breath ___Lightheadedness
___Fatigue (tired) ___Joint problems (specify)____________________

I have the following exercise equipment available

___Stationary bike ____Stair stepper ___Treadmill
___Pool ____Weights ___Other:__________

Equipment/Assistive Device History

I use the following:

___Walker ___Four-point quad cane ___Other:____________________________
___Wheelchair ___Electric cart
___Cane ___Hearing aids

Respiratory Home Care Equipment History

I use the following items: Used how often:

___Peak flow meter _____________________________________
___Incentive spirometer _____________________________________
___Vest therapy _____________________________________
___Other _____________________________________
___Oxygen: ___Flow rate Type: ___Concentrator

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___Liquid

Oxygen used: ___Tank

___Continuously ___Only when I need it ___With sleep ___With exercise

Day-to-Day Living

My present interests and hobbies are:____

____

Former interests and hobbies in which I can no longer participate are:_____________________

____

This is what I do for fun:____

____

I would describe my present temperament (mood) as:_______________________________

(examples: worried, sad, frustrated, depressed, anxious, content, cheerful, ect.)

This is what makes me feel this way:____

____

I use the following to relax

___Read ___Computer ___Deep breathing ___Alcohol ___Smoke

___Tranquilizer ___TV ___Other_________________________________

This has been the most difficult adjustment for me because of my lung disease:____________

____

____

This is how my lung disease has affected how I feel about myself:_______________________

____

____

My Goals for completing pulmonary rehabilitation are:________________________________

____

____

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HEALTH HISTORY REVIEW OF SYMPTOMS

Constitutional	No	Yes	Notes
Fever?			
Night sweats?			
Weight loss?			
Weight gain?			
Eyes			
Glaucoma?			
Dry eyes?			
Irritation?			
Vision changes?			
Ears			
Difficulty hearing?			
Ear pain			
Nose			
Frequent nose bleeds?			
Nose/sinus problems?			
Mouth/Throat			
Sore throat?			
Bleeding gums?			
Snoring?			
Dry mouth?			
Mouth ulcers?			
Oral abnormalities?			
Teeth problems?			
TMJ?			
Cardiovascular			
Chest pain?			
Known heart murmur?			
Light headed upon standing?			
Rapid or irregular heartbeat?			
Respiratory			
Cough?			
Wheezing?			
Shortness of breath?			
Coughing up blood?			
Sleep apnea?			
Gastrointestinal			
Abdominal pain?			
Normal appetite?			
Diarrhea?			
Acid reflux?			
Black or tarry stools?			
Nausea?			
Genitourinary			
Incontinence?			
Difficulty urinating?			
Urinary loss of control?			
Blood in urine?			
Frequent urination?			

Musculoskeletal	No	Yes	Notes
Muscle aches?			
Muscle weakness?			
Arthralgias/joint pain?			
Back pain?			
Swelling in the extremities?			
Skin			
Abnormal mole?			
Jaundice?			
Rashes?			
Itching?			
Dry skin?			
Growths/lesions?			
Neurological			
Loss of consciousness?			
Weakness?			
Numbness?			
Seizures?			
Dizziness?			
Waking up with headaches?			
Frequent or severe headaches?			
Migraines?			
Restless legs?			
Psychological			
Anxiety?			
Depression?			
Endocrine			
Fatigue?			
Increased thirst?			
Hair loss/growth?			
Cold intolerance?			
Hematologic/Lymphatic			
Swollen glands?			
Bruising?			
Excessive bleeding?			
Anemia?			
Allergy/Immunologic			
Runny nose?			
Sinus pressure?			
Itching?			
Hives?			
Frequent sneezing?			
Seasonal allergies?			
Other allergies? (Tape, latex, etc.)			
Other:			

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The questions listed below are for Beneficiaries age 65 or older, and is used to comply with Medicare Regulation 42 CFR 489.20 (F). If this does not apply to you, please skip to next page.

Primary Payor Questionnaire

Name of Patient: ______________________________ SSN: ______________________

1. Are you currently working full or part-time? **Yes / No**
2. If married, is your spouse working full or part-time? **Yes / No**
3. Are you currently under any employer group health plan? **Yes / No**
   If yes; Name of insured:______________________________________
   Relationship to patient:______________Name of employer:_____________________
   Name of carrier:____________________Group/policy#:___________________
4. Are you entitled to Black Lung Benefits? **Yes / No**
5. Is this service for treatment work related? **Yes / No**
   If yes; Name of insurer:____________________Date of injury:_____________
   Name of employer:________________________Policy/claim#:___________________
6. Is this service for treatment related to an auto injury? **Yes / No**
   If yes; Name of insurer:____________________Date of injury:_____________
   Name of policyholder:_____________________Policy/claim#:___________________
7. Are benefits for services being submitted to any other party for reimbursement consideration? **Yes / No**

Patient Signature:___________________________________Date:____________________

Witness:____

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Notice of Privacy Practices

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.

The privacy of your medical information is important to us. At NorthStar Medical Specialists, we respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others for non-permitted uses and disclosure unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, diagnoses, and treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to get authorization to disclose this information for payment purposes.

Use and disclosure of protected health information for treatment, payment, and health operations, to remind you, notification of family, for public health and safety, and other uses as noted below.

For Treatment**:** Information obtained by a therapist, physician, technologist, or other member of our health care team will be recorded in your medical record and used to help decided what care may be right for you.

We may also provide information to others providing your care to help them stay informed about your care.

For Payment**:** We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

For Health Care Operations**:**

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about your appointments and give you information about treatment alternatives or other health related benefits and services
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services including:
  - Medical review by your health plan;
  - Accounting, legal, risk management, and insurance services;
  - Audit functions, including fraud and abuse detection and compliance programs.

To remind you:
We may remind you by phone, voicemail, or mail, that you have a health care appointment with us, or request that you call us regarding your health care. You have the right to request we contact you at an alternative addressor phone number. If you request this, we will contact you at the alternative location, as requested.

Notification of family and others:
We may disclose your private health information to a “personal representative” (a person who is legally authorized to make health care decision on your behalf, such as a parent of a minor child).
In addition, we may disclose health care information about you to assist in disaster relief efforts.
You have a right to object to this use or disclosure. If you object, we will not disclose it.

For public health and safety purposes as required by law:

- to prevent or reduce a serious, immediate threat to the health of a person or the public
- to public health and legal authorities
- to protect public health and safety
- to prevent or control disease, injury, or disability
- to report vital statistics such as births or death
- To report suspected abuse or neglect
- To the Food and Drug Administration relating to problems with products
- In the course of judicial/administrative proceedings
- For law enforcement purposes
- To correction institutions if you are in jail
- With approved medical researchers
- To comply with workers compensation laws
- For health and safety oversight activities, e.g., shared health information with the Department of Health
- For disaster relief purposes
- For work related conditions that could affect employee health
- To the military authorities, U.S. and foreign

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- To funeral directors/coroners consistent with applicable laws for specialized government functions such as national security purposes

Other uses and Disclosure of protected health information

Uses and disclosures not in this notice as allowed and required by law, or with your written authorization

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this notice;
- Abide by the terms of this notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it, or by visiting us at NorthStar Medical Specialists to pick one up.

Your Health Information Rights

The health and billing records we create and store are the property of NorthStar Medical Specialists. The protected health information in your file, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but if we decide to, we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information (“Notice”);
- Request that you be allowed to see and get a copy of your protected Health information, you may make this request in writing.
- Have us review a denial of access to your health information - except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical records, and included with any release of your records;
- When you request, we will give you a list of disclosures of your health information. The privacy rule does not require accounting of disclosure to covered entities for treatment, payment, or health care operations, to the individual (or representative), to persons involved in the individual’s health care, or payment for health care, pursuant to an authorization, of a limited data set, for nation security purposes, to law enforcement officials in certain circumstances, incident to otherwise permitted or required uses or disclosures;
- Ask that your health information be given to you by another means, or at another location. Please sign, date, and give us your request in writing;
- Cancel prior authorizations to use or disclose your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance;

For help with these rights during normal business hours, please contact our Privacy Manager at NorthStar Medical Specialists.

To ask for help or complain

If you have questions, want information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Manager at NorthStar Medical Specialists.

If you believe your privacy rights have been violated, you may discuss your concerns with our Privacy Manager. You may also deliver a written complaint to the Privacy Manager at NorthStar Medical Specialists. You may also file a complaint with the US Secretary of Health and Human Services.

We respect your right to file a complaint with us, or the US Secretary of Health and Human Services. If you complain, we will not retaliate against you.

While you participate in your treatment at NorthStar Medical, some of your activities and treatments will be conducted in a group setting. As a result, some of your protected health information may be discussed with you in the group setting. Please sign below if you agree.

________________________________ ________________________________

Patient Signature Date and Time

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Authorization to Use or Disclose Protected Health Information

Patient name: ___________________________________ Date of birth: _____________________________
Previous name: ____

I. My Authorization - NorthStar Medical Specialists may use or disclose the following health care information (check all that apply):

- □ All health care information in my medical record
- □ Health care information in my medical record relating to the following treatment or condition: ____
- □ Health care information in my medical record for the date(s): ______________________________________
- □ Other (e.g., X-rays, bills)—specify date(s): ____

Uses and Disclosures Requiring Specific Authorization
You may use or disclose health care information regarding testing, diagnosis, and treatment for (check all that apply):

- □ HIV/AIDS
- □ Mental Health or Illness
- □ Reproductive Care (minors only)
- □ Sexually Transmitted Diseases
- □ Drug and/or Alcohol Abuse

Minors – a minor patient's signature is required in order to disclose information related to reproductive care, sexually transmitted diseases (if age 14 and older), HIV/AIDS (if age 14 and older), drug and/or alcohol abuse (if age 13 and older), and mental health or illness (if age 13 and older).

You may disclose this health care information to:

Name (or title) and/or organization of persons: ____

Name (or title) and/or organization of persons: ____

Name (or title) and/or organization of persons: ____

Name (or title) and/or organization of persons: ____

This authorization ends:

- □ on (date): ___________
- □ when the following event occurs: _________________________________
- □ in 90 days from the date signed (if disclosure is to a financial institution or an employer of the patient for purposes other than payment)
- □ This authorization does not have a term date

II. My Rights

1. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits). However, I do have to sign an authorization form:
   - to receive research-related treatment in connection with research studies **or**
   - to receive health care when the purpose is to create health care information for a third party.

Reproducing, duplicating, selling, transforming or modifying any of the content on this form is strictly prohibited without the direct written approval from NorthStar Associates, PLLC.

2. I may revoke this authorization in writing at any time. If I do, it will not affect any actions taken by NorthStar Medical Specialists in reliance on this authorization before it receives my written revocation. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:
   - Fill out a revocation form—a form is available from NorthStar Medical Specialists or
   - Write a letter to NorthStar Medical Specialists

III. **Protection after Disclosure**. I understand that once my health care information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

____

Patient or legally authorized individual signature   Date   Time

____

Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

____

Minor patient’s signature, if applicable   Date   Time

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Cancellation Policy

Thank you for choosing NorthStar Medical Specialists to help you achieve a better quality of life. In the interest of conserving your time, we will make every effort to stay on schedule. Your time is valuable and except for emergency treatment of another patient, you can expect us to be prompt.

We understand there are times when it is unavoidable to cancel an appointment, and your call before the appointment during business hours is appreciated.

When you schedule an appointment, that time has been set aside just for you. There will be a charge for appointments cancelled with less than sufficient notice. No-show and late cancellation fees must be paid before future appointments can be scheduled.

We will hold your appointment for 15 minutes after your scheduled start time. If you arrive late on the date of your appointment, you may be asked to reschedule; however, we will do our best to provide an excellent session with the remaining time. High standards of patient care depend upon equal treatment and consideration; therefore sessions must begin and end on time.

The cancellation/no-show fee schedule is as follows:

48-Hour Notice Required for all Appointment Cancellations:

Physician and physician assistant appointments	$75
Clinician appointments	$45
Respiratory therapy session	$45
Overnight sleep study appointments	$250

Please note, calls to cancel appointments should not be left on the office voice mail within the minimum time frame in attempt to avoid the cancellation fee. Doing so may result in a lapse of the 48-hour notice. If you have any questions or concerns, please do not hesitate to contact our office at (360) 676-1696. Thank you!

I have read and fully understand NorthStar Medical Specialists' Cancellation Policy.

_______________________________________ ______________

Signature Date

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(A)Notifier(s): NorthStar Associates, PLLC
(B) Patient Name: ***(C) Identification Number:***

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If your insurance doesn't pay for the Pulmonary Rehabilitation services below, you may have to pay.

Insurance providers may not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect that your insurance may not pay for the Pulmonary Rehabilitation services below.

(D) Pulmonary Rehab Services	***(E)* Reason Insurance May Not Pay:**	***(F)* Estimated Cost:**
• Office Consultations with Dr. Burden • Pulmonary Function Test • 6 Minute Walk Test • Pulmonary Rehab sessions • Secretion Clearance/Vest Treatment • Smoking Cessation	• It may not be deemed medically necessary • It may be an exclusion on your plan • It may be deemed investigational per your insurance company guidelines.	$5.48-$80 per service/item *(Depending on services rendered)*

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Pulmonary Rehabilitation services listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but you insurance cannot require us to do this.

***(G)* OPTIONS:** **Check only one box. We cannot choose a box for you.**

❑ **OPTION 1.** I want the *Pulmonary Rehabilitation* services listed above. You may ask to be paid now, but I also want insurance billed for an official decision on payment, which is sent to me on an Explanation of Benefits (EOB). I understand that if my insurance doesn't pay, I am responsible for payment, but **I can appeal to my insurance company** by following the directions on the EOB**.** If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑ **OPTION 2.** I want the *Pulmonary Rehabilitation* services listed above, but do not bill my insurance. I may ask to be paid now as I am responsible for payment**. I cannot appeal if insurance is not billed**.

❑ **OPTION 3.** I don't want the *Pulmonary Rehabilitation* services listed above. I understand with this choice **I am** not **responsible for payment, and** I cannot appeal to see if my insurance would pay.

(H) Additional Information:

This notice gives our opinion, not an official decision. If you have other questions on this notice or medical insurance billing, call the customer service phone number on the back of your insurance patient identification card.

Signing below means that you have received and understand this notice. You also receive a copy.

***(I)* Signature:**	***(J)* Date:**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.