NorthStar
MEDICAL SPECIALISTS

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:_____

Home Phone#:_____ Work Phone#:_____ Sex:_____ Age:_____

Employment Status (circle one): Full time / Part time / Not employed / Self employed / Retired / Student

Marital Status: Single / Married / Divorced / Separated / Widowed Spouse's Name:_____

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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Patient Name: _____ **ID#** _____

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

I learn information best by: ___Explanation ___Reading ___Video/TV ___Computer ___Demonstration ___Other: _____

Medical History

Please identify your lung disease:

___Asthma ___COPD ___Bronchiectasis ___Other: _____

Are you diabetic? ___ No ___ Yes, type: _____

Do you have any muscle or joint pain?

___ No ___Yes, please explain: _____

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Do you have any cardiac disease or heart irregularities?

___ No ___Yes, please explain: _____

I have a history of:

___Cancer ___Edema ___Sinus problems ___Circulatory Problems

___Cystic fibrosis ___Osteoporosis ___High blood pressure ___ Muscle Cramps

___Fractures (specify)_____

I experience the following:

___Chest pain ___Ankle swelling ___Dizziness/unsteadiness

___Hoarseness ___Wheezing ___Fatigue ___Weight change

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: _____

I have the most difficulty when exposed to the following irritants (i.e. smoke, tobacco):

_____

Vaccine History

I receive the flu vaccine annually. ___Yes, date: _____ ___No, because: _____

I received the pneumonia vaccine. ___Yes, date: _____ ___No, because: _____

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:_____

___I am currently a smoker

Number of packs smoked per day:_____

___I have attempted to quit smoking. Methods: _____

Exposure to secondhand smoke: ___None ___Home ___Work ___Social situations

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Pulmonary Health History

Cough: ___Yes ___No

___AM ___PM ___Nighttime ___Around the clock

Mucus: Normal color:_____ ___Thick ___Thin ___Moderate

Amount per day: ___½ tsp. ___1 tsp. ___¼ tbsp.

___½ cup ___1 cup ___>1 cup

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 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):_____

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

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

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___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

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:

___Peak flow meter ___Incentive spirometer ___Vest therapy ___Spacer

___Other: _____

___Oxygen: Flow rate: _____

Type: ___Concentrator ___Liquid ___Tank

Used: ___Continuously ___As needed ___With sleep ___With exercise

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:_____

I follow the following type of diet:

___Low saturated fat ___Low sodium (salt) ___Caloric restriction

___Low cholesterol ___Diabetic ___Other_____

My appetite is: ___Good ___Fair ___Poor

I drink this amount of each of these a day:

Water_____ Soda_____ Coffee/Tea_____

Alcohol_____ Milk_____ Juice_____

I have difficulty with: ___Chewing ___Swallowing ___Digesting

I take vitamins: ___No ___Yes: _____

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Sleeping History

Usual Bedtime:_____ Usual time of waking:_____

Naps taken during the day: ___Yes ___No

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

Pulmonary Medications

Please write-in your current inhaled medications or provide your medications list at your appointment.

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

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, etc.)
___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:_____

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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, etc.)

This is what makes me feel this way:_____

_____

I use the following to relax:

___Read ___Computer ___Deep breathing ___Alcohol ___Smoke

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

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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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CONSENT FOR THE RELEASE OF INFORMATION
(Specified Access)

Please complete this form to allow NorthStar Medical Specialists to release your personal information and/or medical records to an individual or group. For example; your referring physician, primary care provider, or any medical specialists. If you wish to share your protected health information at NorthStar with another party, you are required to complete this form.

I hereby authorize NorthStar Associates PLLC to release my medical records, treatments and services to _____.

This access includes: (Check all that apply)

____Reading and/or copying my written medical record

____Accessing, reading and printing my computerized medical record

____Receiving phone information regarding my medical condition and treatments

____Other: Please explain:_____

_____

This health care consent authorizes this access for the following time frames: (Check one)

____Between _____ and _____ (If patient is a minor this agreement ends when
Beginning date Ending Date patient becomes an adult)

____This agreement is open ended and I will notify NorthStar Associates PLLC if I want it revoked.

I hereby release NorthStar Associates PLLC, its agents and employees from all legal responsibility or liability that may arise from the release of this information or records.

_____ _____
Witness Patient Signature

_____
Date of Birth

_____
Custodial parent if patient is a minor

_____
Relationship

_____
Date

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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.