



ATLANTA PULMONARY GROUP, LLC
5667 PEACHTREE-DUNWOODY ROAD, N.E. - SUITE
#350
ATLANTA, GA 30342
TELEPHONE: (404)252-7200
FACSIMILE: (404)252-6780

Dear Patient:

Please help us provide the best medical care by bringing all of your **medications** with you to your first visit. If you are unable to bring the actual bottles, please make a current list which will include the **name of the medication**, the **dosage** and the **number of times taken daily**. Also, please include **all over-the-counter medications** with the same information listed.

Please bring all Chest X-rays and/or CT Scan Films that have been taken since your last office visit, hospital or emergency room visit, as well as other doctor's office visits. **We do require you to bring the actual film with you to your appointment in order to provide a complete examination.**

If you have had any blood tests since your last visit, please call to have the results faxed to us at **(404) 252-4199**.

Thank you for your assistance in providing the above information. Our goal is to provide you the best medical care possible.

Thank you and we look forward to seeing you.

Paul Scheinberg, MD * David Westerman, MD * Leslie Watters, MD *

Robert Albin, MD * Juan Carlos Armstrong, MD



CHEST X-RAY AND/OR CT SCANS

Dear Patient:

In order for your office evaluation to be optimal, it is important for us to have the most **current films and the radiology report at the time of your appointment.** Please bring any Chest X-ray films and/or CT scan disks that you have had in the last two (2) years.

You may have to contact either your physician's office or a hospital radiology film department in order to obtain these films. They will need to have minimum of 48-72 hours notice in order to provide copies.

Please have your physician's office **fax the radiology reports to our clinical department at (404) 252-4199.**

Thank you very much for your assistance in helping us make your visit as comprehensive as possible. If you have any questions regarding this request, please feel free to contact our clinical staff at (404) 252-7200.

Thank you again,

Atlanta Pulmonary Group

Paul Scheinberg, MD * David Westerman, MD * Leslie Watters, MD *

Robert Albin, MD * Juan Carlos Armstrong, MD



ATLANTA PULMONARY GROUP, LLC
5667 PEACHTREE-DUNWOODY ROAD, N.E. - SUITE #350
ATLANTA, GA 30342
TELEPHONE: (404)252-7200
FACSIMILE: (404)252-6780

**IF YOU HAVE ANY OF THE FOLLOWING, PLEASE BRING
TO APPOINTMENT**

Tests done within past 2 years

- Echocardiogram/Heart catheterization
- Chest x-ray (film/CD **AND** report)
- CT scans of chest, abdomen, or thorax (film/CD **AND** report)
- Labwork

Tests/additional information EVER done

- Pulmonary Function Tests
- Cardio or Pulmonary stress tests
- Hospital records pertaining to condition
- Last progress not if ever been to pulmonologist

Medications

- Bring all medications to first visit OR
- A current list including the name of the medicine, dosage, and number of times taken each day (please include all vitamins and over the counter medications in this list)

You may either arrange to pick up records/reports yourself or have them faxed to us at (404)-252-4199. Films will have to be retrieved in person from the office at which they were taken. We must have the actual radiology films/CDs in order to have a successful consultation.

If you are scheduled for a Complete PFT, please wear loose fitting clothing and do not use a rescue inhaler or smoke within 4 hours of the test. It is important not to eat a heavy meal within 3 hours of the test.

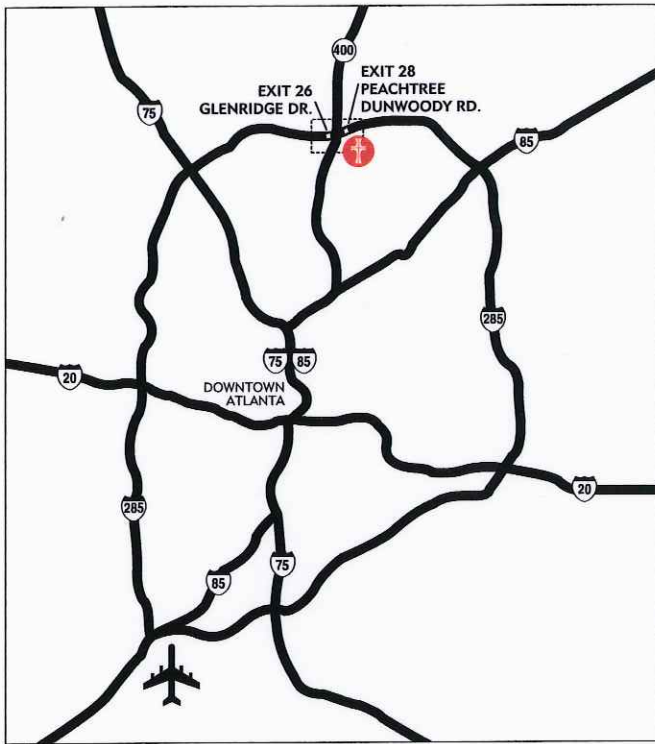
If you have any questions regarding these requests, please feel free to contact our clinical staff at (404)-252-7200.

Thank you for your assistance

Atlanta Pulmonary Group

Paul Scheinberg, MD * David Westerman, MD * Leslie Watters, MD *

Robert Albin, MD * Juan Carlos Armstrong, MD



DIRECTIONS

FROM POINTS SOUTH Travel I-85N to GA 400 (exit 87). Take exit 3 (Glenridge Connector) and turn right onto Glenridge Road. At the second light, turn left onto Peachtree Dunwoody Road. Cross Johnson Ferry Road and immediately enter the right turn lane. Turn right into the hospital campus.

FROM ROSWELL/CUMMING/ALPHARETTA Travel GA 400S to exit 3 (Glenridge Connector) and turn right onto Glenridge Road. At the third light, turn left onto Peachtree Dunwoody Road. Cross Johnson Ferry Road and immediately enter the right turn lane. Turn right into the hospital campus.

FROM POINTS WEST Travel I-20E to I-285N to exit 26 (Glenridge Connector). Turn right at the end of the ramp onto Glenridge Road and immediately enter the left turn lane to turn left onto Johnson Ferry Road. At the third light, turn left onto Peachtree Dunwoody Road and immediately enter the right turn lane. Turn right into the hospital campus.

FROM POINTS EAST Travel I-20W to I-285N. Take exit 28 and turn left onto Peachtree Dunwoody Road. At the third light, just past the MARTA station, turn left into the hospital campus.

FROM THE HOSPITAL TO I-285E Turn right out of the campus onto Peachtree Dunwoody Road. At the second light, turn right onto the ramp.

FROM THE HOSPITAL TO I-285W Turn left out of the campus onto Peachtree Dunwoody Road. At the first light, turn right onto Johnson Ferry Road. At the third light, turn right onto the Glenridge Connector and immediately enter the far left lane. At the next light, turn left onto the ramp.

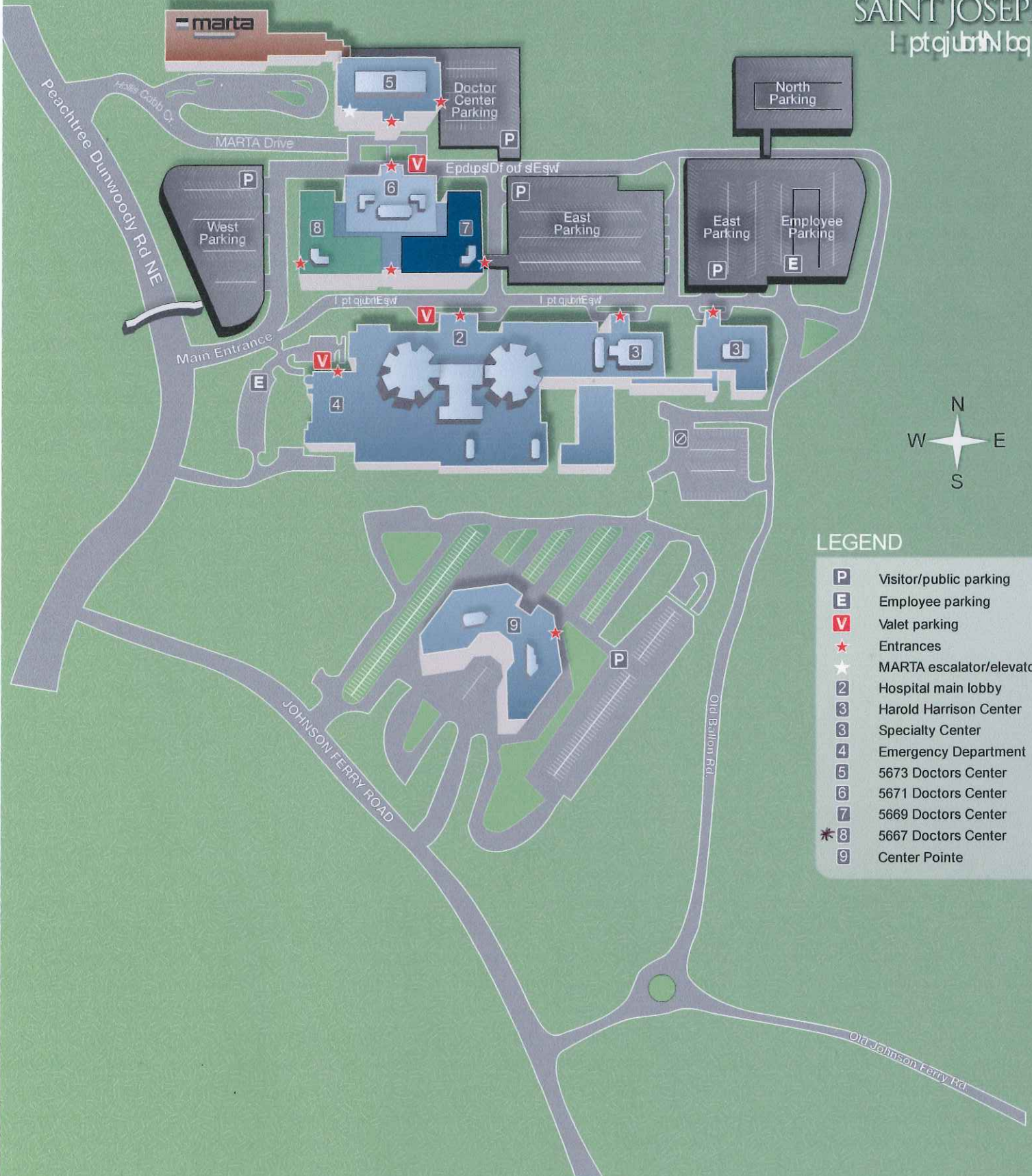
FROM THE HOSPITAL TO GA 400N AND GA 400S Turn left out of the main entrance onto Peachtree Dunwoody Road. At the second light, turn right onto the Glenridge Connector. Turn left at second light to the 400N ramp. Turn left at the third light to the 400S ramp.





SAINT JOSEPH'S

1 pt qubriEsw



LEGEND

- P** Visitor/public parking
- E** Employee parking
- V** Valet parking
- *** Entrances
- ★** MARTA escalator/elevator
- 2** Hospital main lobby
- 3** Harold Harrison Center
- 3** Specialty Center
- 4** Emergency Department
- 5** 5673 Doctors Center
- 6** 5671 Doctors Center
- 7** 5669 Doctors Center
- *8** 5667 Doctors Center
- 9** Center Pointe

Robert J. Albin, M.D., F.C.C.P.
 Juan C. Armstrong, M.D.
 Paul J. Scheinberg, M.D., F.C.C.P.
 Leslie C. Watters, M.D.
 David E. Westerman, M.D., F.C.C.P.



5667 Peachtree Dunwoody Rd.
 Suite 350
 Atlanta, GA 30342
 404 252-7200

PLEASE PRINT

DATE:

REASON FOR APPOINTMENT:

REFERRED BY: _____ PHONE: _____

PATIENT INFORMATION

PATIENT	LAST NAME		FIRST NAME		MIDDLE		NAME CALLED					
	STREET ADDRESS				APT #		CITY		STATE		ZIP	
	SOCIAL SECURITY #			DATE OF BIRTH		SEX	MARITAL STATUS		HOME PHONE ()		CELL PHONE ()	
	EMPLOYED BY					SPOUSE'S NAME				EMPLOYED BY		
	EMPLOYER'S ADDRESS					EMPLOYER'S ADDRESS						
	OCCUPATION			BUS. PHONE (AREA CODE)		OCCUPATION				BUS. PHONE (AREA CODE)		
	NEAREST FRIEND OR RELATIVE NOT LIVING WITH YOU:					RELATIONSHIP TO PATIENT				PHONE		
	PATIENT E-MAIL											

RESPONSIBLE PARTY

Please complete the section below, if someone other than the patient is responsible for the payment of services.

RESPONSIBLE	LAST NAME		FIRST NAME		MIDDLE		RELATIONSHIP TO PATIENT					
	STREET ADDRESS				APT #		CITY		STATE		ZIP	
	DATE OF BIRTH			SOCIAL SECURITY #					HOME PHONE			
	EMPLOYED BY						BUS. PHONE					

Please bring insurance card to front desk.

GENERAL INFORMATION PLEASE READ

____ Please initial that you have received the Notice of Privacy Practices.

I understand that my medical record may be shared with other physicians involved in my care and reviewed by our staff for potential clinical research studies.

A patient who carries Health Care Insurance should remember that professional services are rendered and charged to the patient, not to the Insurance Company. Insured patients are expected to take care of their fees as services are rendered unless other arrangements are made in advance of treatment. You will be given a copy of the paid bill to submit to your insurance company for reimbursement.

I hereby authorize the release of any medical information necessary to process this claim and also authorize payment of medical benefits to ATLANTA PULMONARY GROUP, LLC for services rendered. A photocopy of this authorization and assignment shall be considered as valid as the original.

Signature _____

Date _____

Patient Account # _____

Patient Name _____ Date of Birth _____

Patient E-Mail _____

Primary Phone Number _____ Cell Phone Number _____

Pharmacy Information:

Pharmacy Name _____

Pharmacy Address _____

Pharmacy Phone Number _____



Patient Bill of Responsibilities

Welcome to Atlanta Pulmonary Group. The following are our office policies and procedures. Please read carefully and sign. Also, feel free to ask our office staff if you should have any questions.

1. The office hours are Monday–Friday, 9am–5pm. Closed Saturday and Sunday. Please plan your appointments, medication refills or any other calls accordingly. Please be aware that your doctor is not always in the office during these hours.
2. Please keep your scheduled appointments. **The office requires 24 hours notice if unable to keep your appointment.** The doctor’s schedule may be booked up to 3-4 weeks in advance, making it difficult to reschedule. We cannot accommodate walk-in appointments.

There will be a \$50.00 charge billed to your account for appointments cancelled in less than 24 hours or a no-show. This fee must be paid prior to the next office visit. Frequent no-shows for appointments may result in dismissal from the practice.

3. Medication refill requests will be completed within 24 hours. **Please plan ahead! No refills or narcotics will be called in after office hours or on weekends.**

The doctor may request to see the patient or an outstanding balance may need to be paid before refill requests are complete.

4. Messages received before 3pm, will be returned the same day. Calls after 3pm may not be returned until the next business day. A nurse/medical assistant will return your call and relay your message to your doctor. The doctor will not be interrupted while in the exam room.

Please understand that your callbacks take time. **Remember to unblock your phones.** Time does not allow for repeated calls and busy signals. We will try your phone line twice.

We will not be able to page you. Please leave a phone number where you can be reached.

5. There is no charge for the first set of records/radiological films going to another doctor. Repeat requests for records/films may incur a charge. The patient must sign a “release of records” before any records can be sent.
6. There is a doctor on call if you become ill after hours and on weekends. Please call our office number and the answering service will page the doctor. Remember you must unblock your phone. **If you have a life-threatening emergency, please call 911 or go to the emergency room.**
7. The APG billing office will file claims with your insurance company for services provided. **Any charges not covered by your insurance company will be your sole responsibility.**

Please notify APG immediately of any changes in your insurance coverage. We ask that you bring your insurance card with you each visit.

Due to the overwhelming number of insurance plans, it is impossible for our front desk to verify benefits. It is your responsibility to verify that APG is a member of your plan before presenting to our office for treatment. You are also responsible for obtaining a referral from your Primary Care Physician if required, prior to your scheduled appointment. If you have any questions, please call the customer service number on your insurance card.

8. Payment/co-payments are to be paid at the time of service. We accept cash, checks or credit cards (Visa, Mastercard, American Express and Discover).

(OVER)

9. If you have an HMO insurance plan, it is your responsibility to obtain the necessary referral before services can be provided. Please contact your designated primary care physician in a timely manner. Most primary care physician offices require 72 hours to process referrals to specialists.
10. Patients electing to be seen out of network will be responsible for payment at the time of service.
11. Patients covered under Medicaid-SSI must present current eligibility information and pay copay when applicable. We are not providers with any Medicaid managed care plan.
12. A \$10.00 late fee will be assessed monthly on account balances that become more than 30 days past due. Account balances remain in a current status as long as a payment is received each month.
13. In the event that an account is turned over to a collection agency, a collection fee (33% of balance) will be assessed, plus reasonable attorney fees, court costs, etc.
14. Any NSF/returned checks will be assessed a \$30.00 fee.
15. In situations of severe financial hardship, this office will consider making special arrangements on a case-by-case basis. Please discuss this with our business manager immediately if this applies to you.
16. We are all here to serve. If you have remaining questions, our staff is ready to help find answers.

Thank you for your understanding and cooperation. We are very happy that you have chosen us for your pulmonary needs. We look forward to treating you in the future.

I have read and understand the policies of the Atlanta Pulmonary Group.

Signature

Date



SUMMARY OF PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW HEALTH 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 HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make the significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use the disclosed health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described by this Notice.

Person Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such issues and disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

To Your Family and Friends: We may disclose relevant information to a family member, or friend, to the extent necessary to help with your healthcare or payment for your healthcare, based on our professional judgment that the patient does not object.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counter-intelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your protected health information, with limited exceptions. If you request a copy of your information, we may charge you a fee for the costs of copying, mailing or other costs incurred by us as a result of complying with your request. Requests for access to your protected health information must be made in writing.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. You must make your request in writing. If you request this accounting more than once in a 12 month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. For instance, you may request that we restrict disclosure to only certain individuals involved in your care, such as family members and friends. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). You must make your request in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. You must make your request in writing.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Right to Express Complaints: You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. If you wish to complain to us, you must do so in writing, and direct your complaint to the Privacy Officer.

Right to Obtain a Paper Copy of this Privacy Summary Notice: Upon request, even if you have agreed to accept this notice electronically.

QUESTIONS AND COMPLAINTS

You may complain to us, or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. You may contact our Privacy Officer at (404) 252-7200 for further information about this process.

This notice was published on **April 14, 2003; revision effective January 1, 2012.**

PATIENT

CLINICIAN

Marital Status S M W D
With whom do you live? _____
What is your occupation? _____
List past occupations _____

What are your leisure activities (hobbies)? _____

What is your education level? _____
Place of birth _____
Recent travel outside of Southeast _____

Please check if you have:

- Worked around toxic chemicals or substances
- Asbestos or silica exposure

Do you exercise (including walking) regularly?
 Yes No Describe _____

Has a close family member had lung cancer, tuberculosis, emphysema or chronic bronchitis?
 Yes No Who? _____

Family History

	Living	Age	Medical Problems
Father			
Mother			
Brothers			
Sisters			
Children			

Are you allergic to any medications? Yes No

List medications to which you are allergic & reactions:

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____

Do you have allergies to pets, mold, grass, pollen, etc.?

- Yes No

What kind of symptoms do you experience:

Have you had the following vaccines?

- Influenza ("Flu Shot") Annually When: _____
- Pneumococcal ("Pneumonia") Vaccine When: _____

Social Hx

Occ Hx

Family Hx

Allergies

Vaccinations

PATIENT	CLINICIAN
---------	-----------

Please tell us about your medicines (names, dose or strength, how many times per day). Include over-the-counter medications, birth control pills, vitamins, aspirin and herbs.

- 1 _____
- 2 _____
- 3 _____
- 4 _____
- 5 _____
- 6 _____
- 7 _____
- 8 _____
- 9 _____
- 10 _____
- 11 _____
- 12 _____
- 13 _____
- 14 _____
- 15 _____
- 16 _____
- 17 _____
- 18 _____

Medicines

	REVIEW OF SYMPTOMS AND SYSTEMS
--	--------------------------------

Please circle all symptoms you have:

- Lack of energy, daytime sleepiness, trouble sleeping, snoring, loss of appetite, weight changes, fevers
- Eye problems, such as double or blurred vision, glaucoma, cataracts
- Hearing problems, buzzing or ringing in ears
- Sinus problems
- High blood pressure or palpitations
- Stomach problems, heartburn, indigestion, change in bowel habits, choking on food
- Bloody or tarry stools, jaundice, liver problems, ulcers, gallstones, diverticulitis
- Urinary problems: Frequency, infections, stones, bladder
 - Men: Prostate problems, night-time urination
 - Women: Abnormal menstrual periods, pregnant
- If you are a woman, have you passed menopause?
 - Yes No At what age?
- Do you take estrogen replacement? Yes No
- Kidney disease
- Joint pain, swelling or redness, arthritis, back pain
- Muscle aches or tenderness, gout
- Rash, itching or other skin problems
- Paralysis (even temporary); stroke, numbness, loss of balance
- Seizures, loss of memory, headaches, loss of consciousness
- Unusual thoughts, nervousness, crying or sadness, depression
- Thyroid disorder, diabetes, excess thirst, hunger or urination
- Bleeding, easy bruising, risk factors for HIV, anemia, cancer

Constitutional

HEENT

Cardiac

Digestive

Urinary

Musculoskeletal

Dermatological

Neurological

Psychiatric

Endocrinology

Hematological



ATLANTA PULMONARY GROUP, LLC
5667 PEACHTREE-DUNWOODY ROAD, N.E. - SUITE #350
ATLANTA, GA 30342
TELEPHONE: (404)252-7200
FACSIMILE: (404)252-6780

TO: _____

Please release all records, x-ray, etc.

TO: Atlanta Pulmonary Group
5667 Peachtree Dunwoody Road
Suite 350
Atlanta, GA 30342

Patients Name: _____

Date of Birth: _____

Signature: _____

Witness: _____

Date: _____

Paul Scheinberg, MD * David Westerman, MD * Leslie Watters, MD *

Robert Albin, MD * Juan Carlos Armstrong, MD