CANCELLATION AND NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. With cancellations made less than 24 hours notice, we are unable to offer that slot to other people.

Office appointments which are cancelled with less than 24 hours notification may be subject to a $25.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered a NO SHOW. Patients who No-Show three (3) or more times may be dismissed from the practice thus they will be denied any future appointments. Patients will also be subject to a $25.00 fee for an appointment No-Show. The cancellation and No Show fees are the sole responsibility of the patient and must be paid in full before the patient’s next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based on understanding and good communication. Questions about cancellation and no show fees should be directed to the Billing Department 1-800-403-4746.

Initial:_________
# Medical History Form

<table>
<thead>
<tr>
<th>Name:</th>
<th>DOB:</th>
<th>Today's Date:</th>
</tr>
</thead>
</table>

**What is your Chief Complaint?**

**Respiratory Symptoms:** (Below Circle Yes or No and/or answer related questions)

**Shortness of Breath:**

<table>
<thead>
<tr>
<th>At Rest?</th>
<th>With Activity?</th>
<th>At Night?</th>
<th>Lying Flat to Sleep?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Able to walk a Block?</td>
<td>Yes</td>
<td>No</td>
<td>Able to climb a flight of stairs?</td>
</tr>
<tr>
<td>History of Cough?</td>
<td>Yes</td>
<td>No</td>
<td>For how long?</td>
</tr>
<tr>
<td>History of coughing up blood?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Your cough is worse in (check one):** Morning ☐ Bedtime ☐ All Day ☐

**History of Wheezing:**

<table>
<thead>
<tr>
<th>With Activity?</th>
<th>Yes No</th>
<th>With Cold or Humid Weather?</th>
<th>Yes No</th>
<th>At Bedtime?</th>
<th>Yes No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Wheezing (check one):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Everyday</th>
<th>Once a Week</th>
<th>3 or more times a Week</th>
<th>Once a month</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Allergies?</td>
<td>History of Hay Fever?</td>
<td>History of Postnasal Drainage?</td>
<td></td>
</tr>
<tr>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
<td></td>
</tr>
</tbody>
</table>

**History of (check all that apply):**

- Recurrent Bronchitis ☐
- Pneumonia ☐
- Asthma ☐
- COPD ☐
- Emphysema ☐
- Tuberculosis ☐
- Fibrosis ☐
- Blood Clot ☐
- Pulmonary Hypertension ☐

**Sleep History (Below Circle Yes or No and/or answer related questions):**

- Have you been told that you “quit breathing”? Yes No Do you wake up tired? Yes No

- Are you sleepy during the daytime? Yes No Time to Bed: ____ PM Wake Time: ____ AM

- How many naps do you take during the daytime? (check one) None 1 2 3+

- Do you have a history of restless sleep? Yes No

- Do you have a history of increased limb movements in the evening? Yes No

- Do you have a history of “Creeping and/or Crawling” sensation in your legs in the evening? Yes No

**History of (check all that apply):**

- Sleep Walking ☐
- Narcolepsy ☐
- Restless Leg ☐
- Sleep Apnea ☐
- Seizures ☐
Marital Status:
__ Married  __ Single  __ Divorced  __ Separated  __ Widowed

Occupational History:

Have you worked with (check all that apply):
__ Asbestos  __ Foundry  __ Sandblasting
__ Welding  __ Quarry  __ Other (similar)

Tobacco History (Check all that apply & answer questions):
__ Cigarettes  __ Cigars  __ Pipe
__ Chewing  __ Snuff  __ Dip
__ Never  __ Past  __ Active
Date Started: __________ Date Stopped: __________
How much (ex. Pack a day): ___________________

Alcohol History (check all that apply & answer questions):
__ Never  __ Past  __ Active
__ Liquor  __ Beer  __ Wine
__ Drinks per ___ (ex. 2 Drinks per Day)

Illicit Drug Use (check all that apply & answer the questions):
__ Never  __ Past  __ Active

Drug Type & Frequency: ___________________

Caffeine Use (check all that apply & answer questions):
__ Coffee  __ Tea  __ Soda
__ Never  __ Past  __ Active
__ Cans/Cups/Drinks per ___ (ex. 3 cups per day)
List Allergies:


Current Medications:


Past Medical History (check all that apply):

___ Hypertension
___ Diabetes Mellitus
___ Stroke
___ Coronary Artery Disease
___ Heart Attack
___ Congestive Heart Failure
___ Atrial Fibrillation
___ Blood Clot to Leg
___ Blood Clot to Lung
___ Arthritis
___ Chronic Kidney Disease
___ Glaucoma
___ Cataract
___ Cancer
___ Poor Circulation (Peripheral Vasc. Disease)
___ Prostate Enlargement
___ Acid Reflux
___ Ulcer Disease
___ Increased Cholesterol
___ Others

Past Surgical History (check all that apply):

___ Cataract Surgery (RT)/(LT)
___ Hip Surgery (RT)/(LT)
___ Glaucoma Surgery (RT)/(LT)
___ Knee Surgery (RT)/(LT)
___ Hernia Surgery (Umbilical)/(Inguinal)/(Ventral)
___ Coronary Bypass
___ Heart Valve Surgery
___ Pacemaker
___ AICD
___ Lung Surgery
___ Tonsillectomy
___ Appendectomy
___ C Section
___ Hysterectomy
___ Oophorectomy
___ Back Surgery (Upper)/(Middle)/(Lower)
___ Gastric Bypass
___ Aneurism Surgery (Brain)/(Chest)/(Abdomen)
___ Vascular Bypass Surgery
___ Cholecystectomy
Family History:

Father:

Mother:

Siblings:

Others:

Review of System (check all the conditions you have)

General/GI:
__Weight Loss
__Weight Gain
__Heartburn
__Nausea
__Night Sweat
__Vomiting
__Fever
__Diarrhea
__Constipation
__Colon Polyp

HEENT:
__Eye Problems
__Hearing Defect
__Nasal Congestion
__Sore Throat
__Voice Change

Urinary Symptoms:
__Burning
__Blood in Urine
__Hesitancy
__Dribbling
__Kidney Disease

Skin:
__Psoriasis
__Eczema
__Skin Cancer

CVS:
__Chest Pain
__Irregular Heart Beat
__Heart Murmur
__Heart Failure
__Valve Prolapse
__Blocked Artery
__High Cholesterol

Neuro/Psychiatry:
__Anxiety
__Depression
__Stroke
__Numbness
__Vertigo
__Tremors
__Dizziness

Musculoskeletal:
__Arthritis
__Back Pain
__Osteoporosis
__Fibromyalgia

Vaccinations
(Month/Year ex: Flu- Jan/2014):
Flu –
Pneumococcal –
Shingles –
DTP –
Consent to Treat:

I hereby give my consent to Dr. Iyer and authorize him to provide my medical treatment. I understand that Dr. Iyer will explain my condition(s), foreseeable risks, and methods of treatment for my condition before treatment is provided. I authorize Dr. Iyer to perform any additional or different treatment, which is thought necessary should, in an emergency situation, a condition be discovered which was not known previously.

Initial:__________

Patient Financial Policy:

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience we accept VISA, MasterCard, and Discover.

Your Insurance

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized copayment at the time of service. This office’s policy is to collect this copayment when you arrive for your appointment.
- If you have insurance coverage with a plan for which we do not have a proper agreement, we will prepare and send the claim for you on an unassigned basis. This means that your insurer will send the payment directly to you. Consequently, the charges for your care and treatment are due at the time of service.
- In the event that your health plan determines a service to be “not covered,” you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.
- We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office.

I have read and understand the financial policy of the practice and I agree to be bound by this term. I also understand and agree that the practice may amend such terms from time to time.

Initial:__________
For the Release of your Personal Medical Information, it is Ok to:

Leave a Message on Voice Mail or Answering Machine?  YES  NO

Give information/communicate to your Spouse or Significant Other?  YES  NO

Name: ________________________________

Give information/communicate to Parent/ Child?  YES  NO

Name: ________________________________

Is there anyone else that you would like us to give information/communicate?  YES  NO

Name: ________________________________

In there anyone that you DO NOT want us to give information/communicate?  YES  NO

Name: ________________________________

By Signing Below, I hereby attest that I have fully understood and agree to the Statements Above.

Print: ________________________________  Date: __________________

Sign: ________________________________
RElease of Medical History

To whom it may concern:

I, ____________________________, authorize all physicians, hospitals, and medical attendants to furnish any and all of my medical reports, history and information to Dr. Sridhar K. Iyer. This authorization also includes any examination of all hospital records, x-ray films and furnishing of information including opinions.

________________________________________  ____________________________
Patient Signature                          Date