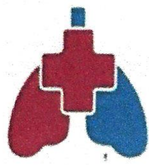

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Office: 404-254-5388
Fax: 404-565-1255

New Patient History Form

Employer and Insurance Information	Patient Information
Employer:	Name:
Address:	Date of Birth:
City/State/Zip:	Sex: ☐ Male ☐ Female
Business Phone:	Address:
Insurance	City/State/Zip:
Policy #	Home Phone:
Group #	Mobile Phone:
	Email address:
	Marital Status: (Please check below) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Significant Other
Emergency Contact	**Primary Care Physician**
Name:	Name:
Phone:	Address:
Relationship:	City/State/Zip:
	Phone:
Pharmacy Name:	Other Physicians:
Address:	Name:
City/State/Zip	Phone:
Phone:	Name:
	Phone:

Past Medical History

Hospitalizations Surgeries/Illnesses or Injuries	Year	Hospital and Physicians

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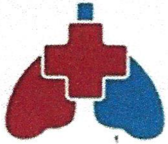
Personal Medical History
If you have had any of the following please write the appropriate date of onset (if available):

Medical Problem	Date	Medical Problem	Date	Medical Problem	Date
Alcohol/Drug Abuse		Heart Problems: Attack, murmur, enlarged, etc.		Thyroid Disease	
Allergies		High Blood Pressure		Treatment (radiation)	
Anemia		High Cholesterol		Bowel Trouble	
Asthma		Kidney Disease		Ulcers	
Bleeding Disorder		Low Blood Pressure		Unconsciousness	
Blood Transfusion		Measles		Urinary Tract Infections	
Breast Lump		Mental Illness		Rheumatic Fever	
Broken Bone		Mumps		Sexually Transmitted Disease	
Cancer		Pneumonia		Liver Disease	
Cataracts		Pulmonary Disease		Eye Disease	
Diabetes		PE/DVT (blood clot)		Gout	
Exposure to TB		Physical/Sexual Abuse		Arthritis	
Gallbladder Disease		Seizures		Stroke	
German Measles (rubella)		Skin Cancer			

Have you ever experienced any of the following?

Yes	No	Problems	Yes	No	Problems
		Weight loss of more than 10 pounds in the past year (without dieting)			Frequent nausea or vomiting?
		Any growth or lumps?			Difficulty swallowing?
		Any visual disturbance?			Difficulty sleeping?
		Hearing problems?			Problems with urination?
		Any problems with your teeth?			Frequent of severe back pain?
		Do you have dentures?			Unusual shakes or tremors?
		Frequent congestion?			Depression?
		Frequent cough or wheezing?			Headaches?
		Shortness of breath?			Difficulty speaking?
		Frequent swelling of your legs or ankles?			Difficulty concentrating?
		Pain or tightness in your chest, with exertion?			Dizziness?
		Difficulty swallowing?			Loss of balance?
		Abdominal Pain?			Difficulty walking?



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FAMILY HISTORY

Do any of your immediate family members have or has had any of the following health conditions?

CONDITIONS	MOTHER	FATHER	CHILDREN	SIBLINGS
Diabetes				
High Blood Pressure				
Heart Disease				
Lung Disease				
Stroke				
Cancer (Type)				
Gout				
Arthritis				
Asthma				
Kidney Disease				
Digestive Tract Problems				
Thyroid Problems				
Obesity				
Ulcers				
Deceased				

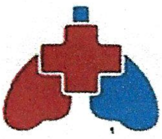
List any health condition(s) that are not mentioned above:

____

____

____

____



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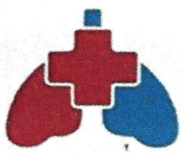
Yes	No	Problems	Yes	No	Problems
		Constipation?			**MEN ONLY**
		Blood in your stool?			Any unusual discharge from the penis?
		Nervousness?			Any lump in the testicles?
		Crying for no apparent reason?			Do you do a self-exam?
		Thoughts of suicide?			**WOMEN ONLY**
		Problems at home or work?			Are you currently going through menopause? If yes, when did it begin?
		Have you ever been exposed to any unusual chemicals?			Any bleeding after menopause?
		Do you practice safe sex?			Hot Flashes?
		Have you recently had sexual relations?			Lump in your breast?
		Do you use any form of birth control? If you do, what form do you use?			Did your mother take diethylstilbestrol (DES) during her pregnancy? (Answer only if you were born after 1945.)
		Frequent urination at night?			Excessive bleeding?
		Diarrhea?			Irregular periods?
					Pap test? When?
		Numbness in your extremities?			Have you had a mammogram? When?
					Abnormal pap test? When?

Please describe any other health problem(s):

IMMUNIZATION HISTORY	DATES	IMMUNIZATION HISTORY	DATES
VACCINE		HEPATITIS A	
DPT		HEPATITIS B	
POLIO		FLU VACCINE	
MMR		PNEUMOCOCCAL VACCINE	
TETANUS/DEPHTHERIA		OTHER (Please list vaccine)	

DRUG ALLERGY OR SENSITIVITY?: (Please state drug and type of reaction)



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CURRENT MEDICATIONS

MEDICATION	Dosage/Route/Frequency (how often taken)
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	

Social History

What is your occupation?

Recreational activities/hobbies:

Living arrangements:		☐ Alone ☐ Spouse ☐ Children	☐ Significant Other
Tobacco Use:	☐ Yes ☐ No	How many years?	Quit/When
Alcohol Use:	☐ Yes ☐ No	How many years?	Quit/When
Do you exercise?	☐ Yes ☐ No	Type of exercise?	How often?

What is your height? What is your weight?

Pain History

Do you have any ongoing pain problems?	☐ Yes ☐ No
Do you have pain now?	☐ Yes ☐ No

If yes, location/intensity of pain:

What is any medications do you take for the pain relief?

Is your pain satisfactorily controlled now?

What relieves or intensifies your pain?

Effect of pain on quality of life (sleep, appetite, activity)

Travel History

List all the places you have lived in or traveled to (below):

1.	4.
2.	5.
3.	6.

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PULMONARY DISEASES ♦ SLEEP MEDICINE ♦ LUNG HEALTH

NGOZIKA ORJIOKE, M.D., F.C.C.P.

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: ____

____

____

Patient Name: ______________________ Date of Birth: ______________

Address: ______________________ Telephone: ______________

City: ______________ Zip Code: __________ Alt. Telephone: ______________

Reason for Request: ____

I HEREBY REQUEST THAT MY
MEDICAL RECORDS BE RELEASED TO:

Name: **Ngozika Orjioke, MD, FCCP**

Medical Records Request:

____ Labs/Other Tests
____ Hospital Notes
____ Sleep Study
____ History & Physical
____ Office Notes
____ PFTs
____ EKG/Stress Tests
____ Progress Notes
____ Other

______________________ (Patient's Signature)

______________________ (Date)

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PATIENT NAME: ______________________________
PHYSICIAN: **NGOZIKA ORJIOKE M.D., F.C.C.P.**

ACKNOWLEDMENT OF RECEIPT OF PRIVACY NOTICE

(I have received a copy of the Privacy Notice with the effective date of January 1, 2016)

____
NAME OF PATIENT OR PERSONAL REPRESENTATIVE

____
DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY

____ ______________
SIGANTURE OF PATIENT OR PERSONAL REPRESETATIVE DATE

I WISH TO BE COMMUNICATED WITHIN THE FOLLOWING MANNER
(PLEASE CHECK ALL THAT APPLY)

____ Home Phone: _______________

___ Can leave Message with detailed information

___ Leave Message with call back number only

___ Cell Phone: _______________

___ Can leave message with detailed information

___ Leave message with call back number only

___ Written Communication

___ Can mail to home address

___ Can mail to office/work address

___ Can fax to this number: _____________

___ Other: _________________________

If you are not available and there is someone you would like us to speak with regarding your medical care please give us their name and phone number:

___________________________________ _____________________
Name Phone number

Covenant Pulmonary CRITICAL CARE

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INTAKE FORM: ASSIGNMENT OF BENEFITS (AOB), FINANCIAL RESPONSIBILITIES, NEW PATIENT

I understand that I am responsible for charges not covered or reimbursed by the above agents. I agree, in the event of non-payment, to assume the cost, interest, collection and legal action (if required).

I authorize my insurance carrier to release information regarding my coverage to Covenant Pulmonary Critical Care (CPCC). I also authorize agents of any hospital treatment center or previous physicians to furnish CPCC copies of any records of my medical history, series or treatments. I also authorize the release of any medical information and/or reports related to my treatment to any federal, state, or accreditation agency, or any physician or insurance carrier as needed. I also agree to a review of my records for purposes of internal audits, research and quality reviews within CPCC.

My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits are hereby assigned to CPCC. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services. In the event that my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to CPCC.

I understand that my patient information arising out of my medical treatment by my physician and this medical practice (without identifying me or any other patient by name or address, unless otherwise permitted by law) may also be shared with interested third parties. These third parties include (a) managed care companies, insurance companies and other payers; (b) companies that produce chemotherapy and other drugs and clinical research companies; (c) governmental bodies (such as the Food and Drug Administration, National Cancer Institute and the Health Care Financing Administration); (d) federally funded registries (which in the case of patients receiving stem cell transplants services may include the sharing of patient identifying information such as my name and address) and universities; (e) representatives and agents of my health benefits plan; (f) persons conduct quality or peer review or patient satisfaction surveys; and (g) other clinical and non-clinical parties that have a contractual relationship with CPCC.

PERSONAL VALUABLES: I acknowledge that CPCC shall not be liable for the loss or damages to any personal property.

CONSENT FOR PHOTOGRAPH: I, the undersigned, give CPCC, its physicians and staff, permission to make photograph of me for placement into my clinical records.

THIS AGREEMENT/CONSENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as the original.

Patient Signature: ______________________________________ Date:______________

Responsible Party Signature: ________________________________ Date:______________

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Tel: 404-254-5388 ♦ 404-565-1255

FINANCIAL POLICY

Patient Name: ______________________________ Date: _______________
(Please Print)

We are committed to meeting your health care needs. Our goal is keep your insurance or other financial agreements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines:

1. You are ultimately responsible for payment of charges for services you receive from our office. Any check dishonored by your bank will result in a $25 returned check charge being added to your account.
2. It is your responsibility to provide us with your current address, telephone number, and insurance information at each visit.
3. It is your responsibility to contact your insurance carrier to confirm that Dr. Orjioke participates on your plan. If Dr. Orjioke is not currently on your plan you will be responsible for payment in full.
4. If your plan requires a referral it is **your responsibility** to obtain this prior to being seen by the doctor.
5. All co-pays are due at the time of service.
6. Laboratory service may be provided by Lab-Corp or Quests. These are contracted outside reference labs. You will be responsible for valid lab charges not covered by your medical insurance plan.
7. All medical records request must be in writing and received in our office 72 hours prior to the date needed. Records over 10 pages will only be mailed not faxed. All medical records request over 5 pages will have a charge of $10. Occasionally, the fee could be higher if there are excessive pages to copy.
8. We prefer that patients give 24 hour notice of cancelling appointments. If an appointment is missed without notice we do charges $25.

Our office also collects an Administrative fee for the following services:

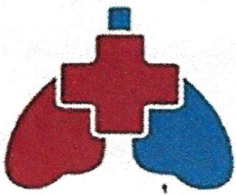
1. Completion of all forms (to include but are not limited to)

a. FMLA, disability, life - $25.00
b. Patient requested computer generated reports (extra claims, statements, payments histories, etc.) - $15.00
c. Foreign travel - $25.00
d. Other miscellaneous - $25.00

Please allow 7 - 10 business days for completion of forms.
Please submit time sensitive forms in a timely manner to have them completed by the due date.

______________________________ ______________________________
Patient Signature Date

NEW PATIENT PACKET



Covenant Pulmonary CRITICAL CARE

1136 Cleveland Avenue, Suite 615 ♦ East Point, GA 30344
Tel: 404-254-5388 ♦ Fax: 404-565-1255

Dr. Ngozika Orjioke, M.D., F.C.C.P.

Dear Patient,

Our EHR system (Practice Fusion) has a Patient Portal feature which enables patients to login in to view their medical information electronically. This is the same information given to you during the time of your office visit. You will be able to view your medical information including lab/test results, diagnosis, medications, immunizations, allergies, procedures, care plans and medication instructions. You will also have the capability to communicate via message, leave feedback on your office visit, and receive appointment reminders in the new Patient Fusion Portal.

To ensure that you have access to the Practice Fusion Patient Portal we need you to provide your updated email address. Once your email address is entered into the EHR system we can enroll you in the Practice Fusion Patient Portal. We will then provide you with a printout that contains your email address and a temporary pin to login into the Practice Fusion Patient Portal. You will then receive an email with a link to the Practice Fusion Patient Portal. Once you click the link, you will be given step-by-step instructions on how to login with your temporary pin and how to create an account on the Patient Portal. After you complete these steps you will be able to be a more active participant in your health care plans.

If you choose not to participate in patient portal, or do not want to provide your email address, or create one to gain access to your medical records through the Patient Portal; please check one the boxes that best describes your situation then sign and date.

We always appreciate feedback; it helps to ensure we provide the best medical care to our patients.

- ☐ **I decline Practice Fusion Patient Portal participation**
- ☐ **I do not want to provide my email address**
- ☐ **I do not have an email account and do not wish to create an email account for Patient Portal participation**
- ☐ **I do wish to provide my email address for Patient Portal participation**

____

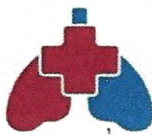
Patient Name: ______________________ Doctor: ______________________

Patient Signature: ______________________ Date: ______________________

NOTICE:

Please keep the remaining (4) pages for your records.

Thank you.



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Tel: 404-254-5388 ♦ 404-565-1255

PATIENT RIGHTS

Other than as stated above, we will not disclose your health information other than with your written authorization. You may revoke your authorization in writing at any time except to the extent that we may have taken action based upon the authorization. At the end of this Privacy Notice is information about how to contact the Privacy Officer to request information, copies, express concerns, complain, or authorize additional uses and disclosure of your health information.

YOU HAVE THE RIGHT TO:

1. **See and copy your medical records** and other records used to make treatment and payment decisions about you. There are some limitations, based upon the federal law. You must submit a written request. We may charge you a fee for copying, mailing, or incurring other costs in complying with your request. We may deny your request to see or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger life or safety of you or another person. You have the right to request a review of this decision.
2. **Request a restriction on uses and disclosures of your protected health information.** The facility is not required to agree to a restriction and we will notify you if we deny your request. If the facility does agree to the requested restriction, we will abide by this agreement unless use of disclosure of the information becomes essential to provide emergency treatment.
3. **The right to request to receive confidential communications by alternative means or at an alternative location.** You have the right to request that we communicate with you in certain ways. We will not require you to provide an explanation for your request. We will accommodate reasonable requests. We may condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact.
4. **The right to request we amend your protected health information.** A request for an amendment must be in writing and it must explain why the information should be amended. Under certain circumstances, we may deny your request.
5. **The right to receive an accounting of disclosures.** You have the right to request an accounting of how we or our business associates disclosed your protected health information for purposes other than treatment, payment or health care operations. We are not required to account for disclosures that you requested, disclosures that you agreed to by signing or authorization form, disclosures to friends or family members involved in your care, or certain other disclosures we are permitted to make without your authorization. The request for an accounting must be made in writing. We are not required to provide an accounting your request disclosures that occurred prior to April 2003 or for periods of time in excess of six years. The first accounting you request during any 12-month period we will be without charge. Additional accounting request may be subject to a reasonable fee.
6. **The right to obtain a paper copy of this notice** at any time.

COMPLAINTS

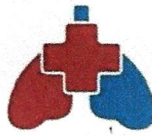
You have the right to express complaints to the facility if you believe that your privacy rights have been violated. We encourage you to express any concerns you have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint. You may complain to the facility's Privacy Officer in person, by phone, or in writing. You also have the right to express complaints to the Secretary of the United States Department of Health and Human Services.

CONTACT PERSON

TO MAKE REQUEST, TO LEARN MORE, TO FILE A COMPLAINT, OR TO EXPRESS CONCERNS, PLEASE CONTACT THE PRIVACY OFFICER. YOU MAY MAKE CONTACT IN PERSON, BY PHONE, OR IN WRITING.

CPCC **COVENANT PULMONARY CRITICAL CARE**

NEW PATIENT PACKET



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PRIVACY NOTICE

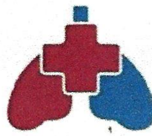
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Privacy Notice describes how we may use and describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes permitted or required by law. We must follow the privacy practices described in this Notice while it is in effect. We reserve the right to change the terms of this Notice and make the new Notice available to anyone. You may request a copy of the current Notice at any time. This Privacy Notice also describes your rights to access and control your "protected health information" which is health information that is created or received by your health care provider.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION We will use and disclose health information to provide treatment, obtain payment, and conduct health care operations.

1. **Treatment:** To provide and coordinate your health care. For example, we may disclose protected health information to physicians or other health care professionals who may be treating you or consulting with us. Examples include your physicians, anesthesia provider, or pharmacist.
2. **Payment:** To obtain payment for the services. This may include contact with your insurance company to get the bill paid and to determine benefits of your health plan. We may also disclose information to another provider involved in your care so the provider can get paid. For example, we may give information to anesthesia providers so they can contact your insurer about payment for their services.
3. **Operations:** To perform our own health care activities such as quality assessment and improvement, licensing or credentialing, and general business administration.
4. **Other Uses and Disclosures:** To remind you of appointments or to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare or with payment for your healthcare, or to notify family or others involved in your care concerning your location or condition. You may object to these disclosures. If you do not or cannot object, we will use our professional judgment to make reasonable assumptions about to whom we can make disclosures.
5. **Other Uses and Disclosures Permitted:** to comply with laws and regulations.
   A. When Legally Required by any federal, state or local law.
   B. When There Are Risks to Public Health such as:
   - To prevent, control, or report disease, injury of disability as required or permitted by law. To report vital events such as birth or death as required by law
   - To conduct public health surveillance, investigations and interventions as required by law.
   - To collect or report adverse events and product defects, track Food and Drug Administration (FDA) regulated products, enable product recalls, repairs or replacements and review.
   - To notifY a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease as authorized by law.
   - To report to an employer information about an individual who is a member of the workforce as legally permitted or required.

   C. To Report Suspected Abuse, Neglect Or Domestic Violence as required by law.
   D. To Conduct Health Oversight Activities such as audits; civil, administrative, or criminal investigations, proceedings, or actions; inspections; licensing or disciplinary actions; or other activities necessary for appropriate oversight as required or authorized by Jaw.
   E. In Connections With Judicial And Administrative Proceedings such as in the course of any judicial or administrative proceeding.
   F. For Law Enforcement Purposes. Examples are:



Covenant Pulmonary
CRITICAL CARE

1136 Cleveland Avenue, Suite 615 ♦ East Point, GA
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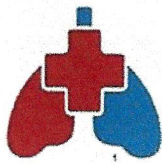
PRIVACY NOTICE CONTINUED

- As required by law for reporting or certain types of wounds or other physical injuries
- Upon court order, court-ordered warrant, subpoena, summons or similar process
- For purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime
- To law enforcement if there is concern that your health condition was the result of criminal conduct.
- In an emergency to report a crime.

G. For Organ Donation or to Coroners or Funeral Directors such as for organ, eye or tissue donations; identification purposes;
Performing other duties authorized by law.
H. For Research Purposes when the use or disclosure for research has been approved by an institutional review board that has reviewed the research proposal and research protocols to address the privacy of your protected health information.
I. In the Event of a Serious Threat to Health or Safety and consistent with applicable law and ethical standards of conduct, if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat, to your health or safety or to the health and safety of the public.
J. For Specified Government Functions relating to military and veterans activities, national security, protective services, medical suitability determinations, correctional institutions, and law or similar programs.
K. For Worker's Compensation to comply with worker's compensation laws or similar programs.
L. The physician performing your surgery may have a percentage of ownership in the surgery center.



Covenant Pulmonary
CRITICAL CARE

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IMPORTANT PATIENT POLICIES

NO SHOW CANCELLATION FEE:

Effective March 15, 2016, Covenant Pulmonary Critical Care requires patients to give 24-hour notice for cancelling and rescheduling of an appointment. If an appointment is missed without notice you will be charged $25.

PRESCRIPTION POLICY:

Please allow 24-hour notice on all prescriptions left on the Phone Line.

MEDICAL RECORDS REQUEST/FORM COMPLETIONS:

Please allow 7 – 10 business days for Medical Records Request and Form Completions. All FMLA/Disability/Life Insurance paperwork requires an administration fee starting at $25.

BILLING QUESTIONS

Our Billing Department is available to answer any questions you might have about your bill. Contact Billing Customer Service at (732) 873-5133 ext. 106 for assistance. Please have your billing paperwork, your doctor's name, and your insurance information available when you call. Someone will be happy to answer your questions and will try to help resolve any issues.

AFTER HOURS EMERGENCIES:

Office hours are between 9am – 5pm, Monday – Friday. Any emergencies after hours will be called into the doctor's Answering Service. Please allow 30 minutes for the doctor to respond to your call after hours. If she does not respond to your call within 30 minutes, please call back and ask for her to be paged again. Please do not call the answering service for prescription refills, appointments, or non-emergency calls.