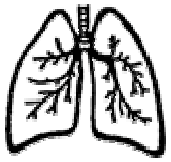

RESPIRATORY SPECIALISTS

(610) 685-LUNG (5864)

WELCOME, _____

(Please enter Your Name)

We welcome you as a new patient to our practice. Our specialty practice is limited to the diagnosis and treatment of lung, breathing, and sleep disorders.

This download from our Web site has 16 pages: *Patient Information Forms* (4 pages), *Privacy Notice* (10 pages), and *Receipt of Notice* (2 pages).

Please complete the enclosed forms prior to your visit and bring them with you. In addition, please bring all your health insurance cards so they may be photocopied for your office chart. **If your insurance company requires an electronic or paper referral, please obtain one from your primary doctor prior to your appointment. If you present yourself without a referral, your appointment may need to be rescheduled.**

Please do **NOT** wear cologne or perfume to your appointment**.**

Any information regarding your condition from your physician would be most helpful in aiding our doctors in taking care of you (this may avoid repeating prior testing). We may order specific tests before your office visit so that results will be available for your first appointment. **It is very important for you to bring a list of ALL your current medications, and your ACTUAL CHEST-XRAY AND/OR CT SCAN FILMS.**

Please note your appointment date and time below. **If you must cancel your appointment, please call 24 hours in advance. Failure to cancel your appointment 24 hours in advance may result in a $50.00 no-show fee.**

We are looking forward to meeting you.

Sincerely,

Respiratory Specialists
Physicians & Staff

You appointment was scheduled with Dr. _____

(Please enter doctor's name)

Date:_____ / _____ / _____ **Time:____ : ____ ☐ AM ☐ PM**

(Please enter scheduled Date) **(Please enter scheduled Time)**

PLEASE ARRIVE 20 MINUTES EARLY FOR YOUR APPOINTMENT.

WYOMISSING OFFICE
2608 Keiser Blvd.
Wyomissing, PA 19610
(610) 685-LUNG (5864)
WWW.LUNGMD.NET

Revision date: 8/26/08 - modified 1/27/09 for Web site download

Patient Information Sheet
Respiratory Specialists
2608 Keiser Blvd.
Wyomissing, PA 19610

Please Print Neatly
Ms./Mrs./
Mr._____ Date of Birth ____ /____ / ____ SSN _____

Address 1_____ Home Phone (_____) _____
Work Phone (_____) _____
Address 2_____ Cell Phone (_____) _____
May we leave a message on your answering machine(s)?
City/State/Zip_____ ☐ Yes ☐ No

Referring of Family Physician_____ Phone (_____) _____

Alternate contact to share protected health information_____

Address_____ Phone (_____) _____

Relationship_____ Additional names may be placed on the back.

Insurance Information:

What is your Primary Insurance?
_____

What is your Secondary Insurance?
_____

Address _____

Address _____

City/State/Zip _____

City/State/Zip _____

ID#_____ Group#_____

ID#_____ Group#_____

Name of insured on your card? _____ SSN_____

Relationship _____ Date of Birth _____ / _____ / _____What is your co-pay? $_____

Yearly Deductible? $_____ Does your insurance pay the physician directly for office visits? _____

Patient Consent

I request that payment of authorized insurance benefits be made to me or on my behalf to Respiratory Specialists for any services or supplies furnished me by those physicians. I authorize Respiratory Specialists, the holder of protected health information about me, to disclose this information to HGSA Administrators, a CMS contracted carrier or my insurance company to determine benefits payable for related services. I understand that co-payments and deductibles not paid by insurance will be the responsibility of me, the patient.

Date _____ /_____ / _____ Signature _

Signature of Parent/Guardian for minor (under 18) or Power of Attorney _

Patient Name_____ Date _____ /_____ / _____

Patient Information Sheet

Respiratory Specialists
2608 Keiser Blvd.
Wyomissing, PA 19610

Please list the names and relationship of any person(s) not listed on the front of this form with whom you would allow us to share information regarding your health, test results, medical condition, or account.

Name _____ Relationship_____ Phone (_____) _____

Name _____ Relationship_____ Phone (_____) _____

Name _____ Relationship_____ Phone (_____) _____

Name _____ Relationship_____ Phone (_____) _____

Name _____ Relationship_____ Phone (_____) _____

Name _____ Relationship_____ Phone (_____) _____

We Exercise a commitment to protecting your privacy and the confidentiality of your information.

Mod 1/27/09 for Web site download

New Patient Questionnaire **Respiratory Specialists**

First Name: _____ Last Name: _____ MI: ____ Date: _____

Age: _____ Date of Birth: ____ / ____ / _____ Country of Birth:_____

Primary Care Physician: _____

What is the nature of the problem that brought you to the office:

_____
_____
_____
_____

Past Medical History (check each condition that applies)

☐ Lung Disease	☐ Sleep Apnea	☐ Heart Disease	☐ High Cholesterol
☐ Asthma	☐ Insomnia	☐ Hypertension	☐ Thyroid Disease
☐ COPD	☐ Restless Leg	☐ Angioplasty/Stents	☐ Diabetes
☐ Emphysema	☐ Recurrent Sinusitis	☐ Heart Failure	☐ HIV
☐ Chronic Bronchitis	☐ Lung Cancer	☐ Stroke	☐ Hepatitis
☐ Tuberculosis	☐ Other Cancer	☐ DVT/Blood Clot	☐ Lupus
☐ Sarcoidosis	☐ Allergies	☐ Pulmonary Emboli	☐ Rheumatoid Arthritis
☐ Pneumonia	☐ Fibromyalgia	☐ Kidney Disease	

Please List All Other Major Illnesses:

_____
_____
_____

Please List All Operations and Dates:

_____
_____
_____

Have you been admitted to the **Hospital** in the Last Two Years?

Date___ / ___ / ___Where_____Reason_____
Date___ / ___ / ___Where_____Reason_____
Date___ / ___ / ___Where_____Reason_____
Date___ / ___ / ___Where_____Reason_____

DME Equipment (Check appropriate answer)

☐ Oxygen ☐ Nebulizer ☐ CPAP/BiPAP

Supplier _____

Health History (circle appropriate answer)

Sex: ☐ **M**ale ☐ **F**emale Height: _____ ft _____ in Weight: _____ lbs

Please rate your current health status: ☐ poor ☐ average ☐ good ☐ excellent

Do you currently smoke? ☐ Yes ☐ No How long? (years) _____ How many packs a day? _____

Did you smoke? ☐ Yes ☐ No How long did you smoke? (years) _____When did you stop? _____

How many packs per day? _____ Why did you stop? _____

Do you have pets such as dogs, cats, or birds? ☐ Yes ☐ No If "Yes" type and #_____

Please rate your current energy level: ☐ poor ☐ average ☐ good ☐ excellent

Do you snore: ☐ Yes ☐ No Do you experience daytime drowsiness? ☐ Yes ☐ No

Do you feel rested in the morning? ☐ Yes ☐ No

How often do you exercise? ☐ Never ☐ occasionally ☐ regularly ☐ frequently ☐ daily

Have you gained weight over the last 5 years? ☐ Yes ☐ No If "yes" how many pounds?_____

Have you lost weight over the last 5 years? ☐ Yes ☐ No If "yes" how many pounds?_____

Alcohol Consumption: _____ # of drinks per ☐ day ☐ week ☐ month ☐ year

Occupation History:

Current: _____
Former: _____
If Retired: (when) _____
If Disabled: (when/why) _____
Any Toxin Exposure? (Asbestos, Beryllium, Lead, Coal Dust, Silica or Other) _____

Family History

Relationship	Age	Medical Problems (please list)	Deceased?
Father			
Mother			
Brother			
Brother			
Brother			
Sister			
Sister			
Sister			
Spouse/Partner			

MEDICATIONS

Please list all your medications below and bring bottles with you to your first appointment
*include inhalers, nebulizer solutions over-the-counter, vitamins and health supplements.

Medications	Dosage	Times per Day

ALLERGIES TO MEDICATIONS

Medication	Reaction

VACCINATIONS

Type	If YES What Year
Flu	
Pneumonia or Pneumovax	
Hepatitis	

REVIEW OF SYSTEMS

(Check those symptoms that YOU experience)

CONSTITUTIONAL

- ☐ Change in weight
- ☐ Fever/chills
- ☐ Night sweats

RESPIRATORY:

- ☐ Shortness of breath
- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma/wheezing
- ☐ Dust inhalation

CARDIAC:

- ☐ Chest pain
- ☐ Shortness of breath on reclining
- ☐ Wake up short of breath
- ☐ Racing/irregular heart beat
- ☐ Blackout spells
- ☐ Ankle swelling
- ☐ Aching legs when walking

ALLERGIC:

- ☐ Allergies to dust, pollen, animals
- ☐ Seasonal hay fever

SLEEP:

- ☐ Excessive sleepiness
- ☐ Insomnia
- ☐ Loud snoring
- ☐ Breath stop at night
- ☐ Leg pain at night

GASTROINTESTINAL

- ☐ Nausea/vomiting
- ☐ Vomiting blood
- ☐ Difficulty swallowing
- ☐ Indigestion
- ☐ Abdominal pain
- ☐ Abdominal swelling
- ☐ Yellow jaundice
- ☐ Blood in stool
- ☐ Black tarry stool
- ☐ Diarrhea
- ☐ Constipation
- ☐ Change in bowel habits
- ☐ Hernia
- ☐ Hemorrhoids

GENITOURINARY:

- ☐ Burning on urination
- ☐ Nighttime urination
- ☐ Blood in urine
- ☐ Change in urine stream

EYES,EARS,NOSE,THROAT:

- ☐ Difficulty hearing
- ☐ Ringing in ears
- ☐ Frequent bloody nose
- ☐ Hoarseness
- ☐ Change in vision
- ☐ Double vision

NEUROLOGICAL:

- ☐ Frequent/severe headache
- ☐ Numbness/tingling
- ☐ Uncoordination
- ☐ Weakness
- ☐ Seizures

SKIN:

- ☐ Itching
- ☐ Rash
- ☐ Change in mole
- ☐ Breast pain/lump
- ☐ New lumps

ENDOCRINE:

- ☐ Heat/cold intolerance
- ☐ Neck irradiation
- ☐ Excessive thirst
- ☐ Unusual dietary craving

HEMATOLOGICAL:

- ☐ Anemia
- ☐ Enlarged lymph nodes
- ☐ Excessive bleeding/bruising
- ☐ Blood clots

MUSCULOSKELETAL:

- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Back pain

I have personally reviewed the past medical history, DME, health history, medications, allergies, social history, family history, and review of system during this visit.

_____ _____ _____ _____

Patient Physician Clinical Staff Member Date

(NPQ 10/08) Mod 1/27/09 for Web site download

NOTICE OF PRIVACY PRACTICES FOR BERKS-SCHUYLKILL RESPIRATORY SPECIALISTS, LTD.

EFFECTIVE DATE: April 14, 2003

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

If you have any questions regarding this notice, you may contact our privacy officer at:

Address: Berks-Schuylkill Respiratory Specialists, Ltd.
Attn: Privacy Officer
2608 Keiser Blvd.
Wyomissing, PA 19610

Telephone: 610-685- (LUNG) 5864

Facsimile: 610-929-1528

I. YOUR PROTECTED HEALTH INFORMATION.

Berks-Schuylkill Respiratory Specialists, Ltd. is required by the federal privacy rule, which is published at 45 C.F.R. Part 164 to maintain the privacy of your health information that is protected by the rule, to provide you with notice of our legal duties and privacy practices with respect to your protected healthcare information, and to abide by the terms of the notice currently in effect.

Generally speaking, your protected health information ("Protected Health Information") is any information that relates to your past, present or future physical or mental health or condition, the provision of health care to you, or payment for health care provided to you, to the extent such information individually identifies you or reasonably can be used to identify you.

Your medical and billing records at our practice are examples of information that usually will be regarded as your Protected Health Information.

II. USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION.

A. Treatment, Payment and Health Care Options.

This section describes how we may use and disclose your Protected Health Information for treatment, payment and health care operations purposes. The descriptions include examples. Not every possible use or disclosure for treatment, payment and health care operations purposes will be listed.

1. Treatment.

We may use and disclose your Protected Health Information for our treatment purposes as well as the treatment purposes of other health care providers. Treatment includes the provision, coordination, or management of all health care services to you by one or more health care providers. Some examples of treatment uses and disclosures include:

- Providing supplemental information to your health insurer so that your health insurer can obtain reimbursement from another health plan under a coordination of benefits clause in your subscriber agreement.

- Sharing your demographic information (for example, your address) with other health care providers who seek this information to obtain payment for health care services provided to you.

- Mailing you bills in envelopes with our practice name and return address.

- Provision of a bill to a family member or other person designated as responsible for payment for services rendered to you.

- Allowing your health insurer access to your medical record for a medical necessity or quality review audit.

- Providing consumer reporting agencies with credit information (i.e., your name and address, date of birth, social security number, payment history, account number, and our name and address).

- Providing information to a collection agency or our attorney for purposes of securing a payment of a delinquent account.

- Disclosing information in a legal action for purposes of securing payment of a delinquent account.

2. Payment

We may use and disclose your Protected Health Information for our payment purposes and as well as the payment purposes of other health care providers and health plans. Payment uses and disclosures include activities conducted to obtain payment for the care provided to you or so that you can obtain reimbursement for that care, for example, from your health insurer. Some examples of payment uses and disclosures include:

- Sharing information with your health insurer to determine whether you are eligible for coverage or whether proposed treatment is a covered service.

- Submission of a claim form to your health insurer.

- Providing supplemental information to your health insurer so that your health insurer can obtain reimbursement from another health plan under a coordination of benefits clause in your subscriber agreement.

- Sharing your demographic information (for example, your address) with other health care providers who seek information to obtain payment for health care services provided to you.

- Mailing you bills in envelopes with our practice name and return address.

- Provision of a bill to a family member or other person designated as responsible for payment for services rendered to you.

- Providing medical records and other documentation to your health insurer to support the medical necessity of a health service.

- Allowing your health insurer access to your medical record for a medical necessity or quality review audit.

- Providing consumer reporting agencies with credit information (i.e., your name and address, date of birth, social security number, payment history, and account number and our name and address).

- Providing information to a collection agency or our attorney for purposes of securing payment of a delinquent account.

- Disclosing information in a legal action for purposes of securing payment of a delinquent account.

3. Health Care Options.

We may use and disclose your Protected Health Information for our health care operation purposes as well as certain health care operation purposes or other health care providers and health plans. Some examples of health care operation purposes include:

- Quality assessment and improvement activities.

- Population based activities relating to improving health or reducing health care costs.

- Reviewing the competence, qualifications, or performance of health care professionals.

- Conducting training programs for medical and other students.

- Accreditation, certification, licensing and credentialing activities.

- Health care fraud and abuse detection and compliance programs.

- Conducting other medical review, legal services, and auditing functions.

- Business planning and development activities, such as conducting cost management and planning related analyses.

- Sharing information regarding patients with entities that are interested in purchasing our practice and turning over patient records to entities that have purchased our practice.

- Other business management and general administrative activities, such as compliance with federal privacy rule and resolution of patient grievances.

B. Uses and Disclosures for Other Purposes.

We may use and disclose your Protected Health Information for other purposes. This section generally describes those purposed by category. Each category includes one or more examples. Not every use or disclosure in a category will be listed. Some examples fall into more than one category - not just the category under which they are listed.

1. Individuals Involved in Care or Payment for Care.

We may disclose your Protected Health Information to someone involved in your care or payment for your care, such as a spouse, a family member, or close friend. For example, if you have surgery, we may discuss your physical limitations with a family member assisting in your postoperative care.

2. Notification Purposes.

We may use and disclose your Protected Health Information to notify, or to assist in the notification of, a family member, a personal representative, or another person responsible for your care, regarding of your location, general condition, or death. For example, if you are hospitalized, we may notify a family member of the hospital and your general condition. In addition, we may disclose your Protected Health Information to a disaster relief entity, such as the Red Cross, so that it can notify a family member, a personal representative, or another person involved in your care regarding location, general condition, or death.

3. Required by Law.

We may use and disclose Protected Health Information when required by federal, state, or local law. For example, we may disclose Protected Health Information to comply with mandatory reporting requirements involving births, deaths, child abuse, disease and prevention and control, vaccine-related injuries, medical device-related deaths and serious injuries, gunshot and other injuries by a deadly weapon or criminal act, driving impairments, and blood alcohol testing.

4. Other Public Health Activities.

We may disclose Protected Health Information for public health activities, including:

- Public health reporting, for example, communicable disease reports.
- Child abuse and neglect reports.
- FDA-related reports and disclosures, for example, adverse event reports.
- Public health warning to third parties at risk of a communicable disease or condition.
- OSHA requirements for workplace surveillance and injury reports.

5. Victims of Abuse, Neglect or Domestic Violence.

We may use and disclose Protected Health Information for purposes of reporting of abuse, neglect or domestic violence in addition to child abuse, for example, reports of elder abuse to the Department of Aging or abuse of a nursing home patient to the Department of Public Welfare.

6. Health Oversight Activities.

We may use and disclose Protected Health information for purposes of health oversight activities authorized by law. These activities could include audits, inspection, investigations, licensure actions, and legal proceedings. For example, we may comply with a Drug Enforcement Agency inspection of patient records.

7. Judicial and Administrative Proceedings.

We may use and disclose Protected Health Information disclosures in judicial and administrative proceedings in response to a court order or subpoena, discovery request or other lawful process. For example, we may comply with a court order to testify in a case at which your medical condition is at issue.

8. Law Enforcement Purposes.

We may use and disclose Protected Health Information for certain law enforcement purposes including to:

- Comply with legal process, for example, a search warrant.
- Comply with a legal requirement, for example, mandatory reporting of gun shot wounds.
- Respond to a request for information for identification/location purposes.
- Respond to a request for information about a crime victim.
- Report a death suspected to have resulted from criminal activity.
- Provide information regarding a crime on the premises.
- Report a crime in an emergency.

9. Coroners and Medical Examiners.

We may use and disclose Protected Health Information for purposes of providing information to a coroner or medical examiner for the purposes of identifying a deceased patient, determining a cause of death, or facilitating their performances of duties required by law.

10. Funeral Directors.

We may use and disclose Protected Health Information for purposes of providing information to funeral directors as necessary to carry out their duty.

11. Organ and Tissue Donation.

For purposes of facilitating organ, eye and tissue donation and transplantation, we may use Protected Health Information and disclose Protected Health Information to entities engaged in the procurement, banking, or transplantation of cadaver organs, eyes, or tissue.

12. Threat to Public Safety.

We may use and disclose Protected Health Information for purposes involving a threat to public safety, including protection of a third party from harm and identification and apprehension of a criminal. For example, in certain circumstances, we are required by law to disclose information to protect someone from imminent serious harm.

13. Specialized Government Functions.

We may use and disclose Protected Health Information for purposes of involving specialized government functions including:

- Military and veteran activities.
- National security and intelligence.
- Protective services for The President and others.
- Medical suitability determinations for the Department of State.
- Correctional institutions and other law enforcement and custodial situation.

14. Worker's Compensation and Similar Programs.

We may use and disclose Protected Health Information as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault. For example, this would include submitting a claim for payment to your employer's worker's compensation carrier, if we treat you for a work injury.

15. Business Associates.

Certain functions of the practice are performed by a business associate such as a billing company, an accountant firm, or a law firm. We may disclose Protected Health Information to our business associate and allow them to created and receive Protected Health Information on our behalf. For example, we may share with our billing company information regarding your care and payment for your care so that the company can file health insurance claims and bill you or another responsible party.

16. Creation of De-Identified Information.

We may use Protected Health Information about you in the process of de-identifying the information. For example, we may use your Protected Health Information in the process of removing these aspects, which could identify you, so that the information can be disclosed to a researcher without your authorization.

17. Incidental Disclosures.

We may disclose Protected Health Information as by-product of an otherwise permitted use or disclosure. For example, other patients may overhear your name being paged in the waiting room.

18. Appointment Notification.

We may disclose Protected Health information to confirm by telephone your future appointment. We reserve the right to leave a message on your answering machine to confirm the date and time of your appointment.

C. Uses and Disclosures with Authorization.

For all other purposes, which do not fall under a category, listed under section IIIA and IIIB, we will obtain your written authorization to use or disclose your Protected Health Information. Your authorization can be revoked at any time except to the extent that what we have relies on the authorization.

III. PATIENT PRIVACY RIGHTS.

A. Further Instructions on Use or Disclosure.

You have a right to request that we further restrict use and disclosure of your Protected Health Information to carry out treatment, payment or health care operations, to someone who is involved in their care or the payment for your care, *or* for notification purposes. We are not required to agree to a request for further restriction.

To request a further restriction, you must submit a written request to our privacy officer. The request must tell us: (a) what information that you want restricted; (b) how you want the information restricted; and (c) to whom you want the restriction to apply.

B. Confidential Information.

You have a right to request that we communicate your Protected Health Information to you by a certain means or at a certain location. For example, you might request that we only contact you by mail or at work. We are not required to agree to requests for confidential communications that are unreasonable.

To make a request for confidential communications, you must submit a written request to our privacy officer. The request must tell us how or where you want to be contacted. In addition, if another individual or entity is responsible for payment, the request must explain how payment will be handled.

C. Accounting of Disclosures.

You have a right to obtain, upon request, an "accounting" of certain disclosures of your Protected Health Information to us (or our business associate). This right is limited to disclosures within six (6) years of the request and other limitations. Also, in limited circumstances, we may charge you for providing the accounting. To request an accounting, you must submit a written request to our privacy officer. The request should designate the applicable time period.

D. Inspection and Copying.

You have a 'right to inspect and obtain a copy of your Protected Health Information that we maintain in a designated record set. This right is subject to limitations and we may impose a charge for the labor and supplies involved in providing copies.

To exercise your right of access, you must submit a written request to our privacy officer. The request must: (a) describe the health information to which access is requested, (b) state how you want to access the information, such as inspection, pick-up of copy, mailing of copy, (c) specify any requested form or format, such as paper copy or an electronic means, and (d) include the mailing address, if applicable.

E. Right to Amendment.

You have the right to request that we amend Protected Health Information that we maintain about you in a designated records set if the information is incorrect or incomplete. This right is subject to limitations. To request an amendment, you must submit a written request to our privacy officer. The request must specify each change that you want and provide a reason to support each requested change.

F. Paper Copy of Privacy Notice.

You have a right to receive, upon written request, a paper copy of our Notice of Privacy Practices. To obtain a paper copy, contact our privacy officer.

IV. CHANGES TO THIS NOTICE.

We reserve the right to change this notice at any time. We further reserve the right to make any change effective for all Protected Health Information that we maintain at the time of the change - including information that we created or received prior to the effective date of the change.

We will post a copy of our current notice in the waiting room of our practice. At any time, patients may review the current notice by contacting our privacy officer.

V. COMPLAINTS.

If you believe that we have violated your privacy rights, you may submit a complaint to the practice or the Secretary of Health and Human Services. To file a complaint with the practice, submit the complaint in writing to our privacy officer. We will not retaliate against you for filing, although we reserve our right to respond to any such complaint.

VI. LEGAL EFFECT OF THIS NOTICE.

This notice is not intended to create contractual or other rights independent of those created in the federal privacy rule.

Berks Schuylkill Respiratory Specialists

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND
CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgment of notice and consent authorizes Berks Schuylkill Respiratory Specialists to use and disclose health information about you for treatment, payment, and health care operations purposes.

Notice of Privacy Practices. Berks Schuylkill Respiratory Specialists has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any changes effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

How to contact our Privacy Officer:

Address:	RESPIRATORY SPECIALISTS, Privacy Officer 2608 Keiser Blvd., Wyomissing, PA 19610
Telephone:	610-685- (LUNG) 5864
Facsimile:	610-929-1528

Acknowledgment and Consent

Print or type all information except the signature

I have received the Notice of Privacy Practices for Berks Schuylkill Respiratory Specialists. Berks Schuylkill Respiratory Specialists is authorized to use and disclose health information about

____

(patient name)

for treatment, payment, and healthcare operations purposes consistent with its Notice of Privacy Practices.

_ ____ / ____ / ____

Signature of patient Date

(or patient's personal representative)

Personal representative information (if applicable):

____

Name of personal representative

____

Relationship to patient (or other authority)

ACKNOWLEDGEMENTT OF RECEIPT OF NOTICE

I acknowledge that I received the Notice of Privacy Practices for Berks Schuylkill Respiratory Specialists.

____
Name of Patient (Print)

_ ____ / ____ / ____
Signature of Patient Date of Receipt
(or patient's personal representative)

Personal representative information (if applicable)

____ ________________________________
Name of personal representative Relationship to patient (or other authority)

GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT RECEIPT OF NOTICE

I provided the above named patient/personal representative with the Notice of Privacy Practices for Berks Schuylkill Respiratory Specialists.

Describe how notice was provided:

_ _ _ _ _ _ _1. Offered copy and individual refused to accept delivery
_ _ _ _ _ _ _2. Offered copy and individual accepted delivery

_ _
Signature Date