Last Name: ______________________

First Name: ______________________

Birthdate:

Bayview Physician Services Office Policy

Thank you for choosing us as your health care provider. Our staff and physicians are committed to providing you the best service we can. The following is a statement of our office policy.

To ensure our system is set up accurately, we ask that you complete our registration form and provide us with a valid medical insurance card and a photo ID, as well as new insurance cards as they become available.

We accept assignment of insurance benefits as a courtesy to our patients. Any remaining balance will be the patient's responsibility. Deductibles applied by your insurance, not covered by another insurance, will also be the patient's responsibility. Services may require a referral or authorization prior to being seen. Please be aware that some services provided may not be covered by Medicare or other insurances and may be considered not medically necessary, experimental or investigational. Unless valid insurance is presented, patients will be responsible for payment in full at the time of visit. All copayments are to be paid at the time service is rendered.

Please be aware that some visits performed by the nursing staff, without seeing a doctor, are considered an office visit and fees will be charged accordingly.

As a service to our patients, we will send you electronic appointment reminders and possibly other important electronic messages. By providing your email address and/or cell phone number, you consent to receive electronic messages by such means. We will not provide your information to any other entity.

To ensure accurate processing of prescriptions, we ask that all refill requests are processed through your pharmacy. Your pharmacy can still request the refill even if you have no refills remaining. Routine refill requests may take up to 48 hours; however our goal is to process all requests the same day.

Referral requests may take several days to process, depending on the insurance company. Please call our receptionist with the name of the specialist, their phone number, date of your appointment and your diagnosis. Also, it may take 24-48 hours to process forms, depending on the amount of detail requested.

We are happy to provide you with a copy of your medical record. There is a fee for copied medical records. We will notify you of the records fee and it should be paid prior to the release of the records. We require at least 5 business days to receive copies of medical records.

We recognize that from time to time, you may need to have a medical form completed. To ensure we are able to meet the appropriate deadlines, please ensure that we receive this form as soon as possible. Depending on the information needed on the form, it could take several days for us to complete it.

Should you arrive late for an appointment, please be aware that you may be asked to reschedule or you may have to wait to be seen between or after the other patients who have arrived at their scheduled time.

Your appointment is very important to us. If you are unable to make your scheduled appointment, unless canceled at least 24 hours in advance, we reserve the right to charge a No Show/Late cancellation fee of up to $50.00. Please help us serve you better by keeping your scheduled appointments.

I, ______________________ have read, understand and agree to the office policy of Bayview Physicians Group.

______________________ Signature of Responsible Party

______________________ Date

Patient Information

BAYVIEW

Patient Information

Last Name	First	Middle Initial	Social Security No.

Address	City	State	Zip Code

Sex	Marital Status	Birthdate	Age	Occupation	Employer
☐ M ☐ F	☐ S ☐ M ☐ D ☐ W	/ /			

Home Phone	Work Phone	Cell Phone

Email Address:	Preferred Contact Method:

Race			Ethnicity	Preferred Language
☐ Native Hawaiian or other Pacific Islander	☐ Other race	☐ Decline	☐ Not Hispanic or Latino	
☐ American Indian or Alaska Native	☐ Asian		☐ Hispanic or Latino	
☐ Black or African American	☐ White/Caucasian		☐ Decline	☐ Decline

Emergency Contact Name	Relationship	Phone

Responsible Party

Responsible Party - Last Name	First	Middle Initial	Birthdate	Social Security No.
			/ /	

Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Relationship to Patient	Occupation	Employer

Privacy

HIPAA Acknowledgements: All patients must initial all that apply:

_____ I hereby acknowledge that I have been provided with a copy of the Bayview Physicians Group Notice of Privacy Policies.

_____ Is it ok to leave a message regarding your health information at your : ☐ Home ☐ Cell ☐ No Messages Initials: _____

_____ By default, no other persons may have access to my medical record except the following people:

Name & Relationship	

Insurance

For your convenience, we will assist you or supply you with the information necessary to file your medical insurance. Please allow us to copy your insurance cards.

Insurance Co. #1		Insurance Co. #2	
Company Name		Company Name	
ID No.	Group No.	ID No.	Group No.
Subscriber's Name	Date of Birth	Subscriber's Name	Date of Birth
Relation to Patient	SS#:	Relation to Patient	SS#:

Consent, Agreements & Signature

Deemed Consent - Consent for Treatment - Release of Medical Information - Electronic Communications - No Guarantee

Under Virginia Law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transm human immunodeficiency virus (HIV) or Hepatitis B or C viruses, you shall be deemed to have consented to testing for infectious with HIV o hepatitis B or C viruses. In addition, you shall be deemed to have consented to the release of such test results to the person who was exposec _____

I, the undersigned, as the patient or on behalf of the above named patient hereof, do hereby consent to and authorize all diagnostic an therapeutic treatment considered necessary or advisable in the judgment of the physician on duty or the referring physician, as well as an testing and/or treatment carried out by Bayview Physician Services, PC staff under the direction of the Medical Director _____

I agree that Bayview Physicians Group may request and use my prescription medication history from other healthcare providers or third-part pharmacy benefit payors for treatment purposes _____

We will send you appointment reminders and other important electronic messages by text and email. By providing your email address and/or ce phone number, you consent to receive electronic messages by such means. We will not share your information. You can opt out at anytime _____

Chaperones will be present during certain examinations. Any request for a chaperone made by a patient and/or family member will be honored. I understand that no guarantee or assurance has been made as to the results which may be obtained from any exam, testing or treatment.

Financial Agreement - Insurance Agreement

I hereby authorize treatment to patient by any Bayview Physicians Group provider and/or affiliated medical staff member(s). I further authoriz release of any and all medical and/or billing information as is necessary for reimbursement from any insurance carrier, Tricare or Medicare I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that payor determines does nc constitute as covered services, including denied Worker's Compensation claims, as well as attorney fees of 33 1/3% and other related costs o collection should such action become necessary.

Signature of Patient/Responsible Party	Relationship to Patient	Date
X		

Last Name: ____________________

First Name: ____________________

Birthdate:

BAYVIEW PHYSICIANS GROUP

Intake History

Immunizations & Preventative Services: *(Check all that apply and indicate date last received.)*

- ☐ Tetanus ______
- ☐ Pneumonia vaccine ______
- ☐ Flu shot
- ☐ Sigmoid or colon exam ______
- ☐ Mammogram ______
- ☐ TB skin test
- ☐ PSA ______

Family History

	Living	Dead	Age	Chronic Condition(s)/Cause of Death
Father				
Mother				
Brothers (No.)				
Sisters (No.)				
Spouse				
Children (No.)				

Check All Conditions Affecting *Your Relatives*

Condition	Relation	Condition	Relation	Condition	Relation
☐ Seizures or convulsions		☐ Heart trouble		☐ Thyroid problems	
☐ Stroke		☐ COPD		☐ Mental illness	
Respiratory		☐ High Blood Pressure		☐ Sarcoidosis	
☐ Allergies		☐ Stomach or duodenal ulcer		☐ Bleeding problems	
☐ Asthma		☐ Liver disease		☐ Sickle cell disease	
☐ Emphysema		☐ Colon or bowel trouble		☐ Cancer, Lungs	
☐ Tuberculosis		☐ Diabetes		☐ Other	

Social/Personal History: *(Please complete the following information about yourself.)*

Current occupation: ______

Education completed:

☐ Grade ______ ☐ High School ☐ College: ______ years, degree/major ______ ☐ Post-graduate: ______

Marital Status:

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Personal Habits: ***(check all that apply)***

- ☐ Currently use *tobacco*: Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless tobacco Amount/day: ______ Years: ______
- ☐ Former smoker: Amount/day: ______ Years: ______ Quit Date: ______
- ☐ Exposed to second-hand smoke
- ☐ Consume *alcohol*: Type: ______ Amount/Day: ______
- ☐ Consume *recreational drugs*: Type: Frequency:

Past Medical History: *Hospitalizations and Surgeries*

Reason/Diagnosis/Procedure	Date	Reason/Diagnosis/Procedure	Date

Patient Name:	DOB:

Intake History (continued)

Medical Illnesses or Conditions: (Conditions you now have or have had in the past.)

Condition	Onset Date	Condition	Onset Date	Condition	Onset Date
☐ Migraine headaches		☐ Stomach or duodenal ulcer		☐ Angina	
☐ Seizures or convulsions		☐ Hepatitis		☐ Enlarged Heart	
☐ Stroke		☐ Cirrhosis		☐ Rheumatic fever	
☐ Glaucoma		☐ Gall stones		☐ High blood pressure	
☐ Cataracts		☐ Colon or bowel trouble		☐ Chronic heartburn/GEDO	
☐ Blindness		☐ Recurrent urinary infections		☐	
☐ Recurrent ear infections		☐ Kidney stones		☐ Recurrent boils	
☐ Deafness		☐ Other kidney disease		☐ Skin problems	
☐ Hay Fever, seasonal allergies		☐ Arthritis		☐ Serious depression	
☐ Recurrent sinusitis		☐ Gout		☐ Serious emotional problems	
☐ Asthma		☐ Varicose veins		☐ Nervous breakdown	
☐ Chronic Bronchitis		☐ Bleeding problems		**Women:**	
☐ Emphysema		☐ Anemia		☐ Menstrual difficulties	
☐ Tuberculosis		☐ Diabetes		☐ Ovarian cyst(s)	
☐ Phlebitis or blood clots		☐ Overactive Thyroid		☐ Breast lump(s)	
☐ Heart murmur		☐ Underactive Thyroid			
☐ LVNG cancer		☐ HIV Infection		**Men:**	
☐ Heart attack		☐ Herpes infection		☐ Prostate trouble	

Current Medications: (Include non-prescription products)

Drug Name	Dose

Allergies: (Include drugs, food, chemicals, insects, etc.)

NOTICE OF PRIVACY PRACTICES

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

Effective Date: 9 /23/2013
If you have any questions about this notice, please contact Bayview Physicians Group's Privacy Officer at :
(757)686-3500.

<u>WHO WILL FOLLOW THIS NOTICE</u>

This notice describes the practices of:
Bayview Physicians Group.
Any health care professional authorized to enter information into your medical record maintained by Bayview Physicians Group.
Any persons or companies with whom Bayview Physicians Group contracts for services to help operate our practice and who have access to your medical information.
All these persons, entities, sites, and locations follow the terms of this notice. In addition, these persons, entities, sites, and locations may share medical information with each other for treatment, payment, or health care operations purposes and other purposes described in this notice.

<u>OUR PLEDGE REGARDING MEDICAL INFORMATION</u>

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive from Bayview Physicians Group. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care and billing for that care that are generated or maintained by Bayview Physicians Group, whether made by Bayview Physicians Group personnel or other health care providers. Other health care providers may have different policies or notices about confidentiality and disclosure that apply to your medical information that is created in their offices or at locations other than Bayview Physicians Group.
This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of your medical information.

We are required by law to:
Make sure that medical information that identifies you is kept private;
Give you this notice of our legal duties and privacy practices at Bayview Physicians Group, and your legal rights, with respect to medical information about you; and
Follow the terms of the notice that is currently in effect.

<u>HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU</u>

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean an try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

<u>For Treatment</u>. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, volunteers, or other personnel who are involved in taking care of you at Bayview Physicians Group. For example, a doctor treating you for a broken hip may need to know if you have diabetes because diabetes may slow the healing process. We also may disclose medical information about yo to people outside Bayview Physicians Group who may be involved in your medical care after you have been treated by Bayview Physicians Group, such as friends, family members, or employees or medical staff members of any hospital or skilled nursing facility to which you are transferred or subsequently admitted.

<u>For Payment</u>. We may use and disclose medical information about you so that the treatment and services you receive from Bayview Physicians Group may be billed by Bayview Physicians Group and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about treatment you received from Bayview Physicians Group so your health plan will pay us or reimburse you for the treatment. We also may disclose information about you to another health care provider, such as a hospital or skilled nursing facility to which you are admitted, for their payment activities concerning you.

<u>For Health Care Operations</u>. We and our business associates may use and disclose medical information about you for health care operations. These uses and disclosures are necessary to run Bayview Physicians Group and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services Bayview Physicians Group should offer, and what services are not needed. We may also disclose information to doctors, nurses, technicians, and other personnel affiliated with Bayview Physicians Group for review and learning purposes. We may also combine the medical information we have with medical information from other health care providers to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of medical information so others may use it to study health care and health care delivery without learning the identities of specific patients. We also may disclose information about you to another health care provider for its health care operations purposes if you also have received care from that provider.

<u>Treatment Alternatives</u>. We may use and disclose medical information to tell you about or recommend different ways to treat you.

<u>Research</u>. Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. Medical information about you that has had identifying information removed may be used for research without your consent. We also may disclose medical information about you to people preparing to conduct a research project (for example, to help them look for patients with specific medical needs), so long as the medical information they review does not leave Bayview Physicians Group. If the researcher will have information about your mental health treatment that reveals who you are, we will seek your consent before disclosing that information to the researcher. Unless we notify you in advance and you give us written permission, we will not receive any money or other thing of value i connection for using or disclosing your medical information for research purposes except for money to cover the costs of preparing and sending the medical information to the researcher.

<u>Individuals Involved in Your Care or Payment for Your Care</u>. We may release medical information about you to a friend or family member who is involved in your medical care. This would include persons named in any durable health care power of attorney or similar document provided to us. We may also give information to someone who helps pay for some or all of your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that

someone who helps pay for some or all of your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so tha your family can be notified about your condition, status, and location. You can object to these releases by telling us that you do not wish any or all individuals involved in your care to receive this information. If you are not present or cannot agree or object, we will use our professional judgment to decide whether it is in your best interest to release relevant information to someone who is involved in your care or to an entity assisting in a disaster relief effort.

As Required or Permitted By Law. We may disclose medical information about you when required or permitted to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when it appears necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would be to someone who appears able to help prevent the threat and will be limited to the information needed.

SPECIAL SITUATIONS

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation, or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

Active Duty Military Personnel and Veterans. If you are an active duty member of the armed forces or Coast Guard, we must give certain information about you to your commanding officer or other command authority so that your fitness for duty or for a particular mission may be determined. We may also release medical information about foreign military personnel to the appropriate foreign military authority. We may use and disclose to components of the Department of Veterans Affairs medical information about you to determine whether you are eligible for certain benefits.

Workers' Compensation. In accordance with state law, we may release without your consent medical information about your treatment for a work-related injury or illness or for which you claim workers' compensation to your employer, insurer, or care manager paying for that treatment under a workers' compensation program that provides benefits for work-related injuries or illness.

Public Health Risks. We may disclose without your consent medical information about you for public health activities. These activities generally include but are not limited to the following:

To report, prevent or control disease, injury, or disability;
To report births and deaths;
To report reactions to medications or problems with products;
To notify people of recalls of products they may be using;
To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and
To report suspected abuse or neglect as required by law.

Health Oversight Activities. We may disclose without your consent medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. The government uses these activities to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we must disclose medical information about you in response to a court or administrative order. We also may disclose medical information about you in response to a subpoena or other lawful process from someone involved in a civil dispute.

Law Enforcement. We may release without your consent medical information to a law enforcement official:

In response to a court order, warrant, summons, grand jury demand, or similar process;
To comply with mandatory reporting requirements for violent injuries, such as gunshot wounds, stab wounds, and poisonings;
In response to a request from law enforcement for certain information to help locate a fugitive, material witness, suspect, or missing person;
To report a death or injury we believe may be the result of criminal conduct; and
To report suspected criminal conduct committed at Bayview Physicians Group facilities.

Coroners and Medical Examiners. We may release without your consent medical information to a coroner or medical examiner. This may be done, for example, to identify a deceased person or determine the cause of death. We also may release medical information about deceased patients of Bayview Physicians Group to funeral directors to carry out their duties.

National Security and Intelligence Activities. We may release without your consent medical information about you as required by applicable law to authorized federal or state officials for intelligence, counterintelligence, or other governmental activities prescribed by law to protect our national security.

Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons, or foreign heads of state, or to conduct special investigations.

Psychotherapy Notes. Regardless of the other parts of this Notice, psychotherapy notes will not be disclosed outside the Bayview Physicians Group except as authorized by you in writing or pursuant to a court order, or as required by law. Psychotherapy notes about you will not be disclosed to personnel working within Bayview Physicians Group, except for training purposes or to defend a legal action brought against Bayview Physicians Group, unless you have properly authorized such disclosure in writing.

Inmates. If you are an inmate of a correctional institution or in the custody of law enforcement, we may release medical information about you to the correctional institution or law enforcement official who has custody of you, if the correctional institution or law enforcement official represents to Bayview Physicians Group that such medical information is necessary: (1) to provide you with health care; (2) to protect your health and safety or the health and safety of others; (3) to protect the safety and security of officers, employees, or others at the correctional institution or involved in transporting you; (4) for law enforcement to maintain safety and good order at the correctional institution; or (5) to obtain payment for services provided to you. If you are in the custody of the North Carolina Department of Corrections ("DOC") and the DOC requests your medical records, we are required to provide the DOC with access to your records.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and receive a copy of your medical record unless your attending physician determines that information in that record, if disclosed to you, would be harmful to your mental or physical health. If we deny your request to inspect and receive a copy of your medical information on this basis, you may request that the denial be reviewed. Another licensed health care professional chosen by Bayview Physicians Group will review your request and the denial. The person conducting the review will not be the person who denied your request. We will do what this reviewer decides.

If we have all or any portion of your medical information in an electronic format, you may request an electronic copy of those records or request that we send an electronic copy to any person or entity you designate in writing.

Your medical information is contained in records that are the property of Bayview Physicians Group. To inspect or receive a copy of medical information that may be used to make decisions about you, you must submit your request in writing to Bayview Physicians Group's Privacy Officer. If you request a copy of the information**we may charge a fee** for the costs of copying, mailing, or other supplies associated with your request, and we may collect the fee before providing the copy to you. If you agree, we may provide you with a summary of the information instead of providing you with access to it, or with an explanation of the information instead of a copy. Before providing you with such a summary or explanation, we first will obtain your agreement to pay and will collect the fees, if any, for preparing the summary or explanation.

Right to Amend. If you feel that medical information we have about you in your record is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for Bayview Physicians Group.

To request an amendment, make your request in writing to Bayview Physicians Group's Privacy Officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

us to amend information that:
Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
Is not part of the medical information kept by or for Bayview Physicians Group;
Is not part of the information that you would be permitted to inspect and copy; or
Has been determined to be accurate and complete.
If we deny your request for an amendment, you may submit a written statement of disagreement and ask that it be included in your medical record.
Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we have made of medical information about you during the past six years. To request this list or accounting of disclosures, submit your request in writing to Bayview Physicians Group's Privacy Officer and state whether you want the list on paper or electronically. Your request must state a time period that may not be longer than six years. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We may collect the fee before providing the list to you.
Right to Request Restrictions. Except where we are required to disclose the information by law, you have the right to request a restriction or limitation on the medical information we use or disclose about you. For example, you could revoke any and all authorizations you previously gave us relating to disclosure of your medical information.
We are not required to agree to your request, with the exception of restrictions on disclosures to your health plan, as described below If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
To request restrictions, make your request in writing to Bayview Physicians Group's Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.
You may request that we not disclose your medical information to your health insurance plan for some or all of the services you receive during a visit to any Bayview Physicians Group location. If you pay the charges for those services you do not want disclosed ***in full at the time of such service***, we are required to agree to your request. "In full" means the amount we charge for the service, not your copay, coinsurance, or deductible responsibility when your insurer pays for your care. Please note that once information about a service has been submitted to your health plan, we cannot agree to your request. If you think you may wish to restrict the disclosure of your medical information for a certain service, please let us know as early in your visit as possible.
Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, or at another mailing address other than your home address. We will accommodate all reasonable requests. We will not ask you the reason for your request. To request confidential communications, make your request in writing to the Privacy Officer and specify how or where you wish to be contacted.
Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice or any revised notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
To obtain a paper copy of this notice, request a copy from Bayview Physicians Group's Privacy Officer in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice at Bayview Physicians Group's office. The notice will contain the effective date on the first page, in the top right-hand corner. If the notice changes, a copy will be available to you upon request.

INVESTIGATIONS OF BREACHES OF PRIVACY

We will investigate any discovered unauthorized use or disclosure of your medical information to determine if it constitutes a breach of the federal privacy or security regulations addressing such information. If we determine that such a breach has occurred, we will provide you with notice of the breach and advise you what we intend to do to mitigate the damage (if any) caused by the breach, and about the steps you should take to protect yourself from potential harm resulting from the breach.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Bayview Physicians Group or with the Secretary of the United States Department of Health and Human Services. To file a complaint with Bayview Physicians Group, contact our Privacy Officer by mail at 3241Western Branch Blvd. Chesapeake, VA 23321. All complaints must be submitted in writing.
You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice may be made only with your written authorization or as required by law. If you authorize us to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. Your revocation will be effective as of the end of the day on which you provide it in writing to Bayview Physicians Group's Privacy Officer. If you revoke your permission, we will no longer use or disclose medical information about you for the purposes that you previously had authorized in writing. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Last Name:	
First Name:	
Birthdate:	

Sleep Apnea Brief Questionnaire

You are going to be evaluated in the Sleep Clinic to rule out the possibility of Sleep Apnea (having pauses in your breathing while you sleep and snoring).

SS#

Best way to get in touch with you to schedule further tests:

Telephone/Cell:	Email:	Address:

Please answer the following questions:

1	What is the time that you most commonly sleep?	☐ Days ☐ Nights
2	Do you snore?	☐ Yes ☐ No ☐ Unknown
3	Is your snore:	☐ Soft/occasional ☐ Loud/can be heard in adjacent room ☐ Loud/can be heard throughout the house
4	Have you been told that you stop breathing, snort, or gasp for air while sleeping?	☐ Yes ☐ No
5	How many pounds have you gained in the last year: ______ Last 5 years: ______ Weight: Height: Collar size of your shirt:	

Sleepiness: Today, how likely are you to doze off or fall asleep in the following situations, in contrast to feeling tired. Check the best answer for each situation.

	0=Never 1=Slight 2=Moderate 3=High	
6	Sitting and Reading	☐ 0 ☐ 1 ☐ 2 ☐ 3
7	Watching TV	☐ 0 ☐ 1 ☐ 2 ☐ 3
8	Sitting inactive in a public place: e.g. theater	☐ 0 ☐ 1 ☐ 2 ☐ 3
9	As a passenger in a car for an hour without a break	☐ 0 ☐ 1 ☐ 2 ☐ 3
10	Lying down to rest in the afternoon, when circumstances permit	☐ 0 ☐ 1 ☐ 2 ☐ 3
11	Sitting and talking to someone	☐ 0 ☐ 1 ☐ 2 ☐ 3
12	Sitting quietly after lunch without alcohol	☐ 0 ☐ 1 ☐ 2 ☐ 3
13	In a car while stopped for a few minutes in traffic.	☐ 0 ☐ 1 ☐ 2 ☐ 3
	Total	

Using this scale, how would you rate the following symptoms:

	0=None 1=Mild 2=Moderate 3=Severe 4=Very Severe	
1	Uncomfortable feelings in the legs and/or arms at rest in the evening or at night:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
2	Need or urge to move around for relief when at rest in evening or at night:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
3	Uncomfortable jerks in your legs or arms that occur when you rest in the evening or at night:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
4	Difficult in getting to sleep when you first lie down to sleep:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
5	Difficult staying asleep during the night after you have first been asleep:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
6	Sleepiness or fogginess during the day:	☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
	Total	

Last Name: ____________	
First Name: ____________	
Birthdate:	

General Questionnaire Section

Directions: Please answer the following questions by checking "yes" or "no" or by filling in the blank.

Work History and Sleep:

#	Question				
1	Are you employed? If answer is "no" skip down to question #8.			☐ Yes	☐ No
2	What is your current job?				
3	How long have you been at your current job?	Years		Months	
4	How many hours per week do you work?			Hours	
5	What time do you report for work?		am		pm
6	What time do you complete your work?		am		pm
7	Do you work rotating shifts?'			☐ Yes	☐ No
8	What time do you usually go to bed on weekdays?		am		pm
9	What time do you wake up on weekdays?		am		pm
10	At what time do you leave your bed after awaking on a typical weekday?				
11	How many naps (actually falling asleep for 5 minutes or more) do you take WHEN NOT INTENDING TO during a usual workday?				naps
12	Do you have a normal schedule? (A normal work schedule begins 8-9am and ends at 4-5pm Monday thru Friday.)			☐ Yes	☐ No

Weekends or Holidays:

#	Question				
13	What time do you actually go to bed on weekends?		am		pm
14	At what time do you wake up on weekends?		am		pm
15	At what time do you leave your bed after awaking on a typical weekend?		am		pm
16	How long does it usually take you to fall asleep after deciding to go to sleep?		hours		min
17	What is the total number of hours of sleep that you usually get a night? (DO NOT INCLUDE time you spend awake in bed during the night.)		hours		min
18	How many times do you wake up during a typical night's sleep?		times		
19	When you wake up, how long do you usually stay awake?		hours		min
20	During the last six months, how many times have you almost been involved in an automobile accident because of sleepiness?		times		
21	Do you try to avoid driving an automobile because you get so sleepy while driving?			☐ Yes	☐ No
22	Do you sleep with someone else in the room?			☐ Yes	☐ No
23	Do you sleep with someone else in the bed?'			☐ Yes	☐ No
24	Have you given up trying to have sexual intercourse because you have had trouble performing?			☐ Yes	☐ No
25	Have you ever been told that you snore while you are asleep?			☐ Yes	☐ No
26	Have you ever been told that you stop breathing while you are asleep?			☐ Yes	☐ No
27	Have you ever "come to" and found yourself doing things without being aware of having started them?			☐ Yes	☐ No
28	Have you taken anything in the last month to help you sleep?			☐ Yes	☐ No
(a)	If you have, what is the name?				
(b)	During the last month, how many nights have you taken something?		nights		
29	How many times do you usually get up during the night to urinate?		times		

30	How many alcoholic drinks do you have during a usual 24 hour period?	**Weekday**	**Weekend**
	Cans of Beer?	Drinks	Drinks
	Glasses of Wine?	Drinks	Drinks
	Shots of mixed drinks of liquor?	Drinks	Drinks

#	Question		
31	Has anyone in your family died suddenly in their sleep?	☐ Yes	☐ No
32	Has anyone in your immediate family (grandparents, parents, children-not including yourself):		
(a)	Had trouble with restless (twitchy) legs while sleeping (or trying to sleep)?	☐ Yes	☐ No
(b)	Had breathing problems at night?	☐ Yes	☐ No
(c)	Had loud snoring at night?	☐ Yes	☐ No
(d)	Died from "cot death" (crib death, sudden infant death syndrome)?	☐ Yes	☐ No

Last Name:		
First Name:		
Birthdate:		

Review of Systems

Please check all that apply to you.

General:			
☐ Weight loss/gain	☐ Increased thirst	☐ Use recreational drugs	☐
☐ Fatigue	☐ Insomnia	☐	☐
Head/Eyes/Ears/Nose/Throat:			
☐ Frequent Headaches	☐ Eye trouble	☐ Motion sickness	☐ Dentures
☐ Blurred vision	☐ Hearing loss	☐ Frequent sore throats	☐ Taste change
☐ See halos on lights	☐ Ringing in ears	☐ Hoarseness	☐ Congested/runny nose
☐ Double vision	☐ Frequent ear infections	☐ Bleeding gums	☐ Frequent nose bleeds
☐ Eye pain/itching	☐ Ear aches	☐ Toothache	☐
Neck:			
☐ Swelling/lump in neck	☐ Neck pain	☐	☐
Lungs:			
☐ Frequent cough	☐ Night sweats	☐ Cough up phlegm	☐
☐ Cough up blood	☐ Wheezing	☐ Sleep on several pillows	☐
☐ Frequent chest colds	☐ Short of breath easily	☐	☐
Heart and Vessels:			
☐ High blood pressure	☐ Dizzy spells	☐ Leg cramps	☐ Skipped heart beats
☐ Racing heart/palpitations	☐ Shortness of breath	☐ Heart murmur	☐
☐ Chest pain	☐ Swollen feet/ankles	☐ Phlebitis/blood clots	☐
Digestive:			
☐ Loss of appetite	☐ Abdominal pain	☐ Heartburn	☐
☐ Trouble swallowing	☐ Change in bowel habits	☐ Hemorrhoids	☐
☐ Nausea/vomiting	☐ Constipation/diarrhea	☐ Change in stool color	☐
Urinary:			
☐ Pain or burning with urination	☐ Frequent infections	☐ Blood in urine	☐
☐ Loss of control	☐ Change in color/odor	☐ Urinate times a night	☐
Male Genital:			
☐ Poor or weak stream of urine	☐ Prostate trouble	☐ Pain in testicles	☐
☐ Discharge	☐ Lump on testicles	☐ Problem with erections	☐
Female Genital:			
☐ Last period begin: ________	☐ Vaginal bleeding	☐ Breast soreness	☐
☐ Pain with sex	☐ Ovary/Uterus trouble	☐ Breast lumps	☐
☐ Loss of desire	☐ Vaginal discharge	☐	☐
Musculoskeletal:			
☐ Muscle aches	☐ Painful swollen joints	☐ Back pain	☐
Skin:			
☐ Rashes	☐ Itching	☐	☐
☐ Bruise/bleed easily	☐ Acne/pimples	☐	☐
Mood:			
☐ Anxiety/Nervousness	☐ Depression	☐ High stress	☐
☐ Crying spells	☐ Mood swings	☐ Poor concentration	☐
☐ Thoughts of suicide	☐ Sexual problems	☐	☐
Sleep:			
☐ Trouble going to sleep	☐ Excessive Daytime Fatigue	☐	☐
☐ Trouble keeping asleep	☐ Gasping at night	☐ Snoring	☐

Comments:

Last Name: ______________________	
First Name: ______________________	
Birthdate:	

Insomnia Severity Index (ISI)

1 Please rate the current (i.e., last week) **SEVERITY** of your insomnia problem(s).

	<30 min None	30-45 Mild	45-90 Moderate	90-120 Severe	>120 Very
Difficulty falling asleep:	0	1	2	3	4
Difficulty staying asleep:	0	1	2	3	4
Problem waking up too early:	0	1	2	3	4

2 How **SATISFIED**/dissatisfied are you with your current sleep pattern?

Very Satisfied				Very Dissatisfied
0	1	2	3	4

3 To what extent do you consider your sleep problem to **INTERFERE** with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)

Not at all Interfering	A Little	Somewhat	Much	Very Much Interfering
0	1	2	3	4

4 How **NOTICEABLE** to others do you think your sleeping problem is in terms of impairing the quality of your life?

Not at all Noticeable	Barely	Somewhat	Much	Very Much Noticeable
0	1	2	3	4

5 How **WORRIED**/distressed are you about your current sleep problem?

Not at all	A Little	Somewhat	Much	Very Much
0	1	2	3	4

Acknowledgement of Receipt

I have been given a copy of Bayview Physicians Group's Notice of Privacy Practices, version effective **September 23, 2013**. I consent to the uses and disclosures of my health information as outlined in the Notice.

Privacy Options

☐ **I want NO ONE to receive my Personal Health Information except myself.**

☐ **I request the following person(s) BE ALLOWED to access my Personal Health Information:**

________________________ ________________________

________________________ ________________________

☐ **I request the following person(s) NOT BE ALLOWED to access my Personal Health Information:**

________________________ ________________________

________________________ ________________________

Communications

I give permission to leave a verbal message at my personal residence.	____ **Yes**	____ **No**
I give permission to leave a message regarding my appointment on my voicemail.	____ **Yes**	____ **No**
I give NowCare permission to release any urgent care notes to my personal physician.	____ **Yes**	____ **No**
I give permission to call me at work. Work Phone: ________________	____ **Yes**	____ **No**

Please Sign

Patient's Name (Print)	Patient's Signature	Date
Lname, Fname		

If you are signing on behalf of the patient, please complete this section:

Representative's Name (Print)	*Representative's Signature*	*Date*

Reason Patient Cannot Sign

*** Office Use Only ***

If acknowledgment of receipt of the Notice of Privacy Practices is not obtained from the patient or the patient's representative, please explain your efforts to obtain acknowledgment and the reason you could not obtain it: