St. Francis
SLEEP, ALLERGY & LUNG
INSTITUTE
Giving of ourselves... so you receive... the best care.

Frank Averill, MD
Medical Director
802 N. Belcher Road
Clearwater, FL 33765
Phone 727.447.3000
Fax 727.210.4600
www.StFrancisMed.com

Welcome to St. Francis Sleep, Allergy & Lung Institute

We are pleased to be your specialist. To provide you with the best quality healthcare we have a top-notch medical team, under the direction of Dr. Frank Averill, to collaborate with you for your health and wellness.

While we do have a team of professionals and support staff who will be involved in your medical care, YOU are the most important member of the team. We need you to become an active participant in managing your health, by making sure we have all the information needed to provide you with care safely and effectively. We ask you to inform us of all changes in medications, primary care, specialists, pharmacy, and insurance, as well as any hospitalizations in between visits.

By following the provider's orders and taking care of yourself, we can help to maintain or improve your health. We encourage you to ask as many questions as possible to make sure you understand the coordination of your care.

As a new patient, please arrive 20 minutes before the scheduled time to allow for registration and 10 minutes before your follow-up appointments. If you are more than 20 minutes late, you may experience longer wait times and may have to reschedule.

We reserve the appointment time especially for you. If you are not able to make the scheduled appointment, it is important that you notify us as soon as possible. If we do not receive notice 24 hours prior to the appointment a fee may be charged.

Please be sure to bring the following to every appointment:

- Your current health insurance card (including secondary if you have one)
- Any co-payment or coinsurance that your insurance requires at the time of service
- Any records related to your appointment
- A list of medications and dosage

Your initial appointment is _____, _____/_____/_____ @ ____: ____ am/pm

New patient forms must be completed prior to your first appointment.

Our entrance is on Belcher Rd located on the west side of Belcher. The driveway is immediately north of the shopping center, which is north of NE Coachman Road.

We look forward to collaborating with you to keep you healthy and happy! Have a blessed day!

The team at St. Francis, Sleep, Allergy & Lung Institute.

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PATIENT ACKNOWLEDGEMENT
APPOINTMENT CANCELLATION POLICY

A cancellation or rescheduling made without proper notice significantly limits our ability to make the appointment available for another patient in need.

To remain consistent with our mission, we have instituted the following policy:

1. If you need to cancel or reschedule your appointment, the office must be notified at least **one business day prior to your appointment, Monday-Friday, between the hours of 9:00 am and noon**.
2. A missed appointment, without proper notification, may be assessed a $25 fee. (Testing appointments such as PFTs, Allergy testing and Sleep tests are assessed a higher fee and require more extensive notification.)
3. This fee is the patient's responsibility and is not billable to your insurance.
4. Additionally, if you are 10 or more minutes late for your appointment, the appointment may need to be rescheduled, or an extended wait time may apply.
5. We make reminder calls for appointments as a courtesy. Please note, if a reminder calls or message is not received, the cancellation policy and the patient's responsibility remain in effect.
6. Repeated missed appointments may result in termination of the physician/patient relationship.
7. Terms of this policy may be amended from time-to-time by St. Francis Medical Institute. Modifications will be posted by St Francis Medical Institute.

Your signature below acknowledges that you read and understand the Appointment Cancellation Policy and accept and will abide by its terms and any amendment to the terms that may follow.

_____	_____	_____
Printed Name of Patient	Patient Signature	Date

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PATIENT INFORMATION

Last Name_____ First Name_____Date of Birth_____

SS #_____Sex (Please Circle) M F Race_____ Hispanic, Latino or Spanish Origin? Yes __ No__

Street Address_____City_____ _____ State_____ Zip_____

Home Phone_____ Cell Phone _____ Work Phone _____

Email _____

Emergency Contact (Name/ Relationship) _____Phone _____

PRIMARY CARE PHYSICIAN_____**PHONE**_____

PHARMACY _____**PHONE**_____

ALL PATIENTS – LIFETIME AUTHORIZATION

I hereby authorize St. Francis Sleep, Allergy & Lung Institute to request my medical records from all physicians or medical facilities they deem necessary for my continuity of care.

PATIENT/GUARDIAN SIGNATURE _____**DATE** _____

NON-MEDICARE PATIENTS & MEDICARE PATIENTS WITH SECONDARY INSURANCE- INSURANCE AUTHORIZATION

To release information and assignment of payments: I hereby authorize St. Francis Sleep, Allergy & Lung Institute to release any information to my insurance company(s), that is necessary to process my medical claims. I further authorize all insurance payments be made directly to St. Francis Sleep, Allergy & Lung Institute. Referrals and authorizations are not a guarantee of payment. I understand that I will be held financially responsible for any charges that are not paid by the insurance company for any reason.

PATIENT/GUARDIAN SIGNATURE _____**DATE** _____

MEDICARE PATIENTS – LIFETIME AUTHORIZATION

I hereby authorize St. Francis Sleep, Allergy & Lung Institute to release any information that is necessary to process my medical claims. I further authorize all Medicare payments be paid directly to St. Francis Sleep, Allergy & Lung Institute. I understand that I will be held financially responsible for my deductible and any balance not paid by my insurance carrier.

PATIENT/GUARDIAN SIGNATURE _____**DATE** _____

Any patient who does not cancel or reschedule an appointment and has not contacted our office with **at least 24 hours' notice** will be considered a no show and may be charged a **$50.00 fee**. Any new patient who does not show for their initial visit may not be rescheduled unless the no show fee is paid prior to the next appointment. The fee is charged to the patient, not the insurance company. When time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

PATIENT/GUARDIAN SIGNATURE _____**DATE** _____

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PATIENT CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS, PER HIPAA REGULATIONS

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment.

I understand that this information serves as:

- a basis for planning my care and treatment,
- a means of communication among the health professionals who contribute to my care, such as referrals,
- a source of information for applying my diagnosis and treatment information to my bill,
- a means by which a third-party payer can verify that services billed were rendered,
- a tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff.

I have been provided with a "***Notice of Patient Privacy Practices***" that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the *"Notice"* prior to acknowledging this consent.
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

PERMISSIONS:

Please tell us with whom we may discuss your protected health information: [I would like to share my information with the following family and friends.]

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

May we leave a message at your **home/cell** using doctor's/practice name: **Yes** ☐ **No** ☐

May we leave a message at your **work** using doctor's/practice name: **Yes** ☐ **No** ☐

(Messages will be of a non-sensitive nature, such as appointment reminders.)

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers. I consent to such disclosure for these uses as permitted by law.

Signing below confirms that I completely understand and accept the information in this consent.

_____

Patient Name (print)

_____ _____

Patient/ Guardian Signature **Date**

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AGREEMENT OF FINANCIAL RESPONSIBILITY

Thank you for choosing St. Francis as your health care provider. Please know that it is our great honor to provide you with the best medical care and caring that is within our capacity.

- Our website and printed materials may have a list of insurance carriers that we have been in network with; however, insurance companies have numerous plans that are subject to change; which is outside of our control. Consequently, the lists and information provided by our staff regarding insurance can in no way serve as confirmation that we are currently participating with your specific plan. It is the patient's responsibility to verify, with their insurance carrier, that Dr Averill and St Francis Sleep, Allergy and Lung Institute is in network with their plan. The patient will be personally financially responsible for any charges and fees not covered by their insurance.
- It is the patient's responsibility to provide us with their current and accurate insurance information.
- It is the patient's responsibility to know their own insurance benefits including copays, deductibles, co-insurance, exclusions in their insurance policy and any pre-authorization requirements.
- If we are participating with your insurance plan, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility.
- Some insurance coverages have *Out-of-Network* benefits that have co-insurance charges, higher co-payments, and limited annual benefits. If you receive services that are part of an *Out-of-Network* benefit, your portion of financial responsibility may be higher than the *In-Network* rate.
- Some insurance plans (mainly HMOs and Advantage plans) require prior authorizations for appointments, testing and treatments. Sometimes the prior authorization must come from the patient's primary care provider. Patients need to assist the office in getting this prior authorization approved by personally contacting their insurance company and primary care physician and asking that they approve the authorization. We cannot see a patient without prior authorization, unless the patient decides to not use their insurance and pay *Self Pay* for that appointment or service.
- Patients not covered by, or not choosing to use their *In Network* or *Out of Network* insurance benefits, will be considered *Self-Pay* patients. Our staff can explain the Self Pay fees for visits, testing and treatments.
- Payment is required at the time of check-in, prior to seeing the provider, testing or receiving treatment. Additionally, payment of any outstanding bills is also required prior to being seen for further appointments, testing or treatments.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance provider denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____ _____
Signature of Patient/ Responsible Party Date

_____ _____
Printed Name of Patient/Responsible Party Relationship to patient

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POWER OF ATTORNEY DISCLOSURE

If this does not apply to you, please proceed to the next section.

If the patient has given Power of Attorney to an individual, please disclose the designee below and provide our office with a copy of the executed Power of Attorney.

Patient's Full Name: _____

POA designee Full Name Printed: _____

POA Designee signature: _____

For office use

POA designated: YES ☐ **NO** ☐

POA documentation received: YES ☐ **NO** ☐

Staff Initial: _____

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MEDICAL QUESTIONNAIRE

Last Name_____ First Name_____Date of Birth_____

What pharmacy do you use? _____ Pharmacy phone_____

Circle One: Sleep Allergy Pulmonary

List All Allergies: ☐ Check here if no known allergies

_____

PAST MEDICAL HISTORY: *(please circle all that apply)*

Allergic Rhinitis	COPD	Heart Disease	Lung nodules	Hypothyroidism
Anemia	Cystic Fibrosis	Hepatitis	Mental illness	
Aneurysm	Depression	Hernia	Narcolepsy	Other
Anxiety	Diabetes	Hives	Pneumonia	_____
Asthma	DVT	HIV	Pulmonary Embolus	_____
Back pain	Emphysema	Hypertension	Pulmonary Fibrosis	_____
Bronchitis	Epilepsy	Hyper Cholesterol	Sickle Cell Anemia	_____
Cancer	Fibromyalgia	Insomnia	Sleep Apnea	_____
*Specify:*_____	GERD	Kidney Disease	Stroke	
Cirrhosis	Headaches	Tuberculosis	Hyperthyroidism	

PAST SURGICAL HISTORY: *(Please circle all that apply. Please specify.)*

Back surgery	Thoracotomy	_____	_____	_____
CABG	Bladder Surgery	_____	_____	_____
Cholecystectomy	Hysterectomy	_____	_____	_____
Mastectomy	Appendectomy	_____	_____	_____

Medications

Please list all your medications and nutritional supplements below or attach a list.

Name	Dosage	Directions

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SOCIAL HISTORY

NAME: _____ DOB: _____Date: _____

(Please check all that apply)

ALCOHOL CONSUMPTION:

☐ Does not drink ☐ Social drinker: Number of drinks per day_____: drinks per month _____

DRUG HISTORY:

☐ No (denies) drug use.
☐ Prescription drug abuse
☐ Marijuana use
☐ Cocaine use
☐ Heroin use
☐ Former drug abuser
☐ Excessive caffeine use
☐ Light caffeine use
☐ No caffeine use

Comments: _____

SEXUAL HISTORY:

☐ Sexually active and monogamous
☐ Sexually active
☐ Not sexually active
☐ Promiscuous
☐ Current/Previous STD(s)
☐ Alternative lifestyle

Comments: _____

TOBACCO:

☐ Former smoker: packs per day _____ Year you stopped smoking _____
☐ Never a smoker
☐ Currently smoking ☐ Cigarettes ____Packs per day ☐ Cigars ☐ Smokeless tobacco ☐ Vape

---

MARITAL STATUS:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Engaged

---

LIVING ARRANGENTS:

☐ Lives alone
☐ Lives with spouse
☐ Lives w/ significant other
☐ Lives with family member_____
☐ Other: _____

DWELLING:

☐ Apartment
☐ Single family house
☐ Condo
☐ Other: _____
☐ Mobile home
☐ Multi-family home

Where were you born? _____

What are your hobbies? _____

Hours of exercise per week: _____ ☐ No Exercise

Occupation: _____

Do you travel? _____

Where have you traveled outside of the USA in the last 2 years? _____

Do you have difficulty sleeping? ☐ Yes ☐ No

How many hours of sleep do you get per night? _____

Are you on a CPAP machine? ☐ Yes ☐ No

Are you on Oxygen? ☐ Yes ☐ No

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FAMILY HISTORY: *(Please check all that apply)*

Family Member	Asthma	Cancer (Specify)	COPD	Diabetes	Heart Disease (Specify)	High Blood Pressure	Lung Disease (specify)	Mental Illness	Heart Attack	Sleep Apnea	Stroke
Father											
Mother											
Brother											
Sister											
Grandmother											
Grandfather											

EPWORTH SCALE

Chance of Dozing: How likely are you to doze off or fall asleep in the following routine daytime situations?

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situation	Chance of dozing (0-3)
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place – (example: theater or meeting)	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you have had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3
Total Score:	