CPI PHYSICIANS, PC
Abul K. Azad, MD, MPH, FCCP
319 S. Manning Blvd – Suite 116 * Albany, NY 12208
Phone (518) 459-1800 Fax (518) 459-1818

DIRECTIONS TO OFFICE:

From the North: Follow the Northway (I-87) south to Western Avenue (Rt 20). Turn left onto Western Avenue and follow for approximately 2.8 miles to S. Manning Blvd. Turn right onto S. Manning Blvd follow for approximately 1 mile to the St. Peter's Hospital entrance on left.

From the South: Follow the NYS Thruway (I-87) north to Exit 24. Take the far right exit to Western Avenue (Rt 20). Turn left onto Western Avenue and follow for approximately 2.8 miles to S. Manning Blvd. Turn right onto S. Manning Blvd and follow for approximately 1 mile to the St. Peter's Hospital entrance.

From the East: Follow I90 west to Exit 4 (Rt 85 Slingerlands). Follow Rt 85 for approximately 2 miles to the Krumkill Rd exit. Turn left at the top of the ramp. Turn right at the immediate light onto Bender St / Krumkill Rd and follow to the next traffic light. Turn left onto New Scotland Avenue and follow for approximately 1 mile. Turn right onto S. Manning Blvd and go to St. Peter's Hospital entrance on the left.

From the West: Follow NYS Thruway (I-90) east to Exit 24. Take the far right exit to Western Avenue (Rt 20). Turn left onto Western Avenue and follow approximately 2.8 miles to S. Manning Blvd. Turn right on S. Manning Blvd and follow for approximately 1 mile to the St. Peter's Hospital entrance on the left.

PARKING INSTRUCTIONS:

St. Peter's is offering a FREE VALET SERVICE to guide patients around the final phase of construction. **Please note:** Because of construction you may use the free valet parking or park in the garage and your parking ticket will be validated by our office staff.

REGISTRATION FORM

NAME _____ DOB: _____/_____/_____ AGE_____
ADDRESS_____ SEX: _____ MALE _____FEMALE
CITY_____ STATE_____ ZIP_____ MARRITAL STATUS:_____
HOME PHONE (_____) _____-_____ SOCIAL SECURITY #____-____-_____
CELL PHONE (_____) _____-_____
NEXT OF KIN_____ HOME PHONE (_____) _____-_____
ADDRESS_____ CELL PHONE (_____) _____-_____
CITY_____ STATE_____ ZIP_____ RELATIONSHIP_____

EMPLOYER _____ EMPLOYER PHONE #:
ADDRESS_____ (_____) _____-_____
CITY_____ STATE_____ ZIP_____

DO YOU HAVE HEALTH INSURANCE? ___ YES ___ NO
PERSON RESPONSIBLE FOR PATIENT'S BILL: ___ PATIENT ___OTHER
NAME_____ RELATIONSHIP _____
ADDRESS_____ EMPLOYER_____
CITY_____ STATE_____ ZIP_____ SOCIAL SECURITY #____-____-_____

PRIMARY HEALTH INSURANCE: SECONDARY HEALTH INSURANCE:

_____ _____
ADDRESS_____ ADDRESS_____
_____ _____
ID # _____ ID # _____
GROUP #_____ GROUP #_____
WHO IS INSURED_____ WHO IS INSURED_____

MEDICARE # _____ MEDICAID #_____

NO FAULT CASE _____YES _____NO LEGAL CASE _____YES _____ NO
NAME OF NO FAULT INSURANCE: ATTORNEY NAME
_____ _____
ADDRESS TO SEND CLAIM: ADDRESS
_____ _____
CITY_____ ST _____ ZIP_____ CITY _____ ST _____ ZIP _____

COMPENSATION CASE _____YES _____NO DATE OF ACCIDENT ____/____/_____
NAME INSURANCE CARRIER
_____
CITY_____ ST _____ ZIP_____

Medical reason(s) for being seen at this office_____
Date of Injury / Illness ____/____/_____
Describe symptoms / how injury occurred_____
_____
Referring Physician _____ Phone # (_____) _____-_____
Address_____
Do you want this doctor to receive a copy of this medical report? _____Yes _____No

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and acknowledge that I am financially responsible for any unpaid balance. I also authorize the physician to release any information required. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT COVERED BY INSURANCE**

PATIENT SIGNUTURE _____ DATE ____/____/_____

MEDICAL HISTORY

Patient's Name _____ Today's Date ___/___/_____
Any known drug allergies_____
_____
Referring Physician _____
Primary Care Physician _____
Have you ever been evaluated by a Pulmonologist in the past? _____Yes _____No
If yes, please explain: _____

Did you see Dr. Azad in the hospital prior to this visit? _____Yes _____No
If yes, please indicate the hospital, date and reason for admission:
_____

Past Medical History / Surgeries (Including childhood):
_____
_____
_____
_____

Current medications (including prescriptions / over-the-counter / inhaled drugs):

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any major Family medical histories. Please include asthma, emphysema, tuberculosis, cystic fibrosis, lung cancer, etc.
_____
_____
_____

Do you currently smoke? _____Yes _____No If yes, how much per day _____
If you smoked in the past, how much and when did you quit _____
Are you exposed to passive smoking either at home or at work? _____Yes _____No

Any alcohol intake? _____Yes _____No If yes, how much _____
Any illicit drug use? (Confidential, for medical purposes only)_____

Please describe your current job_____
Do you feel that your job affects your medical problem_____
Please list past jobs_____
_____

MEDICAL HISTORY CONTINUED

Please indicate history of exposure to the following:
_____Asbestos _____Silicates _____Chemicals _____Fibers/Dust
_____Radiation _____Molds/Organic Subtances _____Heavy Metals
_____Pets – Including ___Dogs ___Cats ___Birds ___Reptiles ___Other: _____

Do you cough? _____Yes _____No If yes, how often:_____
Any sputum production _____Yes _____No If yes, what color _____
Do you cough up blood? _____Yes _____No If yes, what color _____
Do you have chest pains when you cough? ____Yes ____No
Do you have shortness of breath? ____Yes ____No
Are you short of breath only after exertion? ____Yes ____No
Are you short of breath when lying down? ____Yes ____No
Do you wheeze? ____Yes ____No
If yes, what makes wheezing worse?_____
Do you have any leg swelling? _____Yes _____No
Do you have a history of chronic nasal problems? _____Yes _____No

Have you been running a fever? _____Yes _____No
If yes, how often and how high?_____
Is fever during the day? ____Yes ____No Is fever at night? ____Yes ____No
Any night sweats? ____Yes ____No

Do you have reflux disease (GERD)? ____Yes ____No

Have you had any weight gain or loss? ____Yes ____No How many pounds? _____
How long of a time frame did you gain the weight? _____

Have you had any skin rashes? _____
Do you have any history of joint disorders? _____

Have you ever traveled outside of the country? ____Yes ____No
If yes, when and how long?_____

Do you have any sleep problems? ____Yes ____No If yes, please describe:
_____
_____
Do you snore loudly? ____Yes ____No
Do you feel sleepy during the daytime? ____Yes ____No
Do you feel sleepy while driving? ____Yes ____No
Do you have a headache or feel tired in the morning? ____Yes ____No
Does your spouse/partner or anyone told you that you stop breathing while you are sleeping? ____Yes ____No

Is there any other information you would like to provide us with? _____
_____
_____

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES
EFFECTIVE APRIL 14, 2003

Please review this notice carefully. If you have any questions or concerns, please contact CPI Physicians at (518) 459-1800

OUR PLEDGE REGARDING YOUR HEALTH INFORMATION

At CPI Physicians, PC the privacy of your health information is important to us. We understand that health information about you is personal, therefore, we are committed to keeping all records confidential. This is a foundation of providing you with quality care that is also in compliance with the Health Insurance Portability & Accountability Act (HIPAA).

Under the privacy and security provisions of HIPAA, CPI Physicians, PC is required to:

- Make sure that health information that identifies you is kept private.
- Make available this notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

HOW WE DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use or disclose health information about you. Unless otherwise noted, each of these uses and disclosures may be made without your consent or authorization. However, unless we ask for a separate authorization, all of the ways we are permitted to use the disclosure information will fall within one of these categories.

Use And Disclosures Requiring A Consent: Except where we must disclose health information about you because disclosure is necessary to proved service to you or is required by law, we will disclose information about you even when your specific written authorization is not required, only pursuant to your written consent.

For Treatment: We may disclose health information about you to provide you with healthcare treatment and services. We may disclose this information to all who are involved in your treatment such as doctors, nurses and healthcare personnel.

For Payment: We may disclose heath information about you to your insurance company, a state Medicaid agency or third party for billing purposes. This is only when medical records are asked for by these places in order for us to receive payment for services that were provided to you.

For Healthcare Operations: We may use and disclose health information about you for operations of our practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example; we may use health information to review our treatment and services to evaluate the performance of our staff in caring for you. We may also combine health information about patients to decided what additional services we should offer, what services are needed and whether new treatments are effective.

As Required By Law: We will use and disclose health information about you when required to do so by federal, state or local law.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information that we possess about you.

Right To Inspect And Copy: You have certain rights to inspect and copy health information that may be used to make decisions about your care. To inspect or copy information, please submit your request either upon arrive or phone ahead.

Right To Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. We may deny your request if you ask us to amend information that; was not created by us, is not a part of health information kept by or for our practice, is accurate and complete.

Right To An Accounting Of Disclosures: You have the right to request a list (accounting) of any disclosures of your health information that we have made, except for uses and disclosures for treatment, payment and healthcare operations that were previously described. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. (The compliance date of the privacy regulation).

Right To Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care.

Right To Request Confidential Communications: You have the right to request that we communicate with you about healthcare matters in a certain matter or at a certain location. We must accommodate all reasonable requests.

COMPLAINTS

If you believe that your privacy rights have been violated, you may file a complaint with us or the Secretary of the Department of Health and Human Services Office for Civil Rights. You will no be penalized for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change or revise this notice. If such a change or revision occurs, we will post a copy of it in our office. This notice effective date is April 14, 2003.

_____
NAME OF PATIENT (PLEASE PRINT CLEARLY)

_____
SIGNATURE OF PATIENT

_____ DATE: _____/_____/_____
SIGNATURE OF OFFICE STAFF WITNESS

Persons Whom We Can Give Your Medical Information To:

NAME:	RELATIONSHIP TO YOU:	PHONE #:
_____	_____	_____
_____	_____	_____
_____	_____	_____

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AUTHORIZATION FOR MEDICAL INFORMATION

DATE:_____

PATIENT NAME: _____
DATE OF BIRTH: _____

I, _____, do hereby authorize CPI Physicians, PC / Dr. Abul Azad to obtain and share with hospitals / providers / pharmacies all of my medical history as deemed necessary including:

- Laboratory Reports & Other Tests
- List Of Medications
- Any / All Radiology Films
- Discharge Summaries
- Physician Notes

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PATIENT SIGNATURE:

_____

OFFICE STAFF WITNESS:

_____

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FINANCIAL WAIVER FORM

To Our Patients:

This practice participates with many different insurance companies and their various plans. We try to keep up with the terms of each, but this is not always possible. If you are a member of a Managed Care Plan, or an Insurance Plan requiring a referral, you should be aware that most of these plans require your Primary Care Provider to provide prior authorization for specialist visits. If you do not personally request this, please check with someone at our front desk before being seen by the doctor to make sure that we have obtained authorization for you to be seen at this practice.

If no authorization has been obtained prior to your being seen, your insurance company will **NOT** cover the charges for today's visit and you will be responsible for them. Even if authorization is obtained, a Managed Care Plan has the ability to deny payment at a later date, claiming that the procedure is non-covered or not medically necessary. Any insurance plan may deny payment after telling us that it should be covered. This might be because of an error, or exclusion in the policy, or because of a change in your policy between the time the appointment was confirmed and the time it was carried out. It is also possible for them to determine that your coverage is no long valid on the date that the appointment is performed.

Should any of these unforeseen occurrences take place, you will become responsible for the charges involved regardless of what we may have estimated your responsibility to be. Because of the increasing number of insurance companies requiring this type of form to be filed, we ask that you sign the following statement before being seen at this office:

I have read the above statements and understand them and my responsibilities with respect to membership in a Managed Care Program (if applicable). I also understand my financial responsibilities with respect to paying all charges not covered by my insurance company for any reason (not to exceed the allowable fee as determined by my insurance company). I waive my rights to insurance benefits if I have not accurately informed you of my insurance coverage prior to my treatment.

Please note that CPI Physicians does not accept Wellcare Insurance!

_____ DATE: _____
NAME OF PATIENT: PLEASE PRINT CLEARLY

_____ _____
SIGNATURE OF PATIENT OFFICE STAFF WITNESS

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NO SHOW / LATE ARRIVAL / CANCELLATION POLICY

Effective: January 1, 2014 – December 31, 2014

We appreciate the trust that you have placed with our physician(s) and office by choosing us for your healthcare needs. When making an appointment with our physician(s), a set amount of time is reserved for your visits. Please schedule appointments when it is most convenient for you.

Please be aware of our 24-hour cancellation policy. We require at least **24-hours notice** when canceling an appointment. As your physician's office, we expect that you make every effort to adhere to this so that we may provide you and other patients with outstanding healthcare.

Also, please be advised that if you are **more than 15 minutes late** to your scheduled appointment time, we reserve the right to ask you to reschedule your appointment. Being late disrupts patient flow and turns a daily office schedule around.

In accordance to our cancellation policy, please be advised that there will be a **$25.00** charge for each appointment that is not cancelled with 24-hour notification. This fee is **not** covered by your insurance.

Please be advised of our **NO SHOW** policy. Patients that do not show up for scheduled appointments and do not call to notify us that your appointment will be missed, will be charged **$25.00** for each missed appointment. This fee is the patient's responsibility and is **not** covered by your insurance. A total of **3 consecutive NO SHOWS** will result in termination of healthcare services being provided to you at this practice.

I, _____, acknowledge that I have reviewed the **NO SHOW / LATE ARRIVAL / CANCELLATION POLICIES**. I am aware that **24-hours** notice is required for the cancellation of appointments and that I will be asked to reschedule if I am more than 15-minutes late arriving for my appointment. I understand that I am responsible for the $25.00 fee for not adhering to the **NO SHOW / CANCELLATION POLICIES** and that this fee is not covered by my insurance.

Patient's Name: _____

Patient's Signature: _____

Office Staff Witness' Signature: _____

Today's Date: _____