CPI PHYSICIANS, PC
Abul K. Azad, MD, MPH, FCCP & Najiib Azad, MD
319 South Manning Boulevard – Suite 116
Albany, New York 12208
Phone (518) 459-1800 Fax (518) 459-1818

Date: ______________________

Dear ____________________________________:

Thank you for choosing CPI Physicians for your medical needs. It will be our pleasure to see you throughout your medical care.

Enclosed you will find your New Patient Registration Forms. To help us expedite your initial appointment time, please complete all sections on each form and bring them with you to your appointment. In addition to these forms, please bring the following items with you to your first appointment:

- Insurance card(s)
- List of current medications
- Past medical records
- Radiology reports CD
- Referral (if required by your insurance)

On behalf of CPI Physicians, we look forward to meeting you and guiding you through your medical care. If you have any questions regarding your paperwork, insurance, office hours or directions to the office, please do not hesitate to contact us at the number above.

YOUR APPOINTMENT IS SCHEDULED ON:

DATE: ________________________

TIME: ________________________

***Please arrive 15-minutes prior to your scheduled appointment time.**

Sincerely –

Marilyn J. Pickett, LPN
Office Practice Manager

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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:

Please park in the first garage located next to building 319. If no parking spots remain in the garage, you may use the **VALET SERVICE** located by the hospital main entrance. Our office will validate your ticket at your time of appointment

PATIENT REGISTRATION INFORMATION

NAME: ____________________________________ DATE OF BIRTH: _____/_____/_______
GENDER IDENTIFIED AT BIRTH: _____ FEMALE _____ MALE
GENDER IDENTIFIED AS TODAY: _____ FEMALE _____ MALE _____ NON-BINARY
___MARRIED ___SINGLE ___DIVORCED ___SEPARATED ___WIDOWED
ADDRESS:____
CITY: _____________________________________ STATE: ___________ ZIP CODE: __________
HOME PHONE: ___________________________ MOBILE PHONE: ___________________________
EMAIL ADDRESS: ____
EMERGENCY CONTACT: ____
HOME PHONE: ___________________________ MOBILE PHONE: ___________________________
RELATIONSHIP TO YOU: ____

REFERRING PHYSICIAN: ____
DO YOU WISH TO HAVE THIS PHYSICIAN RECEIVE A COPY OF THIS REPORT: _____YES _____NO
PRIMARY CARE PHYSICIAN: ____
DO YOU WISH TO HAVE THIS PHYSICIAN RECEIVE A COPY OF THIS REPORT: _____YES _____NO

OTHER PHYSICIANS SEEN ON A REGULAR BASIS:
NAME: ___________________________________ SPECIALTY: ____________________________
NAME: ___________________________________ SPECIALTY: ____________________________
NAME: ___________________________________ SPECIALTY: ____________________________
NAME: ___________________________________ SPECIALTY: ____________________________
NAME: ___________________________________ SPECIALTY: ____________________________
NAME: ___________________________________ SPECIALTY: ____________________________

PRIMARY INSURANCE: _______________________ ID #: _____________ GROUP # ____________

SECONDARY INSURANCE: ____________________ ID #: _____________ GROUP # ____________

TERTIARY INSURANCE: ______________________ ID #: _____________ GROUP # ____________

ALL COPAYS ARE DUE AT TIME OF SERVICE AND WILL BE COLLECTED AT CHECK-IN

IS THIS VISIT FOR: _____ WORKERS' COMP _____NO FAULT OTHER:_____________________

CLAIM NUMBER OR POLICY ID: ____

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 SIGNATURE ___________________________ **DATE** ____/____/________

PATIENT MEDICAL HISTORY

DO YOU HAVE ANY ALLERGIES TO MEDICATION: _____YES _____NO
If yes, please list all:
MEDICATION NAME___________________________ REACTION_________________
MEDICATION NAME___________________________ REACTION_________________
MEDICATION NAME___________________________ REACTION_________________
MEDICATION NAME___________________________ REACTION_________________
MEDICATION NAME___________________________ REACTION_________________
MEDICATION NAME___________________________ REACTION_________________

DO YOU HAVE ANY ENVIRONMENTAL ALLERGIES? _____YES _____NO
Please specify: ____
DO YOU HAVE ANY ALLERGIES TO ANIMALS? _____YES _____NO
Please specify: ____
DO YOU HAVE PETS IN YOUR HOME? _____YES _____NO
TYPE OF PETS IN YOUR HOME____

DO YOU HAVE EXPOSURE TO ANY OF THE FOLLOWING?

___ASBESTOS	___MOLDS
___CHEMICALS	___ORGANIC SUBSTANCES
___DUST/FIBERS	___RADIATION
___HEAVY METALS	___SILICATES

HAVE YOU SEEN A PULMONOLOGIST IN THE PAST? ___YES ___NO
If yes, who did you see and when? _______________________________________

DID YOU SEE DR. AZAD IN THE HOSPITAL? ___YES ___NO
Hospital date: ________________ Reason for admission: ____________________

PAST MEDICAL HISTORY (check all that apply):

___ALLERGIC RHINITIS / SINUSITIS	___HIGH CHOLESTEROL
___ALPHA-1 ANTITRYPSIN DEFICIENCY	___HYPERTENSION
___ANXIETY DISORDER	___HYPERTHYROIDISM
___ARTHRITIS	___HYPOTHYROIDISM
___ASTHMA	___KIDNEY DISEASE
___COPD	___LIVER DISEASE
___CANCER____________________	___OBESITY
___CORONARY ARTERY DISEASE	___OSTEOPOROSIS
___DEPRESSION	___PULMONARY EMBOLISM
___DIABETES	___PULMONARY FIBROSIS
___DIVERTICULITIS	___SARCOIDOSIS
___FIBROMYALGIA	___SLEEP APNEA
___GERD / ACID REFLUX	___TUBERCULOSIS
___HEART DISEASE	___ Other: _______________________

PATIENT MEDICAL HISTORY – Continued

SMOKING HISTORY:
___Never Smoked
___Current Smoker How much: ____________ # years: _________
___Former Smoker How much: ____________ Quit date: _________
___E-Cigarettes/Vaping How much: ____________
Are you exposed to second hand/passive smoke: ___Yes ___No

Any alcohol intake? ____________________________________
Caffeine consumption? ____________________________________
Illicit drug use? (Confidential) ____________________________________

OCCUPATION: ____
DO YOU FEEL YOUR JOB AFFECTS YOUR CURRENT MEDICAL PROBLEM: ___Yes ___No

SURGICAL HISTORY (Including childhood):
____
____

PLEASE LIST ANY MAJOR FAMILY MEDICAL HISTORIES: (Include asthma, COPD, emphysema, tuberculosis, cystic fibrosis, lung cancer, etc):
____
____

CURRENT MEDICATIONS (Including supplements & over the counter):
______________________________ ________________________________
______________________________ ________________________________
______________________________ ________________________________
______________________________ ________________________________
______________________________ ________________________________
______________________________ ________________________________

Do you frequently cough: ___Yes ___No
Any sputum production: ___Yes ___No What color? __________
Do you cough up blood: ___Yes ___No What color? __________
Experience chest pains when cough: ___Yes ___No
Do you have shortness of breath? ___Yes ___No
Shortness of breath after exertion: ___Yes ___No
Shortness of breath laying down: ___Yes ___No
Experience wheezing? ___Yes ___No
What makes wheezing worse: _____________________________________
Experience any leg swelling: ___Yes ___No
History of chronic nasal problems: ___Yes ___No
Have a fever during the day: ___Yes ___No ________F
Have a fever during night: ___Yes ___No ________F

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 provide 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 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 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 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 not 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 #:

CPI PHYSICIANS, PC
Abul K. Azad, MD, MPH, FCCP & Najiib Azad, MD – Family Practice
319 South Manning Boulevard – Suite 116
Albany, New York 12208
Phone (518) 459-1800 Fax (518) 459-1818

AUTHORIZATION FOR MEDICAL INFORMATION

PATIENT NAME: ____
DATE OF BIRTH: ____

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

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

TO: CPI PHYSICIANS, PC
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PATIENT SIGNATURE: ____

OFFICE STAFF WITNESS: ____

TODAY'S DATE: ____

Dr. Abul Azad, MD, MPH, FCCP & Dr. Najiib Azad, MD * CPI PHYSICIANS, PC
319 South Manning Blvd – Suite 116 * Albany, NY 12208

Patient Acknowledgement of Office Policies and Procedures

Insurance Authorization: I hereby authorize my insurance benefits to be paid directly to CPI Physicians, P.C. and acknowledge that I am financially responsible for any unpaid balance. I understand that I am responsible for any co-payment and/or deductible as required by my insurance at the time of service. I understand that insurance eligibility is not a guarantee of coverage. ______ **(Patient Initials)**

Office No-Show Policy: A **$50** fee will be charged for all missed appointments. Patients that incur 3 consecutive NO SHOW fees will receive a letter discharging him/her from the practice and will be asked to seek healthcare elsewhere. ______ **(Patient Initials)**

I understand that I must give **24 HOUR NOTIFICATION** to cancel an appointment or I will be charged a **$50 No Show** fee. _______ **(Patient Initials)**

I understand that if I am more than **15 minutes** late for my appointment I may be marked as **No Show** and my appointment will need to be rescheduled. _____ **(Patient Initials)**

Test Results: Test results are reviewed by the doctor. You will receive an automated call informing you if test results are normal. **Abnormal** test results require a follow-up appointment with the physician and will not be discussed over the phone. ______ **(Patient Initials)**

Paperwork and Forms: All disability, FMLA forms, work forms and any other paperwork requires a face-to-face appointment with the physician. Please note that some forms may require extra time to complete after your appointment. Please allow **5-7** business days for completion. ______ **(Patient Initials)**

Prescription Requests: Controlled prescriptions require a face-to-face appointment with the physician. Failure to comply will result in prescription denial. Non-controlled prescription refills will be sent to your pharmacy electronically and require 48-72 hours to process. ______ **(Patient Initials)**

Prescription Refill Requests: All refill requests MUST go thru your pharmacy and be sent electronically to our office. ______ **(Patient Initials)**

I acknowledge that I have reviewed and understand the office policies and procedures for CPI Physicians, P.C.

PATIENT NAME (Printed): ____

PATIENT SIGNATURE: ____

STAFF SIGNATURE: ____

TODAY'S DATE: ____