



SLEEP DISORDERS CENTER

MEDICAL & SURGICAL WEIGHT MANAGEMENT

PULMONARY REHABILITATION

1345 King Street
Bellingham, WA 98229-6223

T: (360) 676-1696
F: (360) 676-6636

www.northstarmedicalspecialists.com

Informed Consent for Services

Patient Name: _____

Consent For Treatment: I voluntarily consent to evaluation, treatment, diagnostic, testing and therapy, which my physician and or his/her designees determine to be necessary. I understand that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result to examination or treatment in this facility.

Use of Medical Records in Research: I authorize the use of my medical records for medical or scientific research. I may disagree with the use of my medical records for this purpose by crossing through this paragraph and initialing in the left margin.

Consent for Personnel in Training: I am aware that patients at this facility may be attended by medical, nursing, and other health care personnel in training, who may be present during patient care as part of their education.

Consent for Release of Information: I consent to the release of information about my medical condition to any health care provider involved with my current treatment. I understand that facility personnel may release the fact that I am presently a patient here, without disclosing confidential information, so that I may receive phone calls.

Insurance Consent: I request that payment of authorized benefits be made to NorthStar Medical Specialists and the facility's participating physicians, for any services furnished to me. I authorize this facility to release to Medicare, and or accident or health insurer, medical or financial information as needed for claims processing, fraud investigation, or quality of care review, and studies. I understand that I may revoke this consent for release of information at any time by notifying the facility in writing, but such revocation will not apply to information previously released.

Pre-certification/prior authorization agreement: I understand that I am responsible to comply with the rules and requirements of my insurance company reading pre-certification and prior authorization requirements.

Guarantee of account: I agree to pay NorthStar Associates, PLLC for all charges not covered by any third party payor.

Grievance procedure: I acknowledge that the Operations Director makes themselves readily available to discuss my concerns or questions I may have. I acknowledge that if I have a grievance of any kind, I have the right to utilize the Section 504 Grievance Procedure, posted in the facility lobby.

Patient Signature (or legal representative)

Relationship to patient

Date

Reason patient is unable to sign consent: ___(minor) ___(physical or mental disability) ___(other)



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Patient Registration

Patient's full name: _____ Social Security Number: _____

Mailing Address: _____ Apt#: _____ Birthdate: ____ / ____ / ____

City/State/Zip: _____

Home Phone#: _____ Work Phone#: _____ Sex: _____ Age: _____

Employment Status (circle one): Full time / Part time / Not employed / Self employed / Retired / Student

Marital Status: Single / Married / Divorced / Separated / Widowed Spouse's Name: _____

In case of emergency, contact: _____ Phone#: _____

Relationship to patient: _____ Spouse's Employer: _____

Referring physician: _____ Primary care physician: _____

Reason for referral: _____

How did you hear about NorthStar Medical? (circle one below)

Doctor referral / Friend/family referral / Newspaper / Radio / Other _____

Name of Primary Insurance Company: _____

Subscriber's name: _____ Date of Birth: _____

Subscriber's relationship to patient: _____

Subscriber's #: _____ Group #: _____

Name of Secondary Insurance Company: _____

Subscriber's name: _____ Date of Birth: _____

Subscriber's relationship to patient: _____

Subscriber's #: _____ Group #: _____



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Health History

Name: _____ Today's Date: _____ DOB: _____
 Current Weight: _____ lbs. Height: _____ Recent weight gain/loss: _____ lbs.
 SSN: _____

1. Major Complaints:

- a. _____
- b. _____
- c. _____

2. Sleep Habits:

- a. Length of average night sleep: _____
- b. Normal bedtime/wake time hours: _____
- c. Daytime naps: Yes No
- d. Daytime sleepiness: Yes No
- e. Daytime paralysis or falling episodes: Yes No
- f. Snoring: Yes No
- g. Body movement with sleep: Yes No
- h. Vivid dreams or hallucinations: Yes No
- i. Paralysis upon awakening: Yes No
- j. Sleepy while driving: Yes No
- k. Fallen asleep behind the wheel: Yes No
 If yes, when? _____

7. Headaches? Yes No Frequency: _____ When: _____

8. Head injuries? Yes No Type: _____

9. Recent hospitalizations: _____ For what: _____

10. Medical History: (Check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Urinary Troubles |
| <input type="checkbox"/> Alcoholism/drug abuse | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> CVA |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Pulmonary Disease |
| <input type="checkbox"/> Bowel Troubles | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Compromised Immune System |



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Patient Name: _____

11. Pulmonary:

- | | | | |
|-----------------|-----|----|-------|
| a. Smoker | Yes | No | _____ |
| b. Lung disease | Yes | No | _____ |
| c. Hay fever | Yes | No | _____ |
| d. Allergies | Yes | No | _____ |

12. Do you regularly consume alcohol? Yes No How much per day: _____

13. Do you get leg cramps at night: Yes No

14. Have you had your tonsils removed? Yes No

15. Do you have heartburn at night? Yes No

16. What medications are you taking? (attach list if necessary)

Additional Comments:

Special Needs

Please notify our office immediately if you have specific assistance requirements. This includes, but is not limited; sight, hearing, mental health and physical disabilities.

Northstar Medical Specialists has specific policies in place to accommodate your needs while protecting the health and well being of other patients. If you require a service animal, please notify our office immediately.

Patient signature: _____ Date: _____

PLEASE SIGN AND DATE THE BOTTOM OF THIS FORM



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The questions listed below are for Beneficiaries age 65 or older, and is used to comply with Medicare Regulation 42 CFR 489.20 (F). If this does not apply to you, please skip to next page.

Primary Payor Questionnaire

Name of Patient: _____ SSN: _____

1. Are you currently working full or part-time? **Yes / No**
2. If married, is your spouse working full or part-time? **Yes / No**
3. Are you currently under any employer group health plan? **Yes / No**
If yes; Name of insured: _____
Relationship to patient: _____ Name of employer: _____
Name of carrier: _____ Group/policy#: _____
4. Are you entitled to Black Lung Benefits? **Yes / No**
5. Is this service for treatment work related? **Yes / No**
If yes; Name of insurer: _____ Date of injury: _____
Name of employer: _____ Policy/claim#: _____
6. Is this service for treatment related to an auto injury? **Yes / No**
If yes; Name of insurer: _____ Date of injury: _____
Name of policyholder: _____ Policy/claim#: _____
7. Are benefits for services being submitted to any other party for reimbursement consideration? **Yes / No**

Patient Signature: _____ Date: _____

Witness: _____



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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.

The privacy of your medical information is important to us. At NorthStar Medical Specialists, we respect your privacy. We understand that your personal health information is very sensitive. We will not disclose your information to others for non-permitted uses and disclosure unless you tell us to do so, or unless the law authorizes or requires us to do so.

The law protects the privacy of the health information we create and obtain in providing care and services to you. Your protected health information includes your symptoms, diagnoses, and treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to get authorization to disclose this information for payment purposes.

Use and disclosure of protected health information for treatment, payment, and health operations, to remind you, notification of family, for public health and safety, and other uses as noted below.

For Treatment: Information obtained by a therapist, physician, technologist, or other member of our health care team will be recorded in your medical record and used to help decide what care may be right for you.

We may also provide information to others providing your care to help them stay informed about your care.

For Payment: We request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses; procedures performed, or recommended care.

For Health Care Operations:

- We use your medical records to assess quality and improve services.
- We may use and disclose medical records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact you to remind you about your appointments and give you information about treatment alternatives or other health related benefits and services
- We may contact you to raise funds.
- We may use and disclose your information to conduct or arrange for services including:
 - Medical review by your health plan;
 - Accounting, legal, risk management, and insurance services;
 - Audit functions, including fraud and abuse detection and compliance programs.

To remind you:

We may remind you by phone, voicemail, or mail, that you have a health care appointment with us, or request that you call us regarding your health care. You have the right to request we contact you at an alternative address or phone number. If you request this, we will contact you at the alternative location, as requested.

Notification of family and others:

We may disclose your private health information to a "personal representative" (a person who is legally authorized to make health care decision on your behalf, such as a parent of a minor child).

In addition, we may disclose health care information about you to assist in disaster relief efforts.

You have a right to object to this use or disclosure. If you object, we will not disclose it.

For public health and safety purposes as required by law:

- to prevent or reduce a serious, immediate threat to the health of a person or the public
- to public health and legal authorities
- to protect public health and safety
- to prevent or control disease, injury, or disability
- to report vital statistics such as births or death
- To report suspected abuse or neglect
- To the Food and Drug Administration relating to problems with products
- In the course of judicial/administrative proceedings
- For law enforcement purposes
- To correction institutions if you are in jail
- With approved medical researchers
- To comply with workers compensation laws
- For health and safety oversight activities, e.g., shared health information with the Department of Health
- For disaster relief purposes
- For work related conditions that could affect employee health
- To the military authorities, U.S. and foreign



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- To funeral directors/coroners consistent with applicable laws for specialized government functions such as national security purposes

Other uses and Disclosure of protected health information

Uses and disclosures not in this notice as allowed and required by law, or with your written authorization

Our Responsibilities

We are required to:

- Keep your protected health information private;
- Give you this notice;
- Abide by the terms of this notice.

We have the right to change our practices regarding the protected health information we maintain. If we make changes, we will update this Notice. You may receive the most recent copy of this Notice by calling and asking for it, or by visiting us at NorthStar Medical Specialists to pick one up.

Your Health Information Rights

The health and billing records we create and store are the property of NorthStar Medical Specialists. The protected health information in your file, however, generally belongs to you. You have a right to:

- Receive, read, and ask questions about this notice;
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request, but if we decide to, we will comply with any request granted;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information ("Notice");
- Request that you be allowed to see and get a copy of your protected Health information, you may make this request in writing.
- Have us review a denial of access to your health information - except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing. You may write a statement of disagreement if your request is denied. It will be stored in your medical records, and included with any release of your records;
- When you request, we will give you a list of disclosures of your health information. The privacy rule does not require accounting of disclosure to covered entities for treatment, payment, or health care operations, to the individual (or representative), to persons involved in the individual's health care, or payment for health care, pursuant to an authorization, of a limited data set, for nation security purposes, to law enforcement officials in certain circumstances, incident to otherwise permitted or required uses or disclosures;
- Ask that your health information be given to you by another means, or at another location. Please sign, date, and give us your request in writing;
- Cancel prior authorizations to use or disclose your health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes you cannot cancel an authorization if its purpose was to obtain insurance;

For help with these rights during normal business hours, please contact our Privacy Manager at NorthStar Medical Specialists.

To ask for help or complain

If you have questions, want information, or want to report a problem about the handling of your protected health information, you may contact our Privacy Manager at NorthStar Medical Specialists.

If you believe your privacy rights have been violated, you may discuss your concerns with our Privacy Manager. You may also deliver a written complaint to the Privacy Manager at NorthStar Medical Specialists. You may also file a complaint with the US Secretary of Health and Human Services.

We respect your right to file a complaint with us, or the US Secretary of Health and Human Services. If you complain, we will not retaliate against you.

While you participate in your treatment at NorthStar Medical, some of your activities and treatments will be conducted in a group setting. As a result, some of your protected health information may be discussed with you in the group setting. Please sign below if you agree.

Patient Signature

Date and Time



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**CONSENT FOR THE RELEASE OF INFORMATION
(Specified Access)**

I hereby authorize NorthStar Associates PLLC to release my medical records, treatments and services to _____.

This access includes: (Check all that apply)

Reading and/or copying my written medical record

Accessing, reading and printing my computerized medical record

Receiving phone information regarding my medical condition and treatments

Other: Please explain: _____

This health care consent authorizes this access for the following time frames: (Check one)

Between _____ and _____ (If patient is a minor this agreement ends when
Beginning date Ending Date patient becomes an adult)

This agreement is open ended and I will notify NorthStar Associates PLLC if I want it
revoked.

I hereby release NorthStar Associates PLLC, its agents and employees from all legal responsibility or liability that may arise from the release of this information or records.

Witness

Patient Signature

Social Security No.

Date of Birth

Custodial parent if patient is a minor

Relationship

Date



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Cancellation Policy

Thank you for choosing NorthStar Medical Specialists to help you achieve a better quality of life. In the interest of conserving your time, we will make every effort to stay on schedule. Your time is valuable and except for emergency treatment of another patient, you can expect us to be prompt.

We understand there are times when it is unavoidable to cancel an appointment, and your call before the appointment during business hours is appreciated.

When you schedule an appointment, that time has been set aside just for you. There will be a charge for appointments cancelled with less than sufficient notice. No-show and late cancellation fees must be paid before future appointments can be scheduled.

We will hold your appointment for 15 minutes after your scheduled start time. If you arrive late on the date of your appointment, you may be asked to reschedule; however, we will do our best to provide an excellent session with the remaining time. High standards of patient care depend upon equal treatment and consideration; therefore sessions must begin and end on time.

The cancellation/no-show fee schedule is as follows:

24-Hour Notice Required for the Following:

Physician and physician assistant appointments	\$75
Clinician appointments	\$45
Respiratory therapy session	\$45

48-Hour Notice Required for the Following:

Overnight sleep study appointments	\$250
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Please note, calls to cancel appointments should not be left on the office voice mail within the minimum time frame in attempt to avoid the cancellation fee. Doing so may result in a lapse of the 24 or 48-hour notice. If you have any questions or concerns, please do not hesitate to contact our office at (360) 676-1696. Thank you!

I have read and fully understand NorthStar Medical Specialists' Cancellation Policy.

Signature

Date