www.toledoclinic.com

Jamey Ruiz, MD
Karl Fernandes, MD
Dean Bernardo, MD
Louis Tartaglia, MD
Jenna Fitzpatrick, CNP
Juli Smelser, CNP
Cheryl Jeffers, CNP
Danny Barazi, CNP

Northwest Ohio Pulmonary, Critical Care & Sleep

Thank you for choosing our office for your pulmonary, critical care and sleep needs. Please bring the following with you to your appt:

* **Photo ID**
* **Insurance and Prescription Cards**
* **List of current medications**
* **Completed information sheets (enclosed)**

Your appointment is scheduled for ________________________
at ________am/pm with Dr. ____________________________
Please arrive at _________am/pm.

- o 1661 Holland Rd. #200, Maumee, Oh 43537 (Maumee Office)
  GPS: St. George Professional Building for directions
- o 1050 Isaac St. #134, Oregon, Oh 43616 (Oregon office)

- o You **WILL NOT** need a chest x-ray before your appointment
- o You **WILL** need a chest x-ray before your appointment

- o Enclosed is an order for a chest x-ray that you should take to an outpatient facility accepted by your insurance company prior to your appointment. Please bring your x-ray with you to your appointment. (either actual film of a CD disc)

- o Please pick up all previous x-rays or CT scans (either actual films or a CD disc) and bring them with you to your appointment.

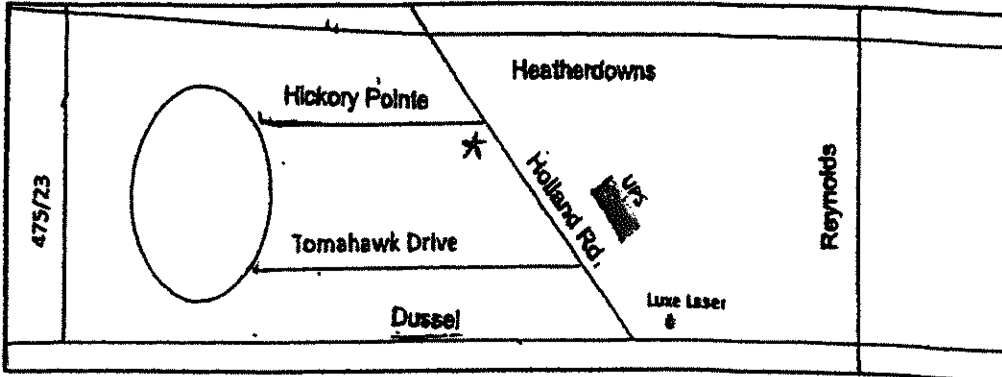
If you are currently using a CPAP/BIPAP machine, please bring the machine and power cord with you to your appointment.

If you have any questions before your appointment, please do not hesitate to contact us at 419-843-7800. Our hours are 8am-4pm, Monday through Friday. Our fax number is 419-843-3444. Website is www.toledoclinic.com.

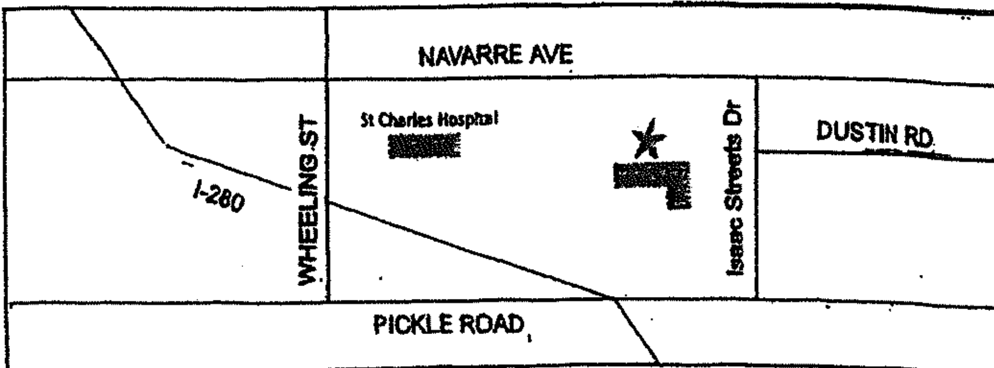
All co-pays are do at the time of service. If you arrive after your scheduled appointment time, you may be asked to reschedule.

The Toledo Clinic | NWO Pulmonary, Critical Care & Sleep

1661 Holland Road Maumee, Ohio 43567
Suite 200
From 475/23 Exit 6 Salisbury/Dussel Road
Head East to Holland Road,
Turn Left on Holland Rd.
Proceed to the Next Light (Corner of Hickory Point and Holland Rd.),
Immediate left into parking lot



1050 Isaac St. Drive Oregon Ohio 43616
Suite 134
From I-280 exit Rt/2 Navarre, Head East on Navarre
Follow Navarre to Isaac Street Dr and Turn Right, Follow signs to St. Charles Mercy Medical office Building (Building is dark brown/1 level just past the nursing home) Turn Right into the parking lot and Enter the main entrance



Choose well, feel better.

NWO Pulmonary, Critical Care & Sleep
1661 Holland Rd, Maumee, OH 43537
P:419-843-7800 F:419-843-3444

Patient Name: ______________________ DOB: __________ Age: ______

Address:______________________

E-mail Address: ______________________

Reason for visit:______________________

____

Referring Physician:______________ **Primary Care Provider:**______________

Preferred Pharmacy: ______________________

Pharmacy Address:______________ **Pharmacy Phone:**______________

Durable Medical Equipment Co.______________________

MEDICATIONS/SUPPLEMENTS

Name	Dosage (mg)	Frequency

Do you use sleeping pills, tranquilizers, or sedatives to sleep? Yes/No______________________

Home Oxygen: ________ Liters __Daytime __Nocturnal __24/7

PAST MEDICAL HISTORY Have you ever had the following conditions? Check all that apply: ____ Patient denies PMH

Asthma	___	Shortness of Breath	___	Arthritis	
Bronchitis	___	Anemia	___	Cancer: Type________	___
Chronic Cough	___	CAD	___	Depression	
COPD	___	Chest Pain	___	Kidney Disease	___
GERD	___	CHF	___	Liver/Hepatitis	___
Emphysema	___	Heart Attack	___	Seizures	___
Pneumonia	___	Heart Disease	___	Thyroid Disease	___
Pulm. Embolism	___	Hypertension	___	Diabetes: Type I/Type II	___
Pulm. Hypertension	___	Hypotension	___	Other__________	
Sarcoidosis	___	Stroke	___	Other__________	

ALLERGIES –List medications, food, environment AND reactions ____ Patient denies allergies

Allergies	Reactions

NWO Pulmonary, Critical Care & Sleep
1661 Holland Rd, Maumee, OH 43537
P:419-843-7800 F:419-843-3444

Patient Name: ______________________________ DOB: __________ Age: ______

PAST SURGICAL HISTORY Check all that apply ______Patient denies surgeries

Procedure		Date	Procedure		Date	Procedure		Date
Angioplasty	___	______	Heart Valve Rep	___	______	Stent Placement	___	______
Appendectomy	___	______	Hernia Repair	___	______	Stomach Repair	___	______
Bronchoscopy	___	______	Hysterectomy	___	______	Tonsils/Adenoids	___	______
Gallbladder	___	______	ICD (defibrillator)	___	______	Other ______________		
Heart Bypass	___	______	Lung Biopsy	___	______	Other ______________		
Heart Cath	___	______	Pacemaker	___	______	Other ______________		

FAMILY HISTORY—If any of your immediate family Membershashad the following conditions, please designate in the blanks below: ______Patient denies family hx

Condition	Relationship	Age/Cause of death
CAD/Heart Attack	______	______
Cancer (type) ______	______	______
COPD/Emphysema	______	______
Diabetes	______	______
Dialysis	______	______
Kidney Disease	______	______
Lung Cancer	______	______
Sleep Apnea	______	______
Stroke	______	______
Tuberculosis	______	______
Other ______	______	______
Other ______	______	______

SOCIAL HISTORY

Marital Status: Single Married Divorced Widowed

Occupation: ______________ Active Not Working Retired Disability

Excessive Exposure at home/work to: (circle all that apply)

Fumes Dust Chemicals Asbestos 2nd-Hand Smoke Other

Shift Work: 1st 2nd 3rd Do you have job stress? Yes/No

Smoking history: Former Current Never

If aformersmoker:

When did you start? ______________ When did you quit? ______________

How much did you smoke per day? ________

If a current smoker:

When did you start? ______________ How much do you smoke daily? ______________

Do you chew tobacco? Yes/No Have you chewed tobacco in the past? Yes/No

Drugs: None Rarely Occasionally Daily—type/frequency ______________

Caffeine: None Rarely Occasionally Daily—amount/cups per day ______________

Alcohol: None Rarely Occasionally Daily—amount per day ______________

Physical Activity: Very Active Somewhat Active Not Active

NWO Pulmonary, Critical Care & Sleep
1661 Holland Rd, Maumee, OH 43537
P:419-843-7800 F:419-843-3444

Patient Name: ______________________________ DOB: __________ Age: ______

FLU AND PNEUMONIA VACCINE

Have you had your flu vaccine this year? Yes/No When? (approximate date) ______________

Have you had a pneumonia vaccine?Yes/No When? (approximate date) ______________

SYSTEM REVIEW

In the last month, have you had the following symptoms?

General
- Loss of energy Y/N
- Fevers/Chills Y/N
- Night sweats Y/N

Skin
- Rashes Y/N
- Change in skin color Y/N
- Unhealed sores Y/N

Blood
- Unusual bleeding Y/N
- Easy bruising Y/N
- Anemia Y/N
- Enlarged Glands Y/N

Endocrine
- Heat/cold intolerance Y/N
- Hair growth/loss Y/N
- Increased hunger Y/N
- Increased thirst Y/N

Lung/Nose
- Cough Y/N
- Wheezing Y/N
- Shortness of breath Y/N
- Nose bleeds Y/N
- Runny nose Y/N
- Colds Y/N

Eyes/Ears/Mouth
- Vision trouble Y/N
- Double vision Y/N
- Eye pain Y/N
- Hearing trouble Y/N
- Ringing in ears Y/N
- Dizziness Y/N
- Dental problems Y/N
- Difficulty swallowing Y/N
- Mouth sores Y/N
- Hoarseness Y/N

Cardiac
- Heart problems Y/N
- Chest pain Y/N
- Heart murmurs Y/N
- Heart attacks Y/N
- Fainting Y/N
- Difficulty lying down Y/N

Gastrointestinal
- Abdominal pain Y/N
- Heartburn Y/N
- Nausea/vomiting Y/N
- Diarrhea Y/N
- Constipation Y/N
- Blood in stool Y/N

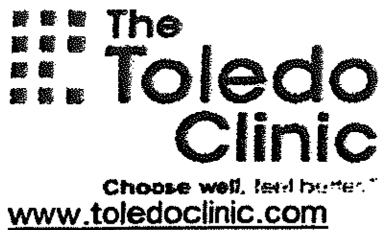
Urinary
- Blood in urineY/N
- Burns while urinating Y/N
- Increased urineY/N
- Trouble in start/stop Y/N
- Flank pain Y/N

Muscle/Skeleton
- Joint pain Y/N
- Morning stiffness Y/N
- Back problems Y/N

Neurologic
- Blackouts Y/N
- Seizures Y/N
- Frequent headaches Y/N
- Muscle weakness Y/N
- Trouble talking Y/N
- Balance problems Y/N
- Memory changes Y/N

Emotion
- Mood swings Y/N
- Crying spells Y/N
- Depression Y/N
- Psychiatric Y/N

Reviewed and reconciled with patient: ______________________________



www.toledoclinic.com

NWO Pulmonary, Critical Care & Sleep

1661 Holland Rd, Maumee Oh 43537

P: 419-843-7800 F: 419-843-3444

Thank you for choosing Pulmonary and Critical Care Specialists for your specialized care. For our physicians to provide you with the best service, it is important that you keep all scheduled appointments.

We understand that there may be a need to cancel, change or reschedule your appointment. We ask that you make any changes **AT LEAST 24 HOURS PRIOR** to your scheduled visit.

Our office makes appointment reminder calls at least 48 hours prior to your appointment. Please make sure that we have the correct contact information on file for you.

Any appointment that is not cancelled within the 24-hour period will be subject to a **$50.00** "no-show/late cancel" fee. New patient no shows will not be rescheduled.

Our physicians and staff look forward to working with you.

SIGNATURE: ______________________ DATE: ______________________

The Toledo Clinic, Inc.
4235 Secor Road
Toledo, Ohio 43623

Financial Policy

We are committed to providing our patients with the best possible medical care and also minimizi administrative costs. This financial policy has been established with these objectives in mind and avoid any misunderstanding or disagreement concerning payment for professional services.

- Our practice participates with numerous insurance companies. For patients who are beneficiaries of on of these insurance companies, our billing office will submit a claim for services rendered. All necessar insurance information, including special forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance in which we do not participate, our office is happy to file the claim upon request however, payment in full is expected at the time of service.
- It is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by the plan at the time of visit. Payments for medical services not covered by an individual's insurance plan are the patient's responsibility, and payment in full is due at the time of visit.
- Payment for professional services can be made with cash, check, or credit card.
- Patients who do not have insurance are expected to pay for professional services at the time of service.
- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of the referral.
- It is the patient's responsibility to provide us with current insurance information and to bring his/her insurance card to each visit. If claims are rejected by insurance company due to untimely filing limits, and the delay is a result of the patient not providing insurance information timely, the patient will be responsible for all charges.
- Our staff is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department. The telephone number is printed on the insurance card.
- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of service. For unaccompanied minors, non-emergent treatment will be denied unless charges have been pre-authorized or payment by credit card, cash, or check at the time of service has been verified. Statements indicating any patient responsible balance will be mailed monthly. Payment in full is due within 30 days .
- Patient balances over 30 days will be subject to a late payment charge equal to 1.25% (15% annual percentage rate) of the balance as of the end of each month.
- Patients will be asked to pay all patient responsible balances in full when they are seen in the office at their next visit.
- Patients with outstanding balances may not be seen by the physician absent medical necessity and are subject to discharge from the practice.
- In the unanticipated event you are unable to pay your bill when due, please contact us as informal arrangements may be worked out.

PATIENT / ACCOUNT INFORMATION
THE TOLEDO CLINIC

DATE	CHART NUMBER

DOCTOR	PRIMARY CARE PHYSICIAN & CITY

A PATIENT INFORMATION

NAME LAST	FIRST	INITIAL	DATE OF BIRTH	AGE	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER

MAIDEN NAME	ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS	MARITAL STATUS	SPOUSES NAME

EMERGENCY CONTACT	RELATIONSHIP	PHONE	EXT	CELLULAR PHONE
ADDITIONAL CONTACT	RELATIONSHIP	PHONE	EXT	CELLULAR PHONE

PREFERRED METHOD OF CONTACT
- ☐ CELLPHONE
- ☐ HOME PHONE
- ☐ E-MAIL
- ☐ TEXT

RACE
- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ HAWAIIAN OR PACIFIC ISLANDER
- ☐ WHITE
- ☐ OTHER
- ☐ UNKNOWN
- ☐ DECLINED

ETHNICITY
- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO
- ☐ UNKNOWN
- ☐ DECLINED

LANGUAGE
- ☐ ARABIC
- ☐ CHINESE
- ☐ ENGLISH
- ☐ FRENCH
- ☐ JAPANESE
- ☐ SPANISH
- ☐ VIETNAMESE
- ☐ UNKNOWN
- ☐ DECLINED

B PERSON RESPONSIBLE FOR PAYMENT - IF PATIENT IS A CHILD, THE PERSON WHO HAS CUSTODY

NAME LAST	FIRST	INITIAL	DATE OF BIRTH	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS

C INSURANCE INFORMATION

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER	
See Cards			
ADDRESS	CITY	STATE	ZIP CODE
NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT
INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	SPECIALIST CO-PAY AMT	

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER	
See Cards			
ADDRESS	CITY	STATE	ZIP CODE
NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT
INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	SPECIALIST CO-PAY AMT	

I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT

SIGNATURE DATE

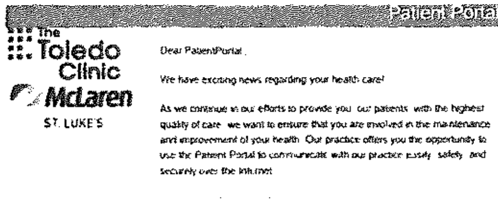
L-2846

The Toledo Clinic
Choose well, feel better.™

Patient Instructions:
First Time Sign-In to the Patient Portal

1. After receiving an email from The Toledo Clinic, click "Set up Portal Account".

Portal login information from your doctor's office


Patient Portal

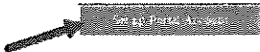
The Toledo Clinic McLaren St. Luke's

Dear PatientPortal,

We have exciting news regarding your health care!

As we continue in our efforts to provide you our patients with the highest quality of care, we want to ensure that you are involved in the maintenance and improvement of your health. Our practice offers you the opportunity to use the Patient Portal to communicate with our practice easily, safely, and securely over the Internet.

To Create Password, Click Below



Username: patientportaltest

2. You will be directed to another page to select a phone number and method of verification – voice call or text message. Once you select the number and method, click "Send Code".

1 User Validation

Welcome PatientPortal

Please select the phone number and the verification code will be sent to the selected number.

Phone Number

*** - *** - 3325 *** - *** - 5332

select an option for each

How would you like to receive a unique code?

Voice Text

If the number(s) or email above are not correct, please call our offices to update your account

Cancel

3. Enter the code you received in the box and then click "Verify".

2 Verification Code

Please enter the validation code you received on the phone number provided

Resend Code

Cancel

4. Create your password and confirm in the second box (*click "Password Guidelines" to ensure you are meeting the password criteria).

3 Reset Password

Please Select your new Password. Refer Password Guidelines* to create secure passwords.

New Password

Confirm New Password

Cancel

5. After reading the consent form, check the box confirming you have read the information, then click "Agree & Next".

4 Consent Form

Please acknowledge reading and accepting conditions in consent form.

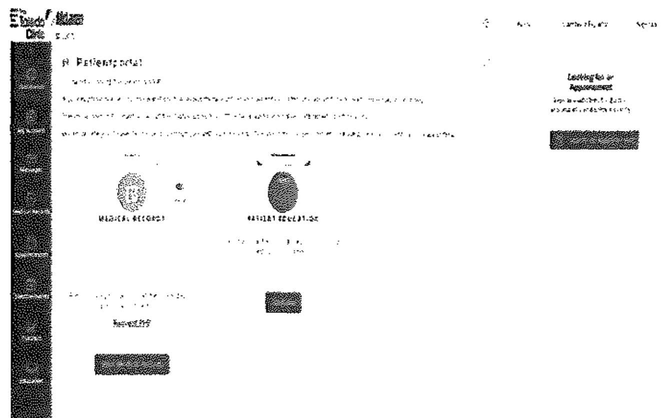
eClinicalworks... Practice Consent Form

ONLINE COMMUNICATION INFORMED CONSENT Instructions for Using Online Communication You agree to take steps to keep your online communication to and from your physician confidential, including the following: Do not store messages on your employer-provided computer; otherwise personal information could be accessed or owned by your employer. Use a screen saver or close your messages instead of leaving your messages on the screen for passersby to read and keep your password safe and private. Do not allow other individuals or other third parties access to the computer(s) in which you store medical communications. Do not use email for medical communications. Standard e-mail lacks security and privacy features and may expose medical communications to employers or other unintended third parties. Withdrawal of this Informed Consent must be done by a written online communication or in writing to your physician's office. Conditions of Using Online Communication The following agreements and procedures relate to online communication: Your physician's office may keep a copy of any online communication from you in your medical record. eClinicalWorks will keep a copy of all medically important online communication in your medical record in an encrypted format. You should print or store (on a computer or storage device owned and controlled by you) a copy of any online communication that is important to you. Neither eClinicalWorks nor your physician's office will forward any online communication from you to third parties except as authorized or required by law. Online communication, including through eClinicalWorks, should be used with caution. eClinicalWorks cannot be used for emergencies or other urgent or time-sensitive matters. Any emergency communication or urgent requests must occur by telephone or through other existing emergency communication tools. If there is other, non-urgent information that you do not want transmitted via online communication, you must contact your physician's practice by phone or fax. eClinicalWorks is not liable for improper disclosure of confidential information. Follow-up is solely your responsibility. You are responsible for scheduling any necessary

☑ I have read the consent form and the above information.

Decline Agree & Next

6. You will now see the dashboard where you can explore the features offered on the patient portal. You are ready to use the patient portal!



Call the EHR Helpline at 419-479-5332 M-F, 8a-5p for help to login to the Patient Portal.