www.toledoclinic.com

Northwest Ohio Pulmonary, Critical Care & Sleep

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

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.

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

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

- 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)

- 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.

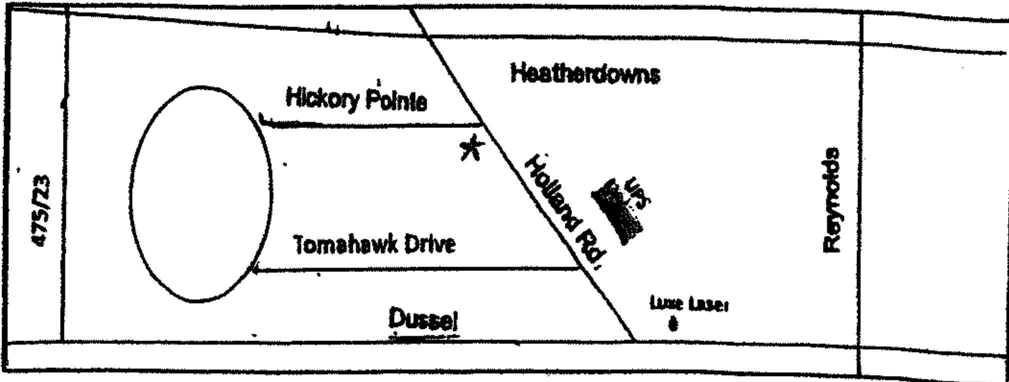
If you are currently using a CPAP/BIPAP machine, please bring the machine and power cord with you to your appointment.

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.

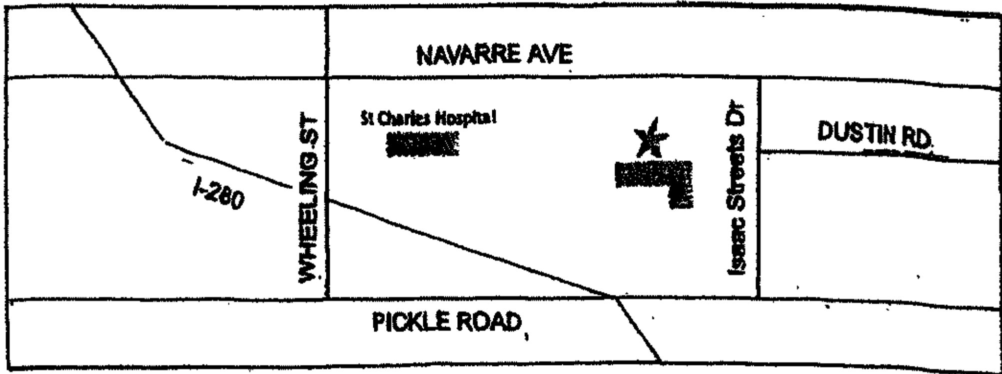
All co-pays are do at the time of service. If you arrive after your scheduled appointment time, you may be asked to reschedule.

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

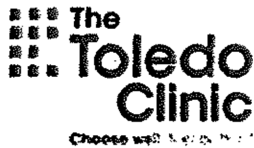


The Toledo Clinic, Inc.
4235 Secor Road
Toledo, Ohio 43623

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 one 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.



NWO Pulmonary, Critical Care & Sleep

Phone: 419-843-7800 Fax: 419-843-3444

Jamey Ruiz, MD   Ryan Griffith, MD   Karl Fernandes, MD

Dean Bernardo, MD   Louis Tartaglia, MD

Name: ____________ **DOB:** ________ **Age:** ______ **Date:** ________

Pharmacy: ____________ **PCP:** ________ **Referring Dr:** ________

Chief Complaint: ____________

When did the problem begin? ____________

Have you ever had a sleep study? If yes, where, and when? ____________

Do you have home oxygen? ____________

Medical Equipment Company used: ____________

Your Medical History:

___ Allergic Rhinitis
___ Angina
___ Arthritis
___ Asthma
___ Bronchitis
___ Cancer
___ COPD
___ Congestive Heart Failure
___ Depression
___ Dizziness
___ Diabetes (Insulin or non-insulin dependent)
___ Emphysema
___ GERD
___ Headache
___ Heart Attack
___ High Blood Pressure
___ Kidney Stones
___ Liver Disease/Hepatitis
___ Low Blood Pressure
___ Pneumonia
___ Prior Intubations
___ Shortness of Breath
___ Sinus
___ Stroke
___ Thyroid (hypo/hyper)
___ Tuberculosis
___ Ulcers
Other: ____________

Surgical History (with Approximate Date):

________ Adenoids   ________ Heart   ________ Stents   ________ Angioplasty
________ Hernia   ________ Stomach   ________ Appendix   ________ Bypass
________ Internal Cardiac Defibrillator   ________ Lung (surgery or biopsy)
________ Tonsils   ________ Gallbladder   ________ Pacemaker
Other: ____________

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Name: ______________________ **DOB:** ______________ **Date:** ______________

Medications/Supplements

Name	Dosage (mg)	Frequency

Allergies with Reactions

Family History

______ Angina
______ Arthritis
______ Asthma
______ Cancer
Type: ____________
______ CHF
______ COPD
______ Depression
______ Diabetes
______ Emphysema

______ Headaches
______ Heart Attack
______ High Blood Pressure
______ Insomnia
______ Kidney Disease
______ Liver Disease/Hepatitis
______ Narcolepsy
______ Obstructive Sleep Apnea
______ Restless Leg Syndrome
______ Thyroid (Hypo or Hyper)

Other: ____

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Name: ______ **DOB:** ______ **Date:** ______

Physical Activity

- Are you: ______ Active ______ Somewhat Active ______ Not Active
- Height: ____________ Weight: ______________
  - Has your weight changed? ____Yes ____ No
    - If yes, how much and over how long? ____________________

Social History

- Caffeine Use: ___________
  - How much per day? ____________________
- Do you smoke? ______Yes ______No
  - If yes, when did you start smoking? ____________ Packs per Day? ____________
  - If former smoker, when did you quit? ____________ How long did you smoke? ________
- Do you use alcohol? ______Yes ______ No
  - If yes, how much per day? ____________________
- Illegal Drug/Substance Abuse? ____________________

Psychosocial History

- Marital Status: ______ Married ______ Divorced ______ Single ______ Widow
- Family Support: ______ Excellent ______ Good ______ Fair ______ Poor ______ None
- Occupation: ______________________ Retired Beginning: ____________
- Shift Worker: ______ Yes ______ No If yes, what shifts? ____________
- Exposure to: ______ Fumes ______ Chemicals ______ Dust ______ Asbestosis
  Other: ______________________________
- Do you have job stress? ______ Yes ______ No
- How long, on average, does it take you to fall asleep? ____________ Minutes/Hours
- How many hours do you sleep at night? ____________________
- Time to bed on WEEKDAYS: ____________ Time Up: ____________
- Time to bed on WEEKENDS: ____________ Time Up: ____________
- How many times do you wake up during the night? ____________
- Do you sleep better away from home? ______ Yes ______ No
- Do you use sleeping pills, tranquilizers, or sedatives to sleep? ______Yes ______No
  - If yes, name and dose of medication: ____________________

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Name: ______________________ **DOB:** ______________________ **Date:** ______________

The Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling "just tired"? This refers to your usual way of life in recent times. Even if you have not had some of these things recently, try to work out how they would have affected you. Use the scale below to choose the most appropriate number for each situation.

0= Would NEVER doze
1= SLIGHT chance of dozing
2= MODERATE chance of dozing
3= HIGH chance of dozing

Situation:	Scale:
1. Sitting and reading	______
2. Watching T.V.	______
3. Sitting inactive in a public place (theater/meeting)	______
4. As a passenger in a car for an hour, without a break	______
5. Lying down to rest in the afternoon, circumstances allowing	______
6. Sitting and talking to someone	______
7. Sitting quietly after lunch, without alcohol	______
8. In a car while stopped for a few minutes in traffic	______
Total:	______

Daytime Functioning

1. How often do you have daytime sleepiness? (Feeling sleepy or struggling to stay awake)
   Daily Weekly Monthly
2. How long ago did your daytime sleepiness start? ______________________
3. How does your sleepiness over the past year compare to prior years?
   Better Worse No Change
4. Do you nap during the day? ______ Yes ______ No
   a. If yes, please state the average number of times per day
      Weekdays ______________ Weekends ______________
   b. If yes, how long is your average nap?
      Weekdays ______________ Weekends ______________
   c. If yes, are you refreshed by your naps? ______ Yes ______ No

The Toledo Clinic
Choose well, feel better.

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5. Do you feel constantly tired and fatigued? ______ Yes ______ No
6. Do you have a difficult time staying awake at work? ______ Yes ______ No
7. Do you doze off while driving? ______ Yes ______ No

8. Have you ever felt weak when you laugh, got angry, or surprised? ______ Yes ______ No
   If yes, please describe: ____________________
   How often has this happened? ____________________
   When did this first start? ____________________
9. Have you ever been unable to move your body as you were falling asleep or waking up?
   ___Yes ____No
   If yes, please describe: ____________________

During the evening/night

1. Do you have an urge to move your legs upon relaxing or falling asleep? ____ Yes ____ No
   If yes, please describe: ____________________
   Does this feeling keep you from falling asleep? ____ Yes ____ No
2. Do you fall asleep more easily in a chair or couch than in bed? ____ Yes ____ No
3. Do you watch T.V, read, or eat in bed prior to falling asleep? ____ Yes ____ No
4. Have you been told that you stop breathing while sleeping? ____ Yes ____ No
   If yes, how often? Rarely Occasionally Frequently
   If yes, when did it start? ____________________
5. Do you ever awaken at night choking or feeling short of breath? ___ Yes ___ No
   If yes, how often? Rarely Occasionally Frequently
6. Do you snore? ___ Yes ___ No ___Unsure
   If yes, how often? Rarely Occasionally Frequently
7. Does your sleep position effect your snoring? ___ Yes ___ No ___Unsure
   If yes, please describe: ____________________
8. Does your snoring or kicking prevent someone from sleeping in the same bed? ___ Yes ___ No
9. Have you ever awakened yourself by kicking your legs at night? ___ Yes ___ No
10. Has your bed partner complained of your legs kicking at night? ___ Yes ___ No
11. Do you have vivid dreams shortly after falling asleep at night? ___ Yes ___ No
12. Do you have nightmares? If so, how frequently?__________ ___ Yes ___ No
13. Do you grind or clench your teeth at night? ___ Yes ___ No
14. Do you walk in your sleep? ___ Yes ___ No
15. Do you talk in your sleep? ___ Yes ___ No
16. Do you toss and turn at night? If yes, how often? ____________ ___ Yes ___ No
17. Has anyone observed unusual movements during your sleep? ___ Yes ___ No
18. Are you easily awakened by noise or light at night? ___ Yes ___ No
19. Do you awaken at night to urinate? If so, how many times?_______ ___ Yes ___ No

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20. Do you have trouble falling asleep? ___ Yes ___ No
21. Do you awaken at night and have trouble falling back asleep? ___ Yes ___ No
22. Do you awaken at night with thoughts racing through your mind? ___ Yes ___ No

In the morning

1. Do you awaken early in the morning and cannot go back to sleep? ___ Yes ___ No
2. Are you bothered by waking up too early and not being able to fall back asleep? ___ Yes ___ No
3. Do you wake up in the morning with a headache? ___ Yes ___ No
4. Do you awaken feeling refreshed? ___ Yes ___ No
5. Do you find it difficult to get out of bed in the morning? ___ Yes ___ No
6. Do you have any other comments on your sleep? ___________________

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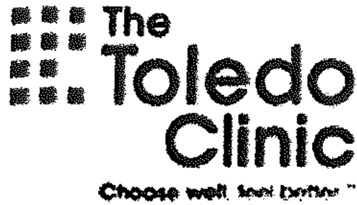
Name: **DOB:** **Date:**

Review of Systems In the last month, have you had any of the following symptoms?

	Admits	Denies
General		[ ]
Loss of energy	[ ]	
Fevers/Chills	[ ]	
Night sweats	[ ]	
Skin		[ ]
Rashes	[ ]	
Change in skin color	[ ]	
Unhealed sores	[ ]	
Blood		[ ]
Unusual bleeding	[ ]	
Easy bruising	[ ]	
Anemia	[ ]	
Enlarged glands	[ ]	
Endocrine		[ ]
Heat/Cold intolerance	[ ]	
Hair growth/loss	[ ]	
Increased thirst	[ ]	
Increased hunger	[ ]	
Eyes/Ears/Mouth		[ ]
Vision trouble	[ ]	
Double vision	[ ]	
Eye pain	[ ]	
Hearing trouble	[ ]	
Ringing in ears	[ ]	
Dizziness	[ ]	
Dental problems	[ ]	
Difficulty swallowing	[ ]	
Mouth sores	[ ]	
Hoarseness	[ ]	
Lungs/Nose		[ ]
Nose bleeds	[ ]	
Cough	[ ]	
Runny nose	[ ]	
Shortness of breath	[ ]	
Wheezing	[ ]	
Cold	[ ]	

	Admits	Denies
Cardiac		[ ]
Heart problems	[ ]	
Chest pain	[ ]	
Heart murmurs	[ ]	
Heart attack	[ ]	
Fainting	[ ]	
Difficulty laying	[ ]	
Gastrointestinal		[ ]
Abdominal pain	[ ]	
Heartburn	[ ]	
Nausea/Vomiting	[ ]	
Diarrhea	[ ]	
Constipation	[ ]	
Blood in stool	[ ]	
	[ ]	
Urinary		[ ]
Burning while urinating	[ ]	
Blood in urine	[ ]	
Increased urine	[ ]	
Flank pain	[ ]	
Trouble in start/stop	[ ]	
Muscle/Skeleton		[ ]
Joint pain	[ ]	
Morning stiffness	[ ]	
Back problems	[ ]	
Neurologic		[ ]
Blackouts	[ ]	
Seizures	[ ]	
Frequent headaches	[ ]	
Muscle weakness	[ ]	
Trouble talking	[ ]	
Balance problems	[ ]	
Memory problems	[ ]	
Emotion		[ ]
Mood swings	[ ]	
Crying spells	[ ]	
Depression	[ ]	
Psychiatric	[ ]	

Name: **DOB:** **Date:**



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SAFETY AND SLEEPINESS

I understand that I am being evaluated for a sleep disorder that is frequently associated with sleepiness during the daytime. The risks of driving and/or operating heavy machinery has been explained to me by a staff physician. I have had the opportunity to ask questions of the sleep physician regarding driving and sleepiness.

Signature: ______________________________

Date: ______________________________

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: ______________________

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 _______________

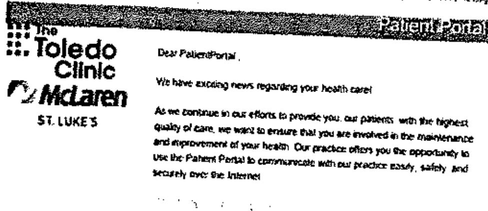
The Toledo Clinic

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



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

*** - *** - 3375 *** - *** - 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 Send Code

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.

Enter code 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 Next

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.

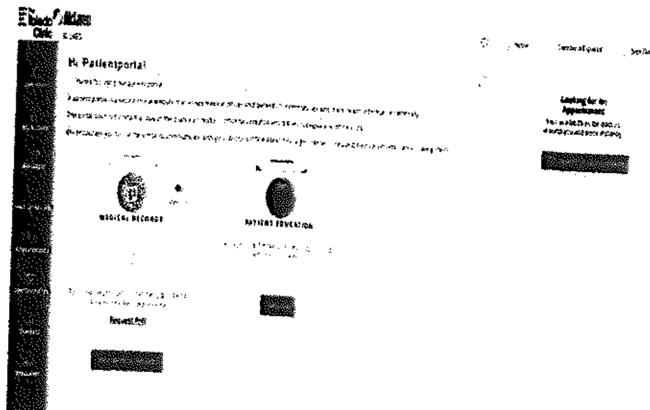
eClinicalworks Practice Consent Form

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.