Lyracore Office Information and Policies

Everything we do is for our patients. Familiarizing yourself with our policies and procedures helps ensure that your visit runs smoothly.

Please arrive on time for appointments. If you're running late, just give us a call, we'll hold your appointment for 15 minutes. If you are over 15 minutes late for your appointment we may need to reschedule it for the next available appointment.

Late Cancellation or Missed Appointment Fees. We understand that life happens. If you need to cancel or reschedule your appointment please call us *at least* 24 hours before your scheduled appointment to avoid a $50.00 fee.

Payment for copays and deductibles are collected at the time of your appointment.

Have a question? We're here. Call us any anytime during our regular business hours for routine non-emergency requests and questions. If you have a medical emergency, please call 911 or go to the nearest emergency room.

Our business hours are
Monday 8:30AM – 4:30PM
Tuesday 8:30AM - 4:30PM
Wednesday 8:30AM – 4:30PM
Thursday 8:30 AM – 4:30PM
Friday 9:00AM – 1:00PM

We do not provide chronic pain management. For chronic narcotic medication management, please contact your primary care physician or pain management physician.

Keep your doctor in the loop. Since non=pulmonary medical problems need to be addressed by a primary care physician (PCP), we recommended that you remain under their care as part of your outpatient pulmonary treatment program. We can help with disability paperwork. Our disability paperwork process takes a minimum of 5-7 days and has a $25 fee. If we haven't seen you in the past 90 days, you will also need to have an office in order for the physician to complete your paperwork.
Returned Check Policy Returned checks must be paid in full within 10 days of notification, plus a $25 fee.

Florida Agency for Health Care Administration (AHCA) 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. YOU DO NOT NEED TO RESPOND TO THIS NOTICE.

AHCA's Responsibilities

The Agency for Health Care Administration is required by law to maintain the privacy of your protected health information in our custody. We must provide you with notice of our legal duties and privacy practices with respect to your health information. We must also follow the terms of this notice.

How AHCA Uses and Safeguards your Health Information

If you are a Medicaid/MediKids recipient, we use your health information to pay for your health services and to operate the Medicaid program. We may also use your health information to tell you about treatment alternatives or other health-related benefits and services.

The following are some examples of how we may use your health information:

- **Your doctor may send us a claim to pay. The claim includes information that identifies you and the type of care you received.**
- **We may share your information with a company that reviews hospital records to check on the quality of care that you received.**
- **We may send appointment reminders for Child Health Check-Up services.**

AHCA may also use and disclose your health information as permitted by law, such as:

- **To entities outside the agency for purposes directly connected with the administration of the State Medicaid plan.**
- **In responding to public emergencies, access to your health information may be granted to persons or agency representatives who are subject to standards of confidentiality comparable to those of AHCA. Such other agencies may include the Federal Emergency Management Agency (FEMA) or the Centers for Disease Control (CDC).**
- **Where disclosure would assist in determining eligibility for benefits, amount of medical assistance payment or otherwise assists the agency in the administration of the Medicaid program.**
- **To the confidential Florida abuse hotline in order to report abuse, neglect and/or domestic violence as per criteria and conditions imposed on the agency by law.**
- **For health oversight activities and/or administration of the Medicaid program, such as inspections, investigations, and audits.**
- **To conduct research to benefit the Medicaid program.**
- **For purposes of treatment, payment, or our operations and as otherwise required by law.**

Other uses or disclosures of your protected health information require your or your personal representative's written authorization. For example, we will not use or disclose psychotherapy notes without your written authorization or as allowed by law. We will not use or disclose your protected health information for marketing purposes without your written authorization and we will not sell your protected health information without your written authorization. We also are prohibited by law from using or disclosing genetic information for insurance underwriting purposes. At any time, you may revoke authorizations in writing. If you cannot give your authorization due to an emergency, we may release your health information if it is in your best interest.

Your Health Information Rights

You have the following rights with respect to your protected health information:

- **To see or obtain a copy of your health information that is maintained by AHCA. We may not be able to provide health information that includes psychotherapy notes, is part of a legal case, or is otherwise excluded from disclosure by law. We may charge a copying fee.**
- **To request that we amend health information we maintain that you believe is incorrect or incomplete.**
- **To request a list of disclosures we have made of your health information. The list may not include disclosures authorized by you, disclosures for treatment, payment and health care operations, or other disclosures permitted by law.**
- **To request that we contact you at a different address or phone number, if contacting you about your health information at your present location would endanger you.**
- **To request that we limit the use and disclosure of your health information. We are not required to agree to your request.**
- **To request another paper copy of this notice.**
- **To opt-out of fundraising communications from us should AHCA ever engage in fundraising.**
- **To receive a notification from us following a breach of your unsecured protected health information.**

Contact Information

If you have any questions, wish to make a request regarding your health information, or would like another paper copy of this notice, please contact the toll-free Medicaid Help Line listed below. We may ask you to make the request in writing.

Florida Medicaid Recipient Help Line: (877) 254-1055

Filing a HIPAA Complaint

If you believe your privacy rights have been violated by AHCA or one of its employees, you may file a complaint with AHCA and/ or the Secretary of the Department of Health and Human Services at the addresses below. You will not be retaliated against for filing a complaint.

Privacy Officer
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop 4
Tallahassee, Florida 32308
(850) 412-3960

Secretary
Department of Health and Human Services
200 Independence Ave. SW
Washington, D.C. 20201
(800) 368-1019

Future Changes to the Notice of Privacy Practices

AHCA reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information that we maintain. If we make a material revision to this notice, we will send a revised copy of the notice to recipient households within sixty (60) days of the revision.

Who receives the Notice of Privacy Practices

We send this notice to every recipient household. This notice applies to all Florida Medicaid recipients.

Patient Name _____ DOB _____

Lyracore Office Information and Policies

Release of Information Policies

All authorizations must be signed by the patient, unless he/she is a minor, deceased, physically and/or mentally impaired, or has appointed a Durable Healthcare Power of Attorney or has a court appointed guardian. Due to State and Federal laws, no exceptions will be made. Please allow 5-7 business days for processing medical records requests. Medical records may be delivered by mail, electronically, or be picked up in the office.

Expiration and Right to Revoke Authorization

To be valid, this authorization must be dated within 12 months of the request for the information. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Lyracore Health Alliance. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

Re-disclosure

I understand that if my health information is disclosed to a party other than a healthcare provider, health plan or healthcare clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

Release and Waiver If the health information that I have requested Lyracore Health Alliance to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/ or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immuno-deficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), Venereal Disease, Tuberculosis, or Hepati-tis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Lyracore Health Alliance and staff from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above. This authorization is given pursuant to Florida law.

Signature of Patient (or Patient's Representative) _____

Date _____ *Printed Name Description of Authority to Act for Patient* _____

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative _____

Date _____ *Printed Name of Patient or Personal Representative* _____

Note: a copy of this completed, signed and dated form must be provided to the patient and/or Patient's representative and a copy must be placed in the patient's medical record

Tampa Office: 602 S. Audubon Ave. Suite B, Tampa, Florida 33609
Sun City Office: 1901 Havorford Ave. Suite 111, Sun City, Florida 33573

Ph: (813) 853-0500 | **Fax:** (813)570-6357 | www.lyracore.com

LYRACORE HEALTH ALLIANCE

Patient Name _____ **DOB** _____

Demographics

Patient Name			*Birth Date* / /
Street Address	*City*	*State*	*ZIP*
Social Security #	*Work Phone*	*Home Phone*	*Cell Phone*
Email			*Sex* ☐ *Female* ☐ *Male*
Marital Status ☐ *Single* ☐ *Married* ☐ *Divorced* ☐ *Widowed*			*Spouse Name*
			Spouse Phone

Pharmacy			*Location*
Primary Care Physician			*City*
Referring Physician			*City*

Primary Insurance ID/Subscriber #	*Group #*
Secondary Insurance ID/Subscriber #	*Group #*

Patient Name _____ DOB _____

Communication Preferences

Release of Information Policies

Patient Name	Birth Date / /

For correspondence of your medical information Lyracore Health Alliance may contact you via:
(please check all that apply)

- ☐ *Mobile Phone*
- ☐ *Home Phone*
- ☐ *OK to mail to my home address*
- ☐ *OK to fax to this number* — *Fax*
- ☐ *OK to email to this address* — *Email*

I authorize Lyracore Health Alliance to communicate with me by e-mail regarding my "protected health information" (PHI) (as that term is defined in the Health Insurance Portability and Accountability Act: HIPAA of 1996 and its implementing regulations) using my email address shown above. By inserting my email address, I acknowledge that:

a) Protected Health Information. Email is not necessarily a secure medium for sending or receiving PHI and, there is always a possibility that a third party may gain access; b) Security. Although the Practice and the Physician will make all reasonable efforts to keep email communications confidential and secure, neither the Practice nor the Physician or Staff can assure or guarantee the absolute confidentiality of email communications;

Emergency Contacts

Please list relatives / friends that you give Lycore Health Alliance permission to discuss your medical condition with. This includes but not limited to test or blood work results, physician's recommendations, etc.

In case of emergency, Lyracore Health Alliance should contact:

Name	Relationship	Phone

Patient Signature

I, _____ give Lyracore Health Alliance, permission to discuss my medical condition with any person listed above.

Communication Preferences

Authorization to Release Medical Records Information

Patient Name	Birth Date / /

I Hereby Authorize Lyracore Health Alliance to DISCLOSE or REQUEST information to/from:

Name			
Street Address	City	State	ZIP
Phone	Fax		

Name			
Street Address	City	State	ZIP
Phone	Fax		

Description of Health Information To Be Disclosed and/or Requested

☐ Procedure Notes ☐ Lab results ☐ Complete Medical Record ☐ Imaging reports

☐ Office notes/Progress notes ☐ Other ☐ None

Contact for Clinical Research Information

Are you interested in hearing about Clinical Research trials? ☐ Yes ☐ No

If yes, you are authorizing Lyracore Health Alliance to share your contact information only with a representative indicated in such research and trials. We will not share any health records unless you authorize their release.

Patient Signature	Date

LYRACORE HEALTH ALLIANCE

Patient Name _____ **DOB** _____

Assignment of Benefits / Consent to Treat

Name of Insured: _____ Date of Birth: _____

(Please Print)

I request that payment of authorized insurance benefits, including Medicare, if I am a Medicare beneficiary, be made on my behalf to Aldor Pulmonary LLC for any medical services provided to me by that organization.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related equipment or services to the organization, the Health Care Financing Administration, my insurance company or other entity, if requested.

I understand that I am financially responsible to the organization for any charges not covered by health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives that claim. I am responsible for the entire bill or balance of the bill as determined by the organization and/or my health care insurer if the submitted claims or any part of the submitted claims are denied. I UNDERSTAND THAT BY SIGNING THIS FORM I AM ACCEPTING FINANCIAL RESPONSIBILTY AS EXPLAINED ABOVE FOR ALL PAYMENTS FOR SERVICES RECEIVED.

By signing this document, I also acknowledge that I have received a copy of the organizations Notice of Privacy Practices as required by HIPAA.

I understand that by signing this form I am giving permission for Aldor Pulmonary LLC to provide medical treatment. I also understand I have the right to refuse any procedure or treatment and have the right to discuss all medical treatments with my physician.

_____ Date: _____

Signature of Insured, Parent or Guardian

_____ _____

Print name if not signed by insured Relationship to Insured

Patient Name _____ DOB _____

Medications

Please list all prescription and non-prescription medications, vitamins, home remedies, and herbs. Please use back of form if additional space is needed.

Medication/Supplements	Dose	Start date	Reason

Tampa Office: 602 S. Audubon Ave. Suite B, Tampa, Florida 33609
Sun City Office: 1901 Havorford Ave. Suite 111, Sun City, Florida 33573

Ph: (813) 853-0500 | **Fax:** (813)570-6357 | www.lyracore.com

LYRACORE HEALTH ALLIANCE

Patient Name _____ **DOB** _____

Medical History

Please indicate whether you have had any of the following medical problems and include dates to indicate when the problem occurred.

- ☐ *Cancer*
- ☐ *Rheumatoid Arthritis*
- ☐ *SLE*
- ☐ *Lupus*
- ☐ *Sleep Apnea*
- ☐ *COPD/Emphysema*
- ☐ *Asthma Heart Attack*
- ☐ *Coronary Artery Disease*
- ☐ *Congestive Heart Failure*
- ☐ *High Blood Pressure*
- ☐ *Stroke*
- ☐ *Bleeding/clotting problems*
- ☐ *Diabetes*
- ☐ *High cholesterol*
- ☐ *Poor circulation*
- ☐ *Depression/suicide attempt*
- ☐ *Other (specify):*

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LYRACORE HEALTH ALLIANCE

Patient Name _____ **DOB** _____

Allergies

Medication Allergires

Please list all medications that you are allergic to and the reaction you had when taking the medication.

Medication	*Reaction*
Medication	*Reaction*
Medication	*Reaction*
Medication	*Reaction*

Are you allergic to Albuterol and/or Xopenex nebulizer solution? ☐ *Yes* ☐ *No*

Have you had a flu shot? *Yes* ☐ *No* ☐ *Date* _____

Have you had a pneumonia shot? *Yes* ☐ *No* ☐ *Date* _____

When/Where was your most recent:

CT Scan Chest *Location* _____ *Date* _____

Chest x-ray *Location* _____ *Date* _____

Echocardiogram *Location* _____ *Date* _____

Sleep Study *Location* _____ *Date* _____

Bone density test *Location* _____ *Date* _____

EKG Breathing Test (PFT) *Location* _____ *Date* _____

Please list any surgeries or procedures you have had in the past.

Procedure _____ *Date* _____

Procedure _____ *Date* _____

Procedure _____ *Date* _____

Procedure _____ *Date* _____

Patient Name _____ DOB _____

Family History

Please indicate with a check mark any family members who have had any of the following medical conditions:

Mother	☐ *Stroke*	☐ *Diabetes*	☐ *Cancer*	☐ *Anemia*	☐ *Asthma*	☐ *Autoimmune disorder*	☐ *Thyroid Disorder*	☐ *Lung Disease*
	☐ *High blood pressure (hypertension)*	☐ *Kidney disease*	☐ *Osteoporosis*	☐ *Peripheral vascular disease*	☐ *Heart Disease*			
Father	☐ *Stroke*	☐ *Diabetes*	☐ *Cancer*	☐ *Anemia*	☐ *Asthma*	☐ *Autoimmune disorder*	☐ *Thyroid Disorder*	☐ *Lung Disease*
	☐ *High blood pressure (hypertension)*	☐ *Kidney disease*	☐ *Osteoporosis*	☐ *Peripheral vascular disease*	☐ *Heart Disease*			
Sister	☐ *Stroke*	☐ *Diabetes*	☐ *Cancer*	☐ *Anemia*	☐ *Asthma*	☐ *Autoimmune disorder*	☐ *Thyroid Disorder*	☐ *Lung Disease*
	☐ *High blood pressure (hypertension)*	☐ *Kidney disease*	☐ *Osteoporosis*	☐ *Peripheral vascular disease*	☐ *Heart Disease*			
Brother	☐ *Stroke*	☐ *Diabetes*	☐ *Cancer*	☐ *Anemia*	☐ *Asthma*	☐ *Autoimmune disorder*	☐ *Thyroid Disorder*	☐ *Lung Disease*
	☐ *High blood pressure (hypertension)*	☐ *Kidney disease*	☐ *Osteoporosis*	☐ *Peripheral vascular disease*	☐ *Heart Disease*			

Patient Name _____ DOB _____

Social History

Tobacco Use

Do you currently smoke cigarettes? ☐ *Yes* ☐ *No*

If yes, at what age did you start smoking? _____

On average I smoke _____packs per day

Do you smoke cigars?

I smoke _____cigars per day.

Do you smoke a pipe?

I smoke _____pipes per day.

Do you use smokeless tobacco (chewing tobacco, snuff)

If yes, at what age did you start? _____

Are you interested in quitting? ☐ *Yes* ☐ *No*

Have you tried to quit in the past? ☐ *Yes* ☐ *No*

Alcohol Use

Do you drink alcohol? ☐ *Yes* ☐ *No*

If yes, how many drinks do you consume per week?_____

Alcohol type:

Drug Use

Do you use illicit drugs? ☐ *Yes* ☐ *No*

Type: _____

Length of use: _____

Patient Name _____ DOB _____

LYRACORE HEALTH ALLIANCE

Environment

Occupational Exposures (such as asbestosis): _____

Pets at home: *Yes* ☐ *No* ☐

Carpet: *Yes* ☐ *No* ☐

Birds at home: *Yes* ☐ *No* ☐

Insect Infestation: *Yes* ☐ *No* ☐

Mold: *Yes* ☐ *No* ☐

Tuberculosis Exposure: *Yes* ☐ *No* ☐

Recent Travel: *Yes* ☐ *No* ☐

If yes, location: _____

Patient Name _____ DOB _____

Graduated Apnea Screening Protocol (GASP) Questionnaire

Have you been told (or noticed on your own) that you snore on most nights?

☐ Yes ☐ No ☐ Unsure

Have you been told that you stop breathing or struggle to breath in your sleep?

☐ Yes ☐ No ☐ Unsure

Are you tired, fatigued, or sleepy on most days?

☐ Yes ☐ No ☐ Unsure

Do you have acid indigestion or high blood pressure (or use medication to control any of these conditions)?

☐ Yes ☐ No ☐ Unsure

Are you overweight?

☐ Yes ☐ No ☐ Unsure

Patient Name _____ DOB _____

The Epworth Sleepiness Scale

On a scale of 0 (never) to 3 (high), please identify the likelihood of dozing off in the following situations.

Activity Score(0-3)				
Sitting and Reading	0 ☐	1 ☐	2 ☐	3 ☐
Watching TV	0 ☐	1 ☐	2 ☐	3 ☐
Sitting, inactive in a public space (i.e., theater or meeting)	0 ☐	1 ☐	2 ☐	3 ☐
As a passenger in a car for an hour without a break	0 ☐	1 ☐	2 ☐	3 ☐
Lying down to rest in the afternoon if the circumstances permit	0 ☐	1 ☐	2 ☐	3 ☐
Sitting and talking to someone	0 ☐	1 ☐	2 ☐	3 ☐
Sitting quietly after lunch without alcohol	0 ☐	1 ☐	2 ☐	3 ☐
In a car, while stopped for a few minutes in traffic	0 ☐	1 ☐	2 ☐	3 ☐