MOHAMED SAMEEN, D.O.
PULMONARY MEDICINE
75. N. Country Road
Port Jefferson, NY 11776
Phone 631-476-2766 Fax 631-476-2772

Patient's Name: ____

Date: ___________________________Time: _____________________

This is confirmation of your appointment with Dr. Sameen.

Enclosed you will find a packet of papers.

On the day of your appointment, ***please bring all of the following:***

- The above-mentioned papers, completely filled out
- Your medical insurance cards
- Any referrals (if required by your insurance company)
- A photo ID

Please call within 48 hours if you cannot make this appointment.

There is a $25.00 charge for any and all missed appointments.

Directions to Dr. Sameen's Office:

Sleep Disorders Center

Mather Hospital

Frey Family Foundation Medical Arts Building

625 Belle Terre Road

Port Jefferson, NY 11777

1st Floor

Mohamed Sameen, MD
3400 Nesconset Highway * Suite 103 *East Setauket NY 11733
NPI 1275577579

PATIENT NAME

Sex: M F

DOB

MARITAL STATUS
Single () Married ()
Widowed () Divorced ()

STREET ADDRESS:

CONTACT NUMBERS:
H:
C:

EMAIL:

CITY / ZIP:

PATIENT SOCIAL SECURITY #:

Name of Employer (IF APPLICABLE)

Business phone

REFFERING PHYSICIAN:

PRIMARY CARE PHYSICAN:

INSURED'S INFORMATION

Person who holds insurance policy: Self__ Spouse__ Parent__ Other__
Insured's Social Security Number :______________________________
Insured's Birthdate:__________
Address (If Different then patient):
Phone (If Different then patient):

INSURANCE INFORMATION

Primary Insurance Name: ID# Insured (circle one)
patient above insured

Secondary Insurance Name: ID# Insured (circle one)
patient above insured

I the undersigned authorize payment of medical benefits to Dr. Sameen, for any services furnished to the patient by him. I understand that I am financially responsible for any amount not covered by my insurance contract. I also authorize you to release to my insurance company or their agent any information concerning health care, treatment plan or supplies provided to me. If there is a default in the payment of any sums due, and the account is forwarded to collections, the responsible party will be held responsible for all collection costs and attorney fees as well as the original payment.

If your insurance requires a referral and you do not provide one, you will be responsible for all charges incurred. There will be a $25.00 charge for any and all missed appointments unless 48hr notice is given.

______________________________ ______________
(Patient Signature) **DATE**

Dr. Mohamed Sameen
3400 Technology Drive * Suite 103* E. Setauket, NY 11733
631-675-9393

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

I hereby authorize the use and disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I also understand that if a person or organization authorized to receive my information is not a health plan or health care provider; the released information may be subject to redisclosure and may not longer be protected by the federal privacy regulations.

Patient Name: ______________________________ **DOB:**______________

Persons / Organizations authorized to disclose my information:
Suffolk Pulmonary & Sleep Disorders
John T. Mather Memorial Hospital
Island Concierge Medical Services, PLLC
St. Charles Hospital
Brookhavey Hospital

******Any Organization, Persons, or Medical Doctors that you would like to receive information from Dr. Mohamed Sameen.**

1.____
____

2.
____
____

3.
____
____

Specific Description of information to be disclosed (including dates):
Test results and diagnosis.

1. I understand that this authorization will expire 12 months from the date listed below.
2. I understand that I may refuse to sign this form and that my health care and the payment for my health care will not be affected if I do not sign this form.
3. I understand that I may revoke this authorization at any time by notifying the providing organization disclosing my patient information in writing, but if I do, the revocation will not have any effect on actions the organization has already taken in reliance on this authorization.

This form MUST be completed before signing.

____ ______________
(Signature of patient 18 years or older or patient's representative) Date

____ ______________
(Parent or Guardian) Date

Mohamed Sameen, MD

3400 Nesconset Hwy, Ste.103
(8 Technology Drive)
East Setauket, NY 11733
Phone: 631-675-9393
Fax : 631-675-9391

PATIENT AGREEMENT OF FINANCIAL RESPONSIBILITY

Please read and sign the following statement regarding your financial responsibility for services rendered at this office.

Participating Insurance Plans
Participating with your insurance plan means that we have agreed to accept their contracted rates as a payment in full for all covered services. This does not include the portion which is the patient's responsibility, such as co pays, deductibles and non-covered services. Insurance plans do not always cover all of the services provided. Additionally, if your insurance company requests information from you regarding other insurance that you may have and you do not comply with their request, you will be responsible for payment of any denied claims.

DEDUCTIBLE AMOUNT $____________

Non Participating Insurance Plans
All fees are due at time of visit. A receipt will be provided for you to submit to your insurance carrier.
FEES FOR CLAIMS MAY SOMETIMES BE SENT TO YOU BY YOUR INSURANCE COMPANY. PLEASE IMMEDIATELY BRING THIS TO THE OFFICE WITH THE EOB (EXPLANATION OF BENEFITS). IF THIS AMOUNT IS NOT FORWARDED TO US WITHIN 3 WEEKS OF YOUR RECEIVING IT, THE ACCOUNT WILL BE SENT TO COLLECTION AND YOU WILL BE RESPONSIBLE FOR THE ENTIRE AMOUNT BILLED (NOT JUST THE INSURANCE PAYMENT) AND ADDITIONALLY YOU WILL BE RESPONSIBLE FOR ALL COLLECTION COSTS.

Past Due Accounts
All accounts that are over 30 days hand have not been paid, will accrue a service charge of $20 per month until the balance is paid in full. If we do not receive payment within 60 days, the account will be placed for collection. The patient will be responsible for all collection costs and attorney's fees. If there is a default in the payment of any sums due, the patient agrees that if the physician retains an attorney, not a salaried employee, to prosecute a claim for unpaid balances, that in such event, the patient will additionally pay reasonable attorney's fees and court costs.

I have read the Financial Policy stated above and agree to its terms.

______________________________ ______________________________
Signature of Patient or Responsible Party Date

Mohamed Sameen, MD

3400 Nesconset Hwy, Ste.103
(8 Technology Drive)
East Setauket, NY 11733
Phone: 631-675-9393
Fax : 631-675-9391

Health Insurance Portability & Accountability Act (HIPAA)

Patient's Name: ______________________________ Date: ________________

This form contains how your Protected Health Information (PHI) will be used in our office. By signing at the end of these policies, you agree to all stipulations:

1. The patient understands and agrees to allow Suffolk Pulmonary and Sleep, Dr. Mohamed Sameen, to use their PHI for the purpose of treatment, payment, health care operations and coordination of care.
2. The patient has the right to their exam and to obtain a copy of his/her own health records at any time and request corrections. The patient may request the disclosures that have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Suffolk Pulmonary and Sleep to assure that your records are not readily available to those who do not need them.
6. I understand that incidental disclosures of my PHI may be made. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.
7. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the office has the right to refuse care.

Assignment of Benefits

1. I authorize, assign and direct my insurance carrier to pay directly to Suffolk Pulmonary and Sleep Disorders, Dr. Mohamed Sameen, for services rendered to me, now or hereafter, which are payable under my insurance contract.
2. Patient agrees that in the event the patient receives checks, drafts or other payment subject to this agreement, to act as fiduciary agent to the office. The office agrees to apply any proceeds to the patient's debt for services rendered.
3. I fully understand and agree that insurance policies are an arrangement between the insurance carrier and me. I will be responsible for expenses not paid by the insurance carrier. I also understand that I am responsible for any referrals required by my insurance carrier.
4. I UNDERSTAND THAT THE PROVIDER IS LEGALLY OBLIGATED TO COLLECT ALL COPAYS, DEDUCTIBLES &/OR COINSURANCE DEEMED TO BE PATIENT/INSURED RESPONSIBILTY BY THE INSURANCE COMPANY.
5. I understand that there may be separate services billed by John T. Mather Memorial Hospital and/or St. Charles Hospital and that these services are separate and distinct services received from the doctor. I also understand that these services would incur separate and distinct copays, deductibles &/or coinsurance.
6. I understand that I must provide all information required for my Worker's Compensation/No Fault insurance or I will be responsible for the expenses incurred. ___Not Applicable ____Information provided.
7. I understand that, if necessary, the office may employ collection counsel and/or an attorney on my bill. I will be responsible for any said collection and/or attorney fees.

I acknowledge that I have read or have had read to me the above information. I have also had the opportunity to ask questions about it and understand that I may receive a copy of this at my request. By signing below I agree to the above mentioned statements.

Signed: ______________________________ Date: ________________

Signature of Patient or Legal Representative

If signed by legal representative, please indicate the relationship: ______________________

Mohamed Sameen, MD DABSM
DIPLOMATE AMERICAN BOARD OF PULMONARY MEDICINE
DIPLOMATE AMERICAN BOARD OF CRITICAL CARE
DIPLOMATE AMERICAN BOARD OF SLEEP MEDICINE
3400 Nesconset Hwy, Ste.103
(8 Technology Drive)
East Setauket, NY 11733

631-675-9393 Fax 631-675-9391

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

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Patient Name: ____________________________________

Persons / Organizations authorized to disclose my information:
Dr. Mohamed Sameen

Organizations/Person who may receive my information:

Referring Dr. ______________________	**Primary Dr.** ________________
Address: __________________________	**Address:** ___________________
Phone: _______________	**Phone:** ____________________

Others who may receive my information: ______________________________
____
____

Specific Description of information to be disclosed (including dates):
Test results and diagnosis.

1. I understand that this authorization will expire 12 months from the date listed below.
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This form MUST be completed before signing.

____ ______________
(Signature of patient 18 years or older or patient's representative) Date

____ ______________
(Parent or Guardian) Date

Mather Hospital Northwell Health® • 75 North Country Road, Port Jefferson, N.Y. 11777

Patient Label

Patient Name:____
Male______ Female______ Age Date of Birth:______
Height ______ Weight ______ Neck Size ______ inches

Primary Care Physician:____________________ Referring Physician:____________________

1. Please describe your sleep problems in your own words. Please be as detailed as possible.
   a. ____
   b. ____
   c. ____
   d. ____

2. How long have you had your sleep problem?____
3. Have you or your partner noted loud snoring or abnormal breathing during sleep?
   ______ Yes ______ No
4. Do you have frequent difficulty concentrating or have lapses in attention due to drowsiness?
   ______ Yes ______ No
5. Do you take naps during the day? ______ Yes ______ No
   i. If yes, how long? _________________________
   ii. Do you awaken refreshed? ______ Yes ______ No
6. What time do you get into bed?____
7. How long does it take you to fall asleep after lights out?_________________________________
8. Do you awaken during the night? ______ Yes ______ No
   i. If yes, how many times? _________________________
   ii. Do you get out of bed? ______ Yes ______ No
   iii. Do you stay in bed trying to get back to sleep? ______ Yes ______ No
   iv. How long does it take for you to fall back asleep?_____________________________
   v. What do you do in the meantime?____
9. What time do you arise in the morning?
   i. Weekdays (Work days) _______________ Weekends (Days off) _______________
   ii. Do you feel more refreshed when you sleep in? ______ Yes ______ No
10. Do you awaken refreshed?______ Yes ______ No
    i. Tired and groggy? ______ Yes ______ No
    ii. With headaches? ______ Yes ______ No
11. Were you a good sleeper prior to your sleep problem?______ Yes ______ No
12. Were you ever unable to more your arms and legs upon awakening?
    ______ Yes ______ No

13. Do you become weak in the knees with laughter or strong emotion?
    ______ Yes ______ No
14. Do you feel sleepy while driving?
    Always ______ Sometimes ______ Rarely ______ Never______
15. Have you ever walked in your sleep? ______ Yes ______ No
16. Are you a restless sleeper, thrash, or kick? ______ Yes ______ No
17. Have you gained or lost significant weight over the last year?______ Yes ______ No
18. Do you get tingling, weakness, cramps, twitches, or other "funny" feelings in your legs that make you keep moving or flexing them and prevent you from sleeping or relaxing?
    ______ Yes ______ No
19. Were you ever knocked unconscious, or suffered a major head injury?
    ______ Yes ______ No
20. Have you ever had a major infection of the central nervous system (meningitis, encephalitis, etc)?
____ ______ Yes ______ No
21. Please list all the medications dose and frequency you are currently taking, or took in the last 3 months:

    ____

    ____

    ____

22. Does anyone in your family snore or have been told they have Sleep Apnea?
    If yes, relationship ______________________
23. Have you ever bee told that you have: ***Circle all that apply:***

High Blood Pressure	Diabetes	Allergic Sinusitis	Deviated Nasal Septum
Asthma COPD	Neuropathy	Thyroid Condition	Seizures or Epilepsy
Heart Condition	Depression	Acid Reflux (GERD)	Psychiatric Disturbances

Other:

____

24. Please list all allergies (pollen/dust), drug allergies, or any other medical facts that you may feel are important?

    ____

    ____

    ____

25. Have your tonsils ever been removed?______________________________
26. Is your nose constantly running or frequently congested?______________________
27. Present occupations and working hours:______________________________
28. **My major problem(s)** ***Check all that apply:***

_____ Sever daytime drowsiness
_____ Difficulty falling or staying asleep
_____ Problems breathing at night or snoring
_____ Doing unusual things in my sleep (i.e. sleep walking, night terrors, night sweats, bed wetting, screaming, etc.)
_____ Other (please explain)

29. Please rate your likelihood to fall asleep under the following conditions?
(0 = Never, 1 = Slight, 2 = Moderate, 3 = Severe)
    i. Sitting and reading ______
    ii. Watching TV ______
    iii. Sitting inactive in a public place ______
    iv. As a passenger in a car for at least an hour without a break ______
    v. Lying down in the afternoon, when circumstances permit ______
    vi. Sitting and talking to someone ______
    vii. Sitting quietly after lunch without alcohol ______
    i. In a car, while stopped for a few minutes in traffic ______
30. Are you presently under unusual stress at home? ______ Yes ______ No
At work? ______ Yes ______ No
31. What medications do you take to help you fall asleep?
____
____
32. Do you ever have a dream like (visual) experiences after wakening?
______ Yes ______ No
33. Do you remember your dreams?
    i. Usually ______ Rarely ______ Never______
    ii. Are they usually: Non-frightening ______ Frightening______
34. Are they vivid? ______ Yes ______ No
Only small fragments? ______ Yes ______ No
35. How many cups of caffeineated beverages do you consume daily?________________________
36. How much alcohol do you consume daily? (please be specific)
____
37. How much do you smoke? ____
38. Do you need assistance to be mobile?______ Yes ______ No
39. Do you need assistance to the bathroom? ______ Yes ______ No
40. Do you have any special needs that we should be aware of?
    a. ____
    b. ____
    c. ____
    d. ____

Person completing interview ____

Date: ______________________ Time: ____________________