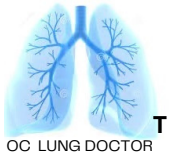


THOMAS J. ASCIUTO, MD CORP

WELCOME TO
THOMAS J. ASCIUTO MD CORPORATION

18111 Brookhurst St. Suite 4600 Fountain Valley, CA 92708

Phone: (714) 861-4545 Fax: (714) 861-4549 Email: oclungdoctor@gmail.com

Name: _____

YOU HAVE AN APPOINTMENT WITH: _____

Day:_____ Date:_____ Time:_____

PLEASE ARRIVE 15 MINUTES EARLY. PLEASE BRING YOUR INSURANCE CARDS, PHOTO ID AND BE PREPARED TO PAY YOUR CO-PAY. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND AMERICAN EXPRESS FOR YOUR CONVENIENCE.

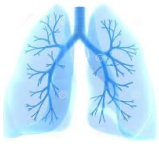
FOR A PULMONARY CONSULTATION PLEASE BRING ANY RECENT CHEST X-RAYS, CT SCANS, FILMS AND REPORTS WITH YOU TO YOUR APPOINTMENT. WRITE DOWN A LIST OF ALL YOUR MEDICATIONS AND THE NAMES AND ADDRESSES OF YOUR REFERRING DOCTORS.

PLEASE FILL OUT ENCLOSED PAPER WORK COMPLETELY

IF FOR ANY REASON YOU NEED TO CANCEL OR RESCHEDULE YOUR SCHEDULED APPOINTMENT, PLEASE NOTIFY THE OFFICE 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT. THIS GIVES US TIME TO SCHEDULE OTHER PATIENTS WHO MAY BE WAITING FOR AN APPOINTMENT. THERE WILL BE A CHARGE OF $75.00 FOR ANY NO SHOWS/ CANCELLATIONS LESS THAN 24 HOURS IN ADVANCED. THANK YOU FOR YOUR UNDERSTANDING.

WE LOOK FORWARD TO MEETING YOU. THANK YOU!

SINCERELY,
DR. THOMAS J. ASCIUTO & STAFF



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OC LUNG DOCTOR

PATIENT INFORMATION

First Name: _____ Middle Name: _____ Last Name: _____

Birth Date: _____ Gender: ◯ Male ◯ Female

Address: _____

City: _____ State: _____ ZIP: _____

Email: _____ Cell Phone: _____

Social Security #: _____ Driver's License #: _____

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Emergency Contact: _____ Phone: _____

Ethnicity: _____ Race: _____

I was referred by: _____ Primary Care Provider: _____

INSURANCE INFORMATION

I will be paying by: ◯ Insurance ◯ Cash ◯ Check ◯ Credit Card

Name of Primary Insurance Company: _____ State: _____

Policy Holder Name: _____ INS Phone #: _____

Member ID: _____ Group #: _____

Name of Secondary Insurance Company: _____ Member ID: _____

Group #: _____ INS Phone #: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

Patient's Employment Status: ◯ Full-Time ◯ Part-Time ◯ Unemployed ◯ Retired

Name of Employer: _____

Employer's Address: _____

City: _____ State: _____ Zip-Code: _____ Phone #: _____

_____ Patient Signature

_____ Date

ph: (714)861-4545 web: oclungdoctor.com Email: oclungdoctor@gmail.com

OC LUNG DOCTOR

THOMAS J. ASCIUTO, MD CORP

General Health History

Medical History

◯ Allergies	◯ High Cholesterol
◯ Asthma	◯ Liver Disease/Hepatitis
◯ Arthritis	◯ Lung/COPD/Emphysema
◯ Atrial Fibrillation	◯ Migraine/Headaches
◯ Bladder/Kidney Disorders	◯ Neurologic/Stroke
◯ Blood Disorders	◯ Osteoarthritis
◯ Breast/GYN Disorders	◯ Osteoporosis
◯ Cancer:_____	◯ Prostate Problems
◯ Chronic eye/ear/nose Disorder	◯ Seizure Disorder
◯ Colitis/Crohn's Disease	◯ Skin Disorder
◯ Concussion	◯ Thyroid Disorder
◯ Depression/Anxiety	◯ Tuberculosis
◯ Diabetes	◯ Ucler
◯ Gastrointestinal Disorder	◯ Other:_____
◯ Heart Disorders	◯ Other:_____
◯ High Blood Pressure	◯ Other:_____

Surgical History / Year

Family History

(please indicate family members with any of the following conditions)

◯ Alcoholism
◯ Alzheimer's Disease
◯ Asthma/COPD
◯ Bleeding Disorders
◯ Cancer:_____
◯ Heart Disease/Heart Attack
◯ Diabetes
◯ High Cholesterol
◯ High Blood Pressure
◯ Mental Health Disorder
◯ Obesity
◯ Osteoarthritis
◯ Osteoporosis
◯ Other:_____

Medications List
(with dosage)

Are you allergic to any mediations? ◯ **Yes** ◯ **No**

If yes, please list: _____

Preferred Pharmacy: _____ _____

Pharmacy name Pharmacy Phone #

_____

Street City State Zip-code

THOMAS J. ASCIUTO, MD CORP

Social History

Have you ever smoked cigarettes, cigars, or pipe? ○ **Yes** ○ **No**

If yes, how many years have you/did you smoke? _____

If yes, how many cigarettes a day (average consumption)? _____

If yes, do you currently smoke? ○ **Yes** ○ **No**

If you are no longer smoking, when did you quit? _____

Do you drink alcohol? ○ **Yes** ○ **No**

If yes,

○ Daily _____ per day

○ Occasionally _____ per month

○ Rarely _____ per year

What is/was your occupation? _____

What are your hobbies? _____

Have you traveled outside the country in the past year? ○ **Yes** ○ **No**

Do you have any pets? If so, what type? _____

Do you exercise regularly,? If so, what type of exercise? _____

Respiratory/Sleep Medical History

1. Were you exposed to dust, gases, or fumes which might make your breathing difficult? ○ **Yes** ○ **No**

   If yes, explain: _____

2. Do you get shortness of breath? ○ **Yes** ○ **No**
3. Do you cough? ○ **Yes** ○ **No**
4. Do you bring up mucus? ○ **Yes** ○ **No**
5. Do you snore? ○ **Yes** ○ **No**
6. How many hours do you sleep? _____ Hours
7. Have you ever been observed to stop breathing at night? ○ **Yes** ○ **No**
8. Have you ever used or currently use a CPAP machine? ○ **Yes** ○ **No**

THOMAS J. ASCIUTO, MD CORP

CANCELLATION POLICY

To ensure that all patients have access to timely care, we kindly ask that you provide at least 24 hours' notice if you need to cancel or reschedule your appointment. This gives us time to schedule other patients who may be waiting for an appointment.

If an appointment is missed or canceled with less than 24 hours' notice of your scheduled appointment, a $75.00 fee will be charged. The fee will be charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

We appreciate your understanding and cooperation in this matter. If you need to reschedule or cancel an appointment, please contact our office by phone (714) 861-4545 or email oclungdoctor@gmail.com at least 24 hours before your scheduled appointment to avoid this fee.

Multiple instances of No Shows or failure to pay may result in termination from the practice.

I acknowledge the No Show/Cancellation Policy and I understand and agree that I am responsible for any fees that may occur.

_____ _____

Patient Signature Date

THOMAS J. ASCIUTO, MD CORP

Billing & Financial Policy Information

- Your insurance company informs all participants that is ultimately your responsibility to verify benefits and coverage information prior to having any services rendered. Every attempt is made to comply with your insurance company's requirements. Since policies and benefits differ among employers and individuals participating with each insurance company, we are unable to know all the specifics of your policy. Thomas J. Asciuto MD Corporation cannot guarantee the cost of services preformed will be covered by your insurance.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. Please contact your insurance company with any questions about your benefits and coverage.
- Insurance companies require submission of all claims within specified time limits. If you have a change in your insurance and you fail to inform us of the change, we may not be aware until your insurance company denies a claim. Denials often arrive after the filing limits have expired, preventing us from re-filing the claim with another insurance. To limit the charges that you may be responsible for, please ensure that we always have up-to-date information regarding your insurance coverage.

You will be responsible for payment of all services if any of the circumstances apply:

- If you do not have insurance
- If you do not have a referral when required and have elected to be seen
- If you are with an insurance company that we are not contracted with
- If a claim denial from the insurance company is not able to be resolved

All payments are due within 90 days from the date of the first statement. If payment is not received within this timeframe, the account balance will be referred to an outside collection agency.

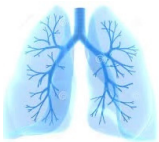
Co-payments are due at the time of service. Please ensure that payment is made at the time of your appointment. This arrangement is part of your contract with your insurance company. We accept cash, check, and credit cards.

By signing this form, I have read the financial policies listed above and agree to all the information, authorize the release of any medical information to necessary to process your claims, and authorize payment of medical benefits to Thomas J. Asciuto MD Corporation. My signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

_____
Signature of patient or responsible party

_____
Print Name

_____
Date



OC LUNG DOCTOR

THOMAS J. ASCIUTO, MD CORP

NOTICE OF PRIVACY PRACTICES

(Effective 12/18/2024)

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.

We care about out patients' privacy and strive to protect the confidentiality of your medical information. Federal legislation requires that we issue this official note of our privacy practices. You have the right to the confidentiality of your medical information, and this practice is required by law to maintain the privacy of that protected health information. The practice is required to abide by the terms and the Notice of Privacy Practices currently in effect. and to provide notice of its legal duties and privacy practices with respect to protected health information. If you have any questions about this Notice, please contact the Privacy Officer at this practice.

WHO WILL FOLLOW THIS NOTICE

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this notice. All subsidiaries, business associates, sites and locations of this practice may share medical information with each other for treatment, payment purposes or healthcare operations described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish this task will be shared.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose medical information without your specific consent or authorization. Examples provided from each category of uses or disclosures. Not every possible use ot disclosure in a a category is listed.

FOR TREATMENT

We may use medical information about you to provide you with medical treatment of services. Example: In treating you for a specific condition we may need to know if you have allergies that could influence medication we prescribe for the treatment process.

FOR PAYMENT

We may use and disclose medical information about you so that the treatment and services you receive from us may be billed and payment may bed collected from you, your insurance company, or a third party. Example: We may need to send your protected health information, such as your name, address, office visit date, and codes identifying your diagnosis and treatment to your insurance company for payment.

FOR HEALTH CARE OPERATIONS

We may use and disclose medical information about you from health care operation to assure that you received quality care. Example: We may use medical information to review our treatment and services and evaluate the preformance of our staff in caring for you,

OTHER USES AND DISCLOSURES THAT CAN BE MADE WITHOUT YOUR CONSENT OR AUTHORIZATION

- As required during an investigation by law enforcement agencies
- To avert a serious threat to public health or safety
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing claims
- In response to a legal proceeding
- Other healthcare providers' treatment activities
- Other covered entities' and providers' payment activities
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)

We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQURING YOUR WRITTEN AUTHORIZATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you give us authorization to use or disclose medical information about you, you may revoke that authorization, in writing at any time. If you revoke your authorization, we will therefore no longer use or disclose medical information about you for the reasons covered in your written authorization. You understand that we are required to retain our records of the care we have provided you.

YOUR INDIVIDUAL RIGHTS REGARDING YOUR MEDICAL INFORMATION

COMPLAINTS- If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Right to Request Restrictions- You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment of health care operations or to someone who is involved in your care or the payment of your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment. To request restrictions, you must submit your request in writing to the Privacy Officer at this practice. In your request, you must tell us what information you want to limit.

Right to Request Confidential Communications- You have the right to request how we should send communication about medical matters, and where you would like those communications sent. To request confidential communications you must make a written request to the Privacy Officer at thei Practice.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

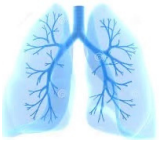
Right to Inspect and Copy- You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal or administrative action or proceeding, and protected health information in which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information, we reserve the right to charge a fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that denial to be reviewed. Another licensed health care professional chosen by the practice will review your request and the denial. The person conducting the review will not be the person who denied your request, We will comply with the outcome of the review.

Right to Amend- If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. We may deny your request if the information was not created by us, is not part of the medical information kept at this practice, is not part of the information which would be permitted to inspect or copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare rebuttal to your statement and will provide you with a copy of such rebuttal. Statements of disagreements and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Right to a Paper Copy of this Notice- You have the right to a paper copy of this Notice at any time. To obtain a paper copy of the current notice, please request and it will be given to you

CHANGES TO THIS NOTICE

We reserve the right to change this Notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as information we receive in the future,



THOMAS J. ASCIUTO, MD CORP

Acknowledgement of Receipt of Notice of Privacy Practices

HIPPA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient, a copy of our Notice of Privacy Practices and for you to sign as acknowledging receipt of the document.

I understand that Thomas J Asciuto MD Corporation may share my health information for treatment, billing and healthcare operations. I have been provided a copy of Thomas J Asciuto MD Corporation Notice of Privacy Practices that describes how my health information is used and shared. I understand Thomas J Asciuto MD Corporation has the right to change this notice at any time.

I acknowledge receipt of the Notice of Privacy Practices of Thomas J Asciuto MD Corporation:

_____

Printed Name | Signature of patient or legally authorized Individual | Date

AUTHORIZATION TO LEAVE MESSAGES

I authorize Thomas J Asciuto MD Corporation to leave messages regarding my protected health information (PHI) to my telephone, answering machine, email, or other designated party listed below:

_____

Printed Name | Relationship | Phone Number

_____

Printed Name | Relationship | Phone Number

Please list (if any) persons, telephone numbers, or addresses that you would not authorize Dr. Thomas Asciuto or any office employee to use:

_____

_____

I agree to release of my insurance and medical information to other health care providers and my isnurance company to facilitate healthcare and processing of insurance claims.

_____
Initial

I agree to allow the practice to use and disclose information regarding my care as needed (choose one)**:**

- Without restrictions: _____ Initial
- Restricted: _____ Initial

_____

Patient signature or legally authorized individual | Date