

Lyracore Health Alliance

New Patient Packet

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

APPOINTMENTS & SCHEDULING

Appointments: Please arrive on time. If you are running late, please call — we will hold your appointment for 15 minutes. Appointments more than 15 minutes late may need to be rescheduled.

Late Cancellation / No-Show Fee: Please call at least 24 hours before your appointment to cancel or reschedule. A no-show fee will apply. See Financial Policy for details.

Copays & Deductibles: Payment for copays and deductibles is collected at the time of your appointment. See Financial Policy for accepted payment methods and full details.

MEDICAL CARE POLICIES

Medical Emergencies: If you have a medical emergency, please call 911 or go to the nearest emergency room. For non-emergency questions, call us during regular business hours.

Chronic Pain Management: We do not provide chronic pain management. For chronic narcotic medication management, please contact your primary care physician or pain management specialist.

Primary Care: Non-pulmonary medical problems should be addressed by your primary care physician. We recommend you remain under their care as part of your pulmonary treatment program.

Questions: Call us anytime during regular business hours for routine, non-emergency questions. For financial questions, please speak with our billing office.

BUSINESS HOURS

	Tampa Office	Sun City Office
Monday	8:30 AM – 5:00 PM	—
Tuesday	8:30 AM – 5:00 PM	—
Wednesday	8:30 AM – 5:00 PM	8:00 AM – 5:00 PM
Thursday	8:30 AM – 5:00 PM	—
Friday	8:30 AM – 2:30 PM	—

Patient Name	Date of Birth	Today's Date
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NOTICE OF PRIVACY PRACTICES (HIPAA)

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.

Our Responsibilities: Lyracore Health Alliance is required by law to maintain the privacy of your protected health information (PHI). We must provide you with notice of our legal duties and privacy practices, and we must follow the terms of this notice.

How We Use Your Health Information: We use your health information to provide treatment, process payment, and operate our practice. We may also use it to inform you of treatment alternatives or other health-related benefits and services. Uses and disclosures beyond those listed here require your written authorization.

Your Rights: You have the right to: (1) request a copy of your health information; (2) request amendment of information you believe is incorrect; (3) request a list of disclosures; (4) request restrictions on use or disclosure; (5) request confidential communications; (6) receive a paper copy of this notice; and (7) receive notification of any breach of your unsecured PHI.

Marketing & Sale of PHI: We will not use or disclose your PHI for marketing purposes or sell your PHI without your written authorization. We are prohibited from using or disclosing genetic information for insurance underwriting purposes.

Filing a HIPAA Complaint: If you believe your privacy rights have been violated, you may file a complaint with Lyracore Health Alliance or with the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Section 1557 — Nondiscrimination Notice: Lyracore Health Alliance complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We provide free language assistance services for patients with limited English proficiency. For assistance, contact our office. To file a civil rights complaint, visit [hhs.gov/ocr/office/file](https://www.hhs.gov/ocr/office/file).

ACKNOWLEDGMENT OF RECEIPT

Notice of Privacy Practices Effective Date: January 1, 2024

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

Signature of Patient or Personal Representative	Printed Name	Date
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Patient Name	Date of Birth	Today's Date
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PATIENT DEMOGRAPHICS

PATIENT INFORMATION

Patient Name (Last, First, MI)		Date of Birth	Today's Date	
Social Security Number	Gender	Preferred Pronouns	Primary Language	
Race	Ethnicity	Marital Status (S/M/D/W)	Interpreter Needed? <input type="checkbox"/> Y <input type="checkbox"/> N	
Street Address	Apt/Unit	City	State	ZIP
Home Phone	Cell Phone	Work Phone	Date of Last Physical Exam	
Email Address				

CONTACTS & PHARMACY

Spouse / Guardian Name		Relationship	Phone	
Emergency Contact 1 Name		Relationship	Phone	
Emergency Contact 2 Name		Relationship	Phone	
Pharmacy 1 Name	Phone	Fax	Mail-Order? <input type="checkbox"/> Y <input type="checkbox"/> N	
Address	City	State	ZIP	
Pharmacy 2 Name	Phone	Fax	Mail-Order? <input type="checkbox"/> Y <input type="checkbox"/> N	
Address	City	State	ZIP	

REFERRING / PRIMARY CARE PHYSICIAN

Referring Physician	Phone	Primary Care Physician
Advance Directive / Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	Healthcare POA on file? <input type="checkbox"/> Yes <input type="checkbox"/> No	DNR Order on file? <input type="checkbox"/> Yes <input type="checkbox"/> No

If yes to any above, please bring a copy to your appointment.

Patient Name	Date of Birth	Today's Date
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COMMUNICATION PREFERENCES & AUTHORIZATIONS

PREFERRED CONTACT METHOD (check all that apply)

OK to call Home Phone
 OK to call Cell Phone
 OK to call Work Phone
 OK to mail to home address
 OK to email (address on file)
 OK to fax (number on file)

EMAIL COMMUNICATION CONSENT

I authorize Lyracore Health Alliance to communicate with me by email regarding my protected health information (PHI). I acknowledge that: (a) email is not a fully secure medium and a third party may potentially gain access; (b) Lyracore will make all reasonable efforts to maintain confidentiality but cannot guarantee absolute email security.

PERMISSION TO COMMUNICATE MEDICAL INFORMATION

I give Lyracore Health Alliance permission to discuss my medical condition, test results, and physician recommendations with the individuals listed below:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

AUTHORIZATION TO RELEASE / REQUEST MEDICAL RECORDS

I hereby authorize Lyracore Health Alliance to disclose or request information to/from:

Name / Organization		Phone	Fax
Address	City	State	ZIP

Information to be disclosed / requested (check all that apply):

Office / Progress Notes
 Lab Results
 Imaging Reports
 Procedure Notes
 Complete Medical Record
 Other

CONTACT AUTHORIZATION FOR CARE-RELATED PROGRAMS

I authorize Lyracore Health Alliance to share my **contact information only** with selected partners below. Medical records will NOT be shared without separate written authorization. Consent may be revoked in writing at any time.

RPM / Remote Patient Monitoring — respiratory monitoring
 Clinical Research & Trials — condition-relevant studies
 Care-Related Services — treatment programs or resources

Patient Authorization:

Patient Signature	Printed Name	Date

Patient Name	Date of Birth	Today's Date
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ASSIGNMENT OF BENEFITS & CONSENT TO TREAT

Aldor-Pulmonary, LLC d/b/a Lyracore Health Alliance

CONSENT FOR TREATMENT

The patient and/or authorized representative does hereby consent to medical treatment which may be deemed advisable by the physician/provider. This grants authority to administer and perform all examinations, treatments, and diagnostic procedures which may be deemed necessary. I understand I have the right to refuse any procedure or treatment and have the right to discuss all medical treatments with my physician.

Patient or Authorized Signature	Printed Name & Relationship (if not patient)	Date
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ASSIGNMENT OF BENEFITS

I request that payment of authorized insurance benefits, including Medicare (if applicable), be made on my behalf to Aldor-Pulmonary LLC / Lyracore Health Alliance for any medical services provided. I authorize the release of any medical or other information necessary to determine these benefits.

I understand that I am financially responsible for any charges not covered by my health care benefits. It is my responsibility to notify the organization of any changes in my health care coverage. A copy of this authorization shall be considered as effective and valid as the original. This serves as a lifetime authorization unless revoked in writing.

Signature of Insured, Parent, or Guardian	Print Name (if not signed by insured)	Relationship to Insured	Date
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RELEASE OF INFORMATION & WAIVER

I authorize the release of any privileged health information (including psychiatric, chemical dependency, communicable/infectious disease, HIV/AIDS) necessary for the purposes described. I release Lyracore Health Alliance from all related liabilities. This authorization is given pursuant to Florida law.

Patient Signature (or Patient's Representative)	Printed Name	Date of Birth	Date
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Patient Name	Date of Birth	Today's Date
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FINANCIAL RESPONSIBILITY POLICY
Aldor-Pulmonary, LLC d/b/a Lyracore Health Alliance
By signing this policy, you confirm that you have read and understand the following financial obligations.

Account Current: Your account is to be kept current. All self-pay amounts, co-pays, co-insurances, and deductibles are due at the time of service. We accept cash, check, Visa, MasterCard, Discover, and American Express. Failure to pay at check-in may result in non-emergent appointments being rescheduled.

Address & Insurance Changes: It is your responsibility to notify our office of any changes to your address, phone number, or insurance information prior to your appointment so coverage can be re-verified.

Insurance Coverage: Your insurance is a contract between you, your employer, and your insurance company. We are not a party to your specific contract. It is your responsibility to know the regulations and limitations of your plan. Not all services are a covered benefit. Although filing your insurance claim is a courtesy we extend to you, all charges are ultimately your responsibility from the date services are rendered.

Referrals & Authorizations: Any required referrals or authorizations must be provided to our office no less than 48 hours in advance of your appointment. You are ultimately responsible for ensuring proper authorization and will be responsible for the cost of services rendered without it.

Missed Appointment / No-Show Fee: Please provide at least 24 hours' notice to cancel or reschedule. Failure to cancel within 24 hours will result in a \$50.00 no-show fee.

Returned Checks: A \$25.00 fee will be charged for all returned checks. Your account will be flagged as cash or credit card only for all future services.

Balance Statements & Refunds: You will receive a statement when your balance reaches \$10.00 or more. Refunds will be issued within 2 weeks of request, provided there are no pending insurance claims.

Collections: If your account is turned over to a collection agency, you will be responsible for all costs incurred in collection, including agency fees up to 50% of your outstanding balance, as well as court costs and attorney fees.

I have read, understand, and agree to the Financial Policy of Lyracore Health Alliance and accept responsibility for all financial obligations as described above.

Patient Signature	Print Name	Date
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Responsible Party (if applicable)	Print Name	Date
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Patient Name	Date of Birth	Today's Date
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TODAY'S VISIT & REVIEW OF SYMPTOMS

Patient Name	Age	Today's Date	Current Occupation
If retired, previous occupation			

REASON FOR TODAY'S VISIT

What is the main reason for today's visit, and when did you first notice this problem?

REVIEW OF SYMPTOMS

Please check any current problems you are experiencing. If yes, please explain.

Yes / No	Symptom	Explain
<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Wheezing	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Cough (with phlegm / with blood)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Hay Fever / Allergies	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Chest Pain	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fevers	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Change	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Sleeping Disorder	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Swallowing	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Fatigue	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Night Sweats	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Snoring	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Falling Asleep	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty Staying Asleep	
<input type="checkbox"/> Yes <input type="checkbox"/> No	Leg Swelling	

Patient Name	Date of Birth	Today's Date
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PAST MEDICAL HISTORY

Please check all conditions you have ever been diagnosed with.

- | | | |
|--|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Aneurysm | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arrhythmias / Irregular Heartbeat |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Aspiration | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bleeding / Clotting Problems | <input type="checkbox"/> Bronchiectasis | <input type="checkbox"/> Bronchitis (Chronic) |
| <input type="checkbox"/> Cancer Type: <input type="text"/> | <input type="checkbox"/> Cardiac Arrest | <input type="checkbox"/> Cardiac Disease |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Cough (Chronic) | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Fissure | <input type="checkbox"/> GERD / Heartburn | <input type="checkbox"/> Heart Attack |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hernia |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Hodgkin's Disease |
| <input type="checkbox"/> Hyperactive Airway | <input type="checkbox"/> Hypertension (High BP) | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Incontinence | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Lupus / SLE |
| <input type="checkbox"/> Melanoma | <input type="checkbox"/> Migraines | <input type="checkbox"/> Neuropathy |
| <input type="checkbox"/> Non-Hodgkin's Lymphoma | <input type="checkbox"/> Obesity | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Pleural Effusion | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Pneumothorax | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Pulmonary Emboli |
| <input type="checkbox"/> Pulmonary Fibrosis | <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Raynaud's Phenomenon |
| <input type="checkbox"/> Renal Failure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Sarcoidosis | <input type="checkbox"/> Scleroderma | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Sinus Condition | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Sleep Disturbance | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Stroke / TIA / CVA |
| <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Tuberculosis (TB) | |

Other (please specify)

Patient Initials: I have reviewed this section and confirm it is accurate and complete.

Patient Name	Date of Birth	Today's Date
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SURGICAL, HOSPITALIZATION & DIAGNOSTIC HISTORY

SURGICAL HISTORY

Please list any surgical procedures you have had. Use additional paper if needed.

Procedure / Surgery	Facility / Hospital	Date

HOSPITALIZATION HISTORY

Please list any hospitalizations, including ER visits for respiratory issues in the past 12 months.

Reason for Hospitalization	Facility / Hospital	Date	Length of Stay

RECENT DIAGNOSTIC TESTS

Please provide the most recent date and location for each test:

Test	Date	Location / Facility	Results (if known)
TB Skin Test			
Chest X-Ray			
CT Scan (Chest)			
Pulmonary Function Test (PFT)			
Sleep Study			
Echocardiogram			
EKG			
Bone Density Test			

Patient Initials: I have reviewed this section and confirm it is accurate and complete.

Patient Name	Date of Birth	Today's Date
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FAMILY HISTORY

Please indicate if any immediate family members have had any of the following conditions. Check (■) all that apply for each relationship.

Condition	Sibling	Parent	Grandparent
Addison's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (list type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lupus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Cancer type(s)

Other (please specify)

Patient Initials: I have reviewed this section and confirm it is accurate and complete.

Patient Name	Date of Birth	Today's Date
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SOCIAL & ENVIRONMENTAL HISTORY

TOBACCO USE

Never Smoked Former Smoker Current Every Day Smoker
 Current Some Day Smoker Current Status Unknown

Quit Date (if former smoker)	Packs per day	Number of years smoked
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If former smoker, how long since you last smoked?

<input type="checkbox"/> Less than 1 month	<input type="checkbox"/> 1-5 years
<input type="checkbox"/> 1-3 months	<input type="checkbox"/> 5-10 years
<input type="checkbox"/> 3-6 months	<input type="checkbox"/> Greater than 10 years
<input type="checkbox"/> 6-12 months	

Other tobacco use (check all that apply):

Pipe Cigar Snuff Chewing Tobacco Vape / E-Cigarette

Are you interested in quitting? Yes No Unsure

Have you tried to quit in the past? Yes No Unsure

ALCOHOL USE SCREENING (AUDIT-C)

Did you have a drink containing alcohol in the past year? Yes No

If 'Yes': How often did you have a drink containing alcohol in the past year?

Never Monthly or less 2-4 times/month 2-3 times/week Daily or almost daily

If 'Yes': How many drinks on a typical day when drinking?

1-2 3-4 5-6 7-9 10+

DRUG USE

Do you use recreational or illicit drugs? Yes No Unsure

If yes, type (e.g., marijuana, vaping, opioids)	Length of use
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ENVIRONMENTAL HISTORY

Occupational Exposures (e.g., asbestos, dust, chemicals, fumes)

Pets at home	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Birds at home	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Carpet at home	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Insect infestation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Mold / Mildew	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Tuberculosis exposure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Recent international travel	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

Patient Initials: I have reviewed this section and confirm it is accurate and complete.