LUNG CENTER
OF AMERICA™

PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME:_____FIRST NAME:_____MI:_____

DATE OF BIRTH: (mm/dd/yyyy)_____

SEX:_____RACE:_____SOCIAL SECURITY #:_____ETHNICITY: _____

ADDRESS 1:_____ADDRESS 2:_____

CITY:_____STATE:_____ZIP:_____

LANGUAGE:_____LANGUAGE COUNTRY:_____

MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ PARTNER ❑ DIVORCED ❑ WIDOWED

PREGNANT: ❑ (Check if applicable) NURSING: ❑ (Check if applicable)

Whom may we thank for referring you to our practice?_____

CONTACT INFORMATION

HOME PHONE:_____WORK PHONE:_____EXT: _____

CELL PHONE:_____EMAIL:_____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME:_____ CONTACT LAST NAME:_____

CONTACT HOME PHONE: _____CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT:_____ CONTACT ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

FAMILY MEMBERS IN THE PRACTICE

NAME:_____RELATIONSHIP TO PATIENT:_____

NAME:_____RELATIONSHIP TO PATIENT:_____

NAME:_____RELATIONSHIP TO PATIENT:_____

NAME:_____RELATIONSHIP TO PATIENT:_____

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME:_____PRACTICE NAME: _____

CITY:_____STATE:_____ZIP:_____

PHARMCY INFORMATION

PHARMACY NAME:_____PHARMACY PHONE: _____

PHARMACY LOCATION:_____

By signing below, I attest that the information provided above is true and accurate:

Signature of Insured / Guardian:_____Date:_____

8371 Yankee Street, Dayton, OH 45458

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PATIENT REGISTRATION

Authorization to release or use information for treatment, payment, or health care operations:

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by the Asthma & Respiratory Center of South Dayton in order to carry out treatment, payment, or health care operations. You should review the Practice s Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to releasing information to me in the following manners:

VIA MAIL — PLEASE INITIAL

- ❑ OK TO MAIL TO HOME ADDRESS _____
- ❑ OK TO MAIL TO WORK ADDRESS _____

VIA HOME TELEPHONE

- ❑ OK TO LEAVE DETAILED MESSAGE _____
- ❑ LEAVE CALL BACK NUMBER ONLY _____

VIA WORK TELEPHONE

- ❑ OK TO LEAVE DETAILED MESSAGE _____
- ❑ LEAVE CALL BACK NUMBER ONLY _____

VIA FAX

- ❑ OK TO FAX TO:_____ _____

If we contact you and you are NOT available, may we leave information such as appointment confirmation, negative test results, surgery information and/or billing matters with another person?

❑ YES ❑ NO

If yes, please list authorized person(s) name(s) here:

_____ _____ _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date:_____

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NOTICE OF ATTENDANCE POLICY

ATTENDANCE POLICY

Our staff will provide you with appointment cards, which will indicate the day, date, and time for each appointment.

We will attempt to notify you of your scheduled appointment by phone but this is a courtesy call and is not required by our office.

We will do our best to schedule your appointments for the days and times that are most convenient for you.

Please understand that we do not accept walk-in patients. All of our appointments are scheduled.

This policy is to ensure that we can schedule new patients in a timely manner, along with offering our current patients convenient and timely appointments.

CANCELLATIONS

We understand that occasionally difficulties arise which may prevent you from keeping a scheduled appointment.

You will be charged a fee of $50.00 for each appointment not cancelled within 24 hours of your scheduled appointment. This fee is not billable to your insurance company and is your responsibility.

If you miss more than (3) three appointments, you will be dismissed from the practice.

LATE ARRIVALS

We will make every effort to see you at your scheduled time. In case of an emergency at the hospital or office we will offer you the option to wait to see the physician or to reschedule your appointment.

If you are more than (15) fifteen minutes late for your appointment you may be asked to reschedule.

I acknowledge being informed about the Asthma & Respiratory Center of South Dayton, Inc. Attendance Policy.

Print Patient Name_____

_

Patient Signature_____Date_____

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PATIENT QUESTIONNAIRE

LAST NAME:_____FIRST NAME: _____D.O.B.:_____

Do you have any allergies to food or medications? If yes, please list below.

_____

_____

_____

Do you have any pets? If yes, what kind and how many?

_____

Are you a current smoker, if so, how long? _____

Do you have history of any of the following, please answer yes or no:

Diabetes	❑	YES	❑	NO
COPD	❑	YES	❑	NO
High Blood Pressure	❑	YES	❑	NO
Cancer	❑	YES	❑	NO
Asthma	❑	YES	❑	NO
Sleep Apnea	❑	YES	❑	NO
Emphysema	❑	YES	❑	NO
Bronchitis	❑	YES	❑	NO

If you answered yes for any of the above, please specify:

_____

_____

What is your occupation? If retired, what was your occupation? _____

Are you married?	❑	YES	❑	NO
Do you have children?	❑	YES	❑	NO

If yes how many? _____

Have you had any of the following vaccinations? If yes when?

Flu	❑	YES	❑	NO	When_____
Pneumonia	❑	YES	❑	NO	When_____
Shingles	❑	YES	❑	NO	When_____
Prevnar 13	❑	YES	❑	NO	When_____

Have you had any recent visits to ER, hospital stays, chest X-rays?
If yes, please provide name of hospital and dates.

_____

List of current medications:

Name of medications_____Dosages_____How often_____

Name of medications_____Dosages_____How often_____

Name of medications_____Dosages_____How often_____

Name of medications_____Dosages_____How often_____

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Ivermectin Protocol Drug Consent Form

Off-Label Use - ivermectin is widely used and approved for the treatment of parasites such as River Blindness. It has not been reviewed and approved by the US Food and Drug Administration (FDA) for use in COVID-19 or any other viral illness and its use is considered "off-label."

Medical Controversies *- the use of ivermectin is highly controversial and has been the subject of professional disagreement and substantial public misinformation on both sides of the question. The medical literature contains a considerable number of clinical studies, metastudy reviews that analyze available studies, and epidemiological investigations following populations that have been treated as a preventive measure. Some metastudies have concluded that ivermectin is safe with moderate to significant effectiveness, particularly at initial stages of the disease, while others have found no evidence of effectiveness at all.* ***Conclusions vary in part because of the level of dosing used and disagreements over the validity of study designs and the rigor of some studies.***

Part of a Protocol - the use of ivermectin is part of a protocol (developed by Frontline Covid19 Critical Care Alliance (FLCC)) to address COVID-19 and works best when followed its protocol if followed entirety rather than relying entirely just on ivermectin.

There are some critical factors that appear to be clear from studies and clinic experience about which patients should be aware:

1. Public Health Measures - a patient taking ivermectin, whether to reduce the risk of contracting the disease or as treatment, cannot assume that they are therefore at any less risk of spreading the disease. All public health measures, including social distancing and wearing of masks along with vaccination, should be strictly followed as appropriate.
2. Ivermectin; Notice of Public Health Agency Positions - the view of public health agencies, ns expressed by the Centers for Disease Control and Prevention (CDC) is that:
    a. Clinical trials and observational studies to evaluate the use of ivermectin to prevent and treat COVID-19 in humans have yielded insufficient evidence of the NIH COVID-19 Treatment Guidelines Panel to recommend its use. Da from adequately sized, well-designed, and well-conducted clinical trials are needed to provide more specific, evidence-based guidance on the role of ivermectin in the treatment of COVID-19." https://emergency.cdc.gov/han/2021/han004 9 .asp
3. Timing - ivermectin has the best chance to work against COVID-19 when taken early in the disease. It should be started as soon as possible.
4. Dosing - ivermectin is controversial in part because it requires high dosing to reach antiviral and therapeutic levels. The potential for side effects is greater a high dose; dose levels required vary by patient weight and the stage of disease.
5. Veterinary Forms ivermectin - patients should only take what is prescribed and obtained from a pharmacy and not take veterinary ivermectin or purchase it on the internet, as these forms may contain concentrated ingredients and excipients toxic to humans.

Potential Side Effects - ivermectin has been administered in over 4 billion doses worldwide for parasitic disease and is generally considered to have an excellent safety profile. Most of the significant side effects resulting from such use are due to the die-off of the parasite. Dosing for parasitic diseases is based on weight up to a maximum of five 3 mg pills a day to 5 days. Dosing for the treatment of COVID-19 is higher in order to achieve therapeutic levels.

Clinical effects of ivermectin are generally mild and can include gastrointestinal symptoms such as nausea, vomiting, and diarrhea; hypotension and neurologic effects such as low blood pressure, headache, blurred vision, dizziness, tachycardia, visual hallucinations, altered mental status, confusion, loss of coordination and balance, orthostatic hypotension, central nervous system depression, and seizures. Cardiovascular side effects have included tachycardia but are rare. EKG changes have been reported in rare cases including prolonged PR interval, flattened T waves, and peaked T waves. Significant overdoses are associated with effects sue as decreased consciousness, confusion, hallucinations, seizures, coma, and death.

Get emergency medical help if you have signs of an allergic reaction to ivermectin hives; difficult breathing; swelling of your face, lips, tongue, or throat.

Drug interactions - ivermectin does not have known major interactions but it may potentiate the effects of other drugs that cause central nervous system depression such as benzodiazepines and barbiturates. Some drugs can enhance or reduce the blood levels and effects of ivermectin. Make sure your physician knows all of the other drugs that you are taking.

Your consent and signature are required to receive treatment while at LCOA.

Date: _____ *Patient signature:* _____