Houston Pulmonary Sleep & Allergy Associates

21216 Northwest Freeway, Suite 430, Cypress, TX 77429

Phone: 281-955-0338 Fax: 281-469-0741

NEW PATIENT PAPERWORK

****Please provide us with your insurance card(s) and state-issued photo ID at the time of your visit****

Physician Referred By: ________________________ Primary Care Physician (First, Last Name): ________________________

Primary Care Physician's Phone Number: ________________________

Reason for Visit ____

Patient Information

Last: ______________________________________ First: ______________________________________ Middle Initial: _____

Date of Birth: _____________ Social Security #: _______________________ DL #:_____________________

Home Address: ____

City: ___________________________ State: ___________________________ Zip: _________________________

Home #: ______________________ Work #: ________________________ Cell #: _______________________

Email Address: ____

Sex: ______ Male ______Female Marital Status: ____M ____S ____W ____D

Employer's Name: ____

Address: ______________________________________ Phone #: ___________________________________

Occupation: ____

Emergency Contact Information

Name:____

Relation: ______________________________________ Phone #: ___________________________________

Pharmacy Information

Name: ____ Phone #: ___________________________________

Policy Holder's Information

Last: ______________________________________ First: ______________________________________ Middle Initial: _____

Date of Birth: _____________ Sex: ______Male ______Female Social Security #: _______________________

Home Address: ____

City: ___________________________ State: ___________________________ Zip: _________________________

Home #: ______________________ Work #: ________________________ Cell #: _______________________

Relationship of Policy Holder to the Patient: ______Self ______Spouse ______Child _______Parent

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List prescription and over-the-counter medications/drugs you are taking or recently have taken:

Name **Dosage** **How often** **Reason**

____

____

____

____

Year Vaccine or Exam Was Taken

Influenza _________ Pneumonia_________

Past Medical History – Are you or have you ever been under care for any of the following:
Please put an "X" under the appropriate column.

	YES	NO
Hypertension		
Diabetes		
COPD		
Asthma		
OSA (obstructive sleep apnea)		
Pulmonary Embolism		
Deep Venous Thrombosis		

List any allergies to medications and the reaction that occurs

Name **Reaction**

____

____

____

____

Surgical History (Not Including Pregnancies)

Year Illness or Operation

______ ____

______ ____

______ ____

Hospital Admissions (Not Including Pregnancies)

Year Illness

______ ____

______ ____

______ ____

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Family History - If any relative listed below, has suffered any of the following, please list who on the correct line or put N/A if not applicable.

Mother/Father/Brother/Sister/Grandparents

Sleep Apnea: ____

COPD: ____

Lung Cancer: ____

Asthma: ____

Emphysema: ____

Current Symptoms/Problems - Please mark a 'X' in the appropriate box below.

RESPIRATORY	**YES**	**NO**		**YES**	**NO**
Shortness of Breath at rest			Coughing Up Blood		
Shortness of Breath with Exertion			Chest Pain		
Cough					
Wheezing					
CARDIAC					
Chest Pain at Rest			Passing Out		
Chest Pain with Exertion			Swelling of Feet		
Palpitation			Dizziness		
SLEEP					
Daytime Sleepiness			Insomnia		
Snoring			Hypersomnia		
Apnea					
G.I.					
Nausea			Abdominal Pain		
Vomiting			Blood in Stool		
Vomiting Blood					
G.U.					
Increased Urine Frequency					
Blood in Urine					
Pain on Urination					

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Updated Financial and Billing Policies:

1. You are ultimately responsible for knowing what your plan does and does not cover. This includes in-network/out-of-network, out of pocket, copayment, coinsurance, deducible, prior authorizations, referrals, etc.
2. Be prepared to show your photo identification and insurance card at every visit.
3. As a courtesy, we will verify your insurance benefits and eligibility. However, due to insurance policy changes and real-time/up-to-date system information, we cannot guarantee that the information received is accurate.
4. Once your benefits have been determined, payments of any copays, coinsurance, deductible, and fees are required at the time services are rendered.
5. Once your insurance company has processed a claim, any balance as determined by your insurance company to be "patient's responsibility" and/or "non-covered service", will be your responsibility.
6. If you disagree with the "patient responsibility" amounts due to our office per your insurance's Explanation of Benefits (EOB), please immediately call your insurance company and our billing company, GroupOne, at 800-893-3557 for further explanation.
7. Failure to provide current insurance information to our office and/or reply back to insurance's request for additional information may result in the entire bill being your responsibility.
8. For Self-Pay patients, full payment for your visit and any testing (pulmonary function test, spirometry, 6 minute walk, etc) is expected at the time services are rendered.
9. Any outstanding balance owed to our office is also due, unless payment arrangements have been made in advance with our office.
10. Our office does not bill third parties (i.e.: automobile insurance). Your visit will be self-pay and a receipt will be given to you to file with your auto insurance. Our office does not accept workman's compensation cases.
11. Please notify us in advance if you cannot keep your appointment. We reserve the right to ask you to seek care from another physician if you miss three appointments without notification. If you are more than 30 minutes late for your appointment, you may be asked to reschedule.
12. There will be a $35 charge for all returned checks.
13. Once a payment deemed patient responsibility has not been made on your account after three months, you may be sent to collection agency.

Updated Medication Refill Policies:

1. Allow at least one week left on current medication when calling the pharmacy for a refill.
2. Allow at least 48 hours after we receive the refill request from the pharmacy to process the request.
3. Refills will not be processed as an "emergency". Please plan ahead.
4. Patient is responsible for keeping track of the amount of medication remaining, and for taking the medication as prescribed.
5. No refills will be made during weekends or holidays.
6. Narcotics require an appointment for every refill. There are no exceptions.
7. Triplicate prescriptions require an appointment every 3-6 months (or sooner if changes are needed).
8. All other maintenance medications require a 3-6 month follow up appointment for consideration on therapeutic regimen and necessary blood work.
9. It is per the discretion of the physician if an appointment will be required before a refill is granted. Many factors and circumstances are considered before a final decision is made.

*Please note, if you are more than 30 minutes, we have the right to reschedule your appointment.

By signing below, I acknowledge that I have read and understood <u>all</u> of the above policy updates.

Patient Name (please print): ____ Date of Birth __________________

Signature: ____ Date: _________________________

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Acknowledgement Form

I have reviewed the 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.

______________________________________	______________________________________
Name of Patient or Personal Representative	Description of Personal Representative's Authority
______________________________________	______________________________________
Signature of Patient or Personal Representative	Date

Insurance Coverage Waiver

Should your insurance fail to pay, you will be responsible for any amount classified as patient's responsibility, according to your insurance carrier.

______________________________________	______________________________________
Name of Patient or Personal Representative	Description of Personal Representative's Authority
______________________________________	______________________________________
Signature of Patient or Personal Representative	Date

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Patient-Family Communication Authorization

Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care operations).

1. Name ____ Relationship________________________

   Phone Number________________________________ DOB_______________________________

2. Name ____ Relationship________________________

   Phone Number________________________________ DOB_______________________________

Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

3. Name ____ Relationship________________________

   Phone Number________________________________ DOB_______________________________

4. Name ____ Relationship________________________

   Phone Number________________________________ DOB_______________________________

I understand I have the right to revoke this authorization in writing at any time to the Practice Manager, except to the extent that action has been taken in reliance upon it. I hereby release and hold harmless Houston Pulmonary and Sleep Associates, its physicians, staff, employees, agents, and any other persons involved, from any liability, damage or claim that may result from my authorization of the above communications.

Printed Name____ DOB________________________

Signature____ Date________________________

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eClinical Messenger

Effective JANUARY 1ST, 2016, Houston Pulmonary, Sleep & Allergy Associates will begin using eClinical Messenger thru our Electronic Medical Record (EMR) system to contact patients regarding appointments and prescriptions. **In order for us to update your chart, please select the following:**

PHONE CALLS:

1. Preferred Phone Number
   - ☐ Cell ______________________
   - ☐ Home ______________________
2. Preferred Time to Call - ***(Please only select one)***
   - ☐ Morning
   - ☐ Afternoon
   - ☐ Evening
3. Type of Reminders to be called regarding:
   - ☐ Appointments
   - ☐ Prescriptions (you will be notified once we have faxed your prescription to your pharmacy)
   - ☐ Appointments and Prescriptions

TEXT MESSAGING:

☐ I would like to be contacted by text message. *I understand text messaging rates apply.*

4. Preferred Phone Number ______________________
5. Type of Reminders to be texted regarding:
   - ☐ Appointments
   - ☐ Prescriptions (you will be notified once we have faxed your prescription to your pharmacy)
   - ☐ Appointments and Prescriptions

____ ______________________

Patient Signature Date

____

Patient Name