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

Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

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

_____ _____
_____ _____
_____ _____

Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

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					

Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

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: _____

Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

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

Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

Sleep Interview Questionnaire

Date: _____ Referring Physician: _____

1. Name: Last_____ First _____ MI: ____ Male/Female
2. Marital Status: _____Religion_____ Race_____
3. Date of birth: ____/____/_____ Age: ___ SSN: ____-____-____ Occupation_____
4. Employer_____ Employer Address_____
5. Emergency Contact_____ Emergency Phone#_____

The following information will help us obtain a better understanding of your sleeping and waking behavior. Please answer all questions to the best of your ability. If possible, please fill out the questionnaire with the assistance of someone familiar with your sleep/wake habits.

Section I: Main Complaint

6. What is your main sleep complaint? _____
7. How long has this been a problem? _____
8. Were there any events (weight gain, stress, illness, etc.) associated with the onset of your complaints? _____
9. Have you had a sleep study or home screen? ____ How long ago? ____ Where? _____
10. Have you ever used nasal CPAP or BiPAP? No____ Yes ____
    If so, how long? _____ Pressure setting _____ Mask _____

Section II: History of Sleep/Wake Disorder

Epworth Sleepiness Scale (ESS):

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you haven't done some of these activities recently, think about how they would have affected you. Use this scale to choose the most appropriate number for each situation:

0 = would never doze 1 = slight chance of dozing
2 = moderate chance of dozing 3 = high chance of dozing

Situation	Chance of Dozing			
1. Sitting and reading	0	1	2	3
2. Watching television	0	1	2	3
3. Sitting inactive in a public place (e.g. theater or meeting)	0	1	2	3
4. As a passenger in a car for an hour without a break	0	1	2	3
5. Lying down to rest in the afternoon	0	1	2	3
6. Sitting and talking to someone	0	1	2	3
7. Sitting quietly after lunch (when you've had no alcohol)	0	1	2	3
8. In a car, while stopped in traffic	0	1	2	3
		Total _____		

Do you fall asleep or become sleepy when:	Never	Sometimes	Often	Always
1. Driving?	0	1	2	3
2. At work?	0	1	2	3
3. Do you take intentional naps?	0	1	2	3

Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

4. Do you feel unable to move (paralyzed) when falling asleep?	0	1	2	3
5. Suddenly awaken choking or gasping for breath?	0	1	2	3
6. Grind your teeth?	0	1	2	3
7. Hold your breath? Or have you been told you stop breathing?	0	1	2	3
8. Have leg or arm jerks, twitches, or kicks?	0	1	2	3
9. Do you experience short periods of muscle weakness or loss of muscle control (especially with laughter or excitement)?	0	1	2	3
	Never	Sometimes	Often	Always
10. Do you think you need a sleeping pill, either prescription drug or over-the-counter sleeping aids in order to fall asleep?	0	1	2	3
11. Have nightmares?	0	1	2	3
12. Do you ever experience an uncomfortable or restless sensation in your legs when you relax or are first going to sleep that is relieved by moving or getting out of bed and walking?	0	1	2	3
13. Toss and turn or have restless sleep?	0	1	2	3
14. Walk or talk in your sleep? (circle appropriate event)	0	1	2	3
15. Snore?	0	1	2	3
16. Do you experience vivid dreamlike episodes when falling asleep?	0	1	2	3
17. Awaken with heartburn or acid reflux? (acid taste in mouth)	0	1	2	3
18. Wake up with a dry mouth?	0	1	2	3
19. Wake up with headaches?	0	1	2	3
20. Move about or engage in aggressive behaviors while asleep or awakening from sleep?	0	1	2	3
21. Do you consume wine or another alcoholic beverage in order to fall asleep?	0	1	2	3
22. Have you been taking sleeping pills or non-prescription sleeping aids on a nightly basis for more than three weeks?	0	1	2	3
23. Do you lay in bed for more than thirty minutes unable to go to sleep or return to sleep?	0	1	2	3
24. Do you dread getting into bed because you think you will "never" fall asleep?	0	1	2	3
25. How would you rate your overall sleepiness?	None	Mild	Moderate	Severe

While asleep do you:

Section III: Sleep Habits

26. What time do you go to bed on weekdays? _____ weekends? _____
27. How long does it take you to fall asleep? _____
28. What percentage do you sleep on your Back ___% Stomach ___% Left/Right side ___/___%
29. a.) How often do you awaken at night? _____
    b.) How long do you stay awake? _____
    c.) What reason? (bathroom, etc.) _____
30. What time do you get up on weekdays? _____ weekends? _____
31. How many hours of sleep do you get in a typical night? _____

Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

32. How do you feel in the morning?
Very sleepy? _____ Sleepy, but wake up soon _____ Wide awake, ready to go _____

33. When do you function best?

Morning:	Best	Medium	Worst
Afternoon:	Best	Medium	Worst
Evening:	Best	Medium	Worst

Section IV: Medical History
1. Please outline your medical history: Do you have or have ever been told you have:

□ Abnormal Behavior During Sleep □ Frequent Nighttime Urination □ Parkinson's
□ Anemia □ GI Disease □ Prior History of Restless Legs
□ Arthritis □ Heart Disease □ Prior History of Sleep Apnea
□ Cancer □ High Blood Pressure □ Seizures or Epilepsy
□ Dementia (Alzheimer's, etc.) □ Liver Disease □ Sinus Problems
□ Depression and/or Anxiety □ Lung Disease □ Stroke
□ Diabetes □ Migraine/Frequent Headaches □ Thyroid Problems
□ Elevated Cholesterol □ Obesity

Past Medical or Surgical History (include all hospitalizations within the past five years)

Problem	Date of onset	Treatment	Resolved/Current

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

Name	Dosage	How often	Reason

3. Your weight? _____Your height? _____
4. Do you smoke? _____ If yes, how long? _____ How much? _____/ day
5. Do you drink alcohol? ___ If yes, how long? _____ How much? ____/ day/wk/mo
6. Do you drink caffeinated beverages (coffee, tea, cola)? _____ How much? ____/ day/wk/mo

Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

General History

1. Are you having any other problems (e.g. stress, anxiety, or pressures)? _____
   If yes, explain: _____
   _____
2. Have you noticed any changes in your mood or irritability lately? _____
   If yes, explain: _____
   _____
3. Have you been depressed lately? _____
   If yes, explain: _____
   _____
4. Have you had any recent problems with your memory or concentration? _____
   If yes, explain: _____
   _____
5. Do you often travel across time zones, thereby affecting your sleep/wake schedule? _____
   If yes, explain: _____
   _____
6. Are you having any sexual problems (impotency, lack of desire, premature ejaculation, etc.)?_____
   If yes, explain: _____
   _____
7. Do you work night shifts and/or rotating shifts? _____
   If yes, explain: _____
   _____

Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

TO BE COMPLETED BY BED PARTNER

Check any of the following behaviors that you have observed the patient doing while asleep.

____ Loud Snoring
____ Light Snoring
____ Sitting up in bed while asleep
____ Rocking or banging head
____ Twitching of legs or feet
____ Kicking legs while asleep
____ Pauses in breathing
____ Getting out of bed while asleep
____ Grinding teeth
____ Becoming very rigid and/or shaking
____ Talking in sleep
____ Sleep Walking

How long have you been aware of the sleep behaviors that you have checked above?

_____
_____
_____
_____
_____
_____

Describe the behaviors checked above in detail. Include description of activity, time it occurs, frequency during the night and whether it happens every night.

_____
_____
_____
_____
_____
_____

Any additional comments

_____
_____
_____
_____
_____
_____

Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

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_____

Houston Pulmonary Sleep & Allergy Associates
21216 Northwest Freeway, Suite 430, Cypress, TX 77429
Phone: 281-955-0338 Fax: 281-469-0741

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