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_____ Tetanus_____ MMR_____

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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Current symptoms (Check all that apply):

_____ Headaches
_____ Watery Eyes
_____ Post Nasal Drip
_____ Enlarged Glands
_____ Difficulty Exercising
_____ Difficulty Breathing
_____ Wheezing
_____ Cough
_____ Absences from Work/School
_____ Sneezing
_____ Snoring
_____ Hoarseness
_____ Diarrhea
_____ Dry/Itchy Skin
_____ Hives
_____ Rash
_____ Difficulty Sleeping
_____ Chest Tightness
_____ Heartburn
_____ Abdominal Pain
_____ Frequent Infections
_____ Difficulty Swallowing
_____ Puffy Eyes
_____ Red/Itchy Eyes
_____ Loss of Hearing
_____ Ear Pain
_____ Runny Nose
_____ Nasal Congestion
_____ Other: _____

How long have you had your symptoms? _____

How often do your symptoms occur? _____ Daily _____ Weekly _____Monthly _____Occasionally

When do your symptoms occur? _____Winter _____Spring _____Summer _____Fall _____ All Seasons

Symptoms are better when:
_____ Resting
_____ Weather Changes
_____ Exercising
_____ Indoor
_____ Taking Medications

Symptoms are worse when:
_____ Exercising
_____ Stressed
_____ Eating
_____ Outdoor
_____ Indoor
_____ Around Smoke
_____ Traveling
_____ Drinking
_____ Weather Changes
_____ Around Fumes /Odors
_____ Around animals

How severely do these symptoms interfere with your daily life?
1 2 3 4 5 6 7 8 9 10 (Severe)

Have you been tested for allergies before? _____ Yes _____ No

If Yes, What year? _____.
Did you starts allergy shots?____ Yes ____ No.
Were they beneficial? ____ Yes ____ No

What is your current occupation? _____

Do you use tobacco products? ____ Yes ____ No
If yes, How often: _____ How many Years? _____

What tobacco products do you use? _____ Cigarettes _____ Cigars _____ Pipe _____Chewing Tobacco

Do you drink alcohol? ____ Yes ____ No Frequency? _____

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Does it result in a problem: ____ Yes ____ No

Check all that apply to describe the patient's bedroom.

_____ Carpet	_____ Mattress	_____ Bookcase	_____Stuffed Toys
_____ Linoleum	_____ Box Spring	_____ Plants	_____ Blankets
_____ Wood floors	_____ Dust Covers	_____ Ceiling Fan	_____ Curtains
_____ Tile Floors	_____ Waterbed	_____ Blinds	_____ Quilts
_____ Rugs	_____ Pets	_____ Feather Pillows, Mattress or comforters	

Hobbies: _____

Pets: _____ Dog(s) _____ Cat(s) _____ Bird(s) _____ Rabbit(s) _____ Horse(s) Other: _____

Do you **currently have or ever had** any of the following conditions?

___AIDS	___Dental Problems	___Lupus (SLE)
___ Aids Related Complex	___Diabetes	___Pneumonia
___Anemia	___Drug Use	___Poisoning
___Angina	___Emphysema	___Psychiatric Disorders
___Arthritis	___Eczema	___Seizures
___Asthma	___Heart Disease	___Sexually Transmitted Disease: _____
___Blood Transfusion	___Heart Murmur	___Thyroid Disease: _____
___Cancer	___Hepatitis	___Ulcers
___Chronic Bronchitis	___Hypertension	___Warts
___Chicken Pox	___Hives	___Yeast Infections
___Frequent Infections	___Psoriasis	___Frequent Infections

___Other: _____

Family History: Please Check all that apply.

	Father	Mother	Sibling(s)	(Maternal) Grandparents	(Paternal) Grandparents
Asthma	_____	_____	_____	_____	_____
Hay fever	_____	_____	_____	_____	_____
Sinusitis	_____	_____	_____	_____	_____
Hives	_____	_____	_____	_____	_____
Eczema	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____
Blood Pres	_____	_____	_____	_____	_____
Migraines	_____	_____	_____	_____	_____

System Review

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General	Eyes	Ears	Nose	Oropharynx	Lungs	Heart
__Fatigue	__Blurry	__Drainage	__Bleeding	__Hoarseness	__Cough	__Exercise
__Fever	__Discharge	__Hearing	__Congestion	__Soreness	__Sputum	__Chest Pain
__PM Sweats	__Itching	__Itching	__Drainage	__PND	__Tightness	__Breath
__Weigh loss	__Tearing	__Pain	__Sneezing	__Dental Work	__Wheezing	__Palpitations

Intestinal	Urinary	Endocrine	Muscle/ Skeletal	Skin	Neuro/Psych	Growth Dev.
__Bloody Stool	__Accidents	__Heat/Cold	__Joint Pain	__Dry	__Anxiety	_____
__Constipation	__Frequent	__Hormones	__Joint swelling	__Hives	__Depression	_____
__Diarrhea	__Painful	__Hair Loss	__Muscle Pain	__Jaundice	__Headaches	_____
__Heartburn	__Nightly Freq.	__Thyroid	__Weakness	__Rash	__Seizures	

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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