TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

1201 Fairmount Avenue
Fort Worth, Texas 76104
(817) 335-5288
(817) 338-0927 Fax

Patient Name:_____ Referring Physician:_____

You have been scheduled for an initial consultation or hospital follow-up appointment with _____ on _____ at _____. *****PLEASE ARRIVE 30 MINUTES EARLY TO COMPLETE TESTING***** The next page of this packet is a detailed map to our facility. Below is a list of important information to assist you in preparing for this appointment.

- Please complete the enclosed packet of paperwork prior to your appointment. Be sure that all highlighted lines have a signature. The HIPAA privacy information is available in our office for your review if you are not already familiar with its contents.

- It is very important that the doctor have any old and new chest x-rays, CT chest scans or PET scans (**patient must bring the CD/DVD** and reports) for this appointment.

- Please have your referring physician fax to our office or send with you any recent office notes and lab work.

- ***You must bring all of your current medications (actual bottles please) so a correct list can be made for your chart.***

- New patients should plan to be in the office for a period of two to four hours. Patients seen in follow-up after hospitalization should plan approximately one hour for the appointment.

- If your insurance requires a referral, please make sure your referring physician has this completed and faxed to our office prior to your appointment.

- Many of our patients have sensitive respiratory conditions. Please avoid use of scented body spray, perfume, cologne, aftershave, or anything with a heavy scent.

- As a courtesy to our patients, we file charges to your insurance but all co-payments are expected at the time of service.

- **If you cannot keep your appointment, please call us at 817-335-5288 as early as possible. Please help us serve you better by keeping scheduled appointments.**

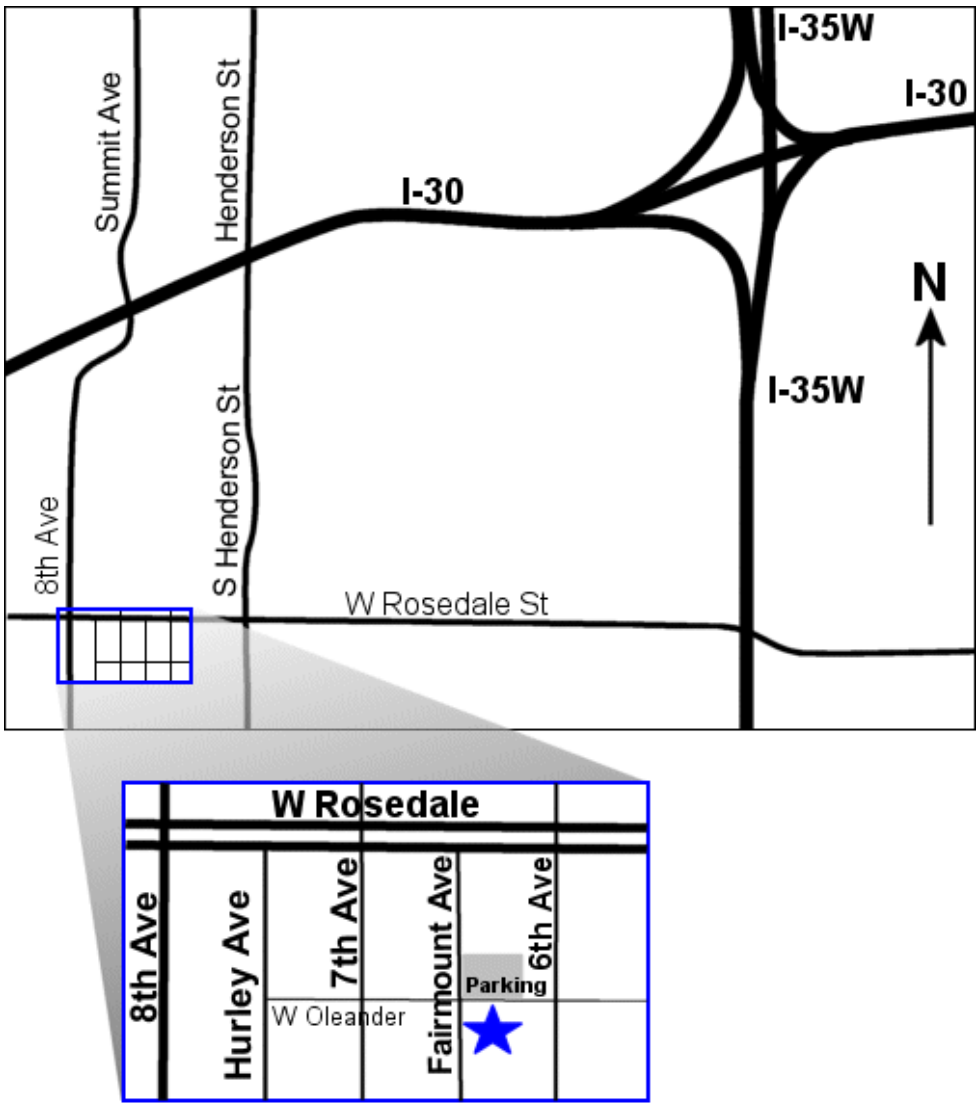
We look forward to meeting you at your first office visit. If we can assist you with questions prior to your visit, please feel free to call. You may also see our website at http://www.texaspulmonary.com for answers to questions you may have.

Sincerely,

Scheduling Secretary

TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

1201 Fairmount Avenue
Fort Worth, TX 76104
817.335.5288



DIRECTIONS:

Heading North/Southbound on I-35W, take the W Rosedale Street exit. Head west on Rosedale. Drive approximately 18 blocks. You cannot turn left on Fairmount from Rosedale going west. Either turn left on 6th Avenue, then right on W Oleander Street, or make a U-turn on 8th Avenue and turn right on Fairmount. Park in the lot at the northeast corner of W Oleander Street and Fairmount, just north of our building.

East/Westbound I-30, exit Summit/8th Avenue. Turn south on Summit. (Summit becomes 8th Avenue.) Turn left on W Rosedale Street. Turn right on Fairmount Avenue. Park in the lot at the northeast corner of W Oleander Street and Fairmount, just north of our building.

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Instructions for Pulmonary Function Testing

- **Do not use inhalers or nebulizer medication for four hours prior to your breathing test. *Please take all other prescribed medications.*** If you experience severe shortness of breath and feel you need to use your inhaled or nebulized medication, do so and call the office. Please ask to speak with the staff in the Pulmonary Function Lab to inform them of your medication use.
- Do not drink any carbonated beverages or ingest caffeinated drink for at least three hours prior to testing.
- Fasting is not required for this test, but avoid eating a heavy meal two hours before testing.
- **Do not smoke for at least three hours prior to the breathing test.**
- Do not drink alcohol for at least four hours before the test.
- Do not exercise 30 minutes before the test.
- Wear loose, comfortable clothing that does not restrict your breathing.
- Please inform the technician prior to testing if you have hearing loss or will need an interpreter on the day of your breathing test. If you are not fluent in English, please bring a translator with you on the day of the test.
- If you wear dentures, you will be asked to remove them during the test.
- If you experience any chest pain, pressure, discomfort or severe shortness of breath on the day of your test, please contact our office and ask to speak with the staff in the Pulmonary Function Lab. Your test may be canceled or delayed due to these symptoms or may be performed with the physician's consent.
- We do not allow children in the Pulmonary Function Lab. Please make arrangements for the care of your children while you are away.
- You will be asked to empty your bladder before the procedure to optimize comfort.

If you have any questions, please call our office at **817-335-5288** and ask to speak with the staff in the Pulmonary Function Lab.

Patient Name: _____

Testing Date and Time: _____

Name: _____ Date: _____

History

Brief description of present problem/complaint: _____

Past History

Have you ever had (X = Yes answers, If NO leave blank):

____ Asthma	____ Emphysema	____ Pulm fibrosis / Scarring	____ Cancer
____ Tuberculosis	____ Bronchitis	____ Sleep apnea	____ Kidney Problems
____ Pneumonia	____ Diabetes Mellitus	____ Stroke	____ Ulcers
____ Sarcoidosis	____ Thyroid problems	____ Atrial fibrillation	____ GERD / Indigestion
____ Blood clots	____ Liver problems	____ Congestive Heart Failure	____ High Blood Pressure
____ Seizure	____ HIV / AIDS	____ Heart attack / Angina	____ Arthritis

Date of last **Flu shot** (Influenza vaccine)_____ Date of last **Pneumonia shot** (Pneumococcal vaccine)_____

Have you had surgery?

Date: _____ Type of surgery: _____

Date: _____ Type of surgery: _____

Date: _____ Type of surgery: _____

Date: _____ Type of surgery: _____

Date: _____ Type of surgery: _____

Social History

Occupation / Describe what do you do at work: _____

Pets: _____ **Children**: _____

Do you **smoke**? _____ If yes, how much? ____ Pks per day

If you quit, when and why? _____

Do you drink **alcoholic beverages**? _____ If yes, how many per week? _____

Have you ever used marijuana or any other hard drug? _____

Allergies

Are you allergic to any medications? (List / give reaction) _____

Are you allergic to anything else? _____

Family History

Relationship	Age(s) (if living)	Age(s) at death	Illnesses / cause(s) of death
Mother			
Father			
Sisters			
Brothers			
Children			

Review of Systems (Please check yes or no)

Yes	No		Yes	No	
General:					
_____	_____	Recent weight change	_____	_____	Sleeping problems
_____	_____	Fever/chills	_____	_____	Loud snoring
_____	_____	Sweats	_____	_____	Morning headaches
_____	_____	Fatigue	_____	_____	Feeling that sleep is not restful
Skin:					
_____	_____	Skin rash	_____	_____	Any new skin marks/spots
Head/Eyes/Ears/Nose/Throat:					
_____	_____	Visual problems/changes	_____	_____	Headaches
_____	_____	Itchy eyes or nose	_____	_____	Drainage
_____	_____	Nose bleeds	_____	_____	Sore Throats
_____	_____	Hoarseness	_____	_____	Sinus infections
Respiratory:					
_____	_____	Coughing	_____	_____	Coughing up blood
_____	_____	Wheezing	_____	_____	Coughing mucus (color_____)
_____	_____	Frequent colds or bronchitis	_____	_____	Shortness of breath
Cardiovascular:					
_____	_____	Chest pain	_____	_____	Heart attack
_____	_____	Swelling of feet/ankles	_____	_____	Dizziness
_____	_____	Heart murmur	_____	_____	Shortness of breath w/ walking
_____	_____	Irregular heart beat	_____	_____	Palpitations
Gastrointestinal:					
_____	_____	Nausea/Vomiting	_____	_____	Abdominal pain
_____	_____	Vomiting blood	_____	_____	Heartburn/Indigestion
_____	_____	Constipation	_____	_____	Diarrhea
_____	_____	Difficulty swallowing	_____	_____	Bloody/black stools
Genitourinary:					
_____	_____	Blood in urine			
Musculoskeletal:					
_____	_____	Joint pain/swelling	_____	_____	Muscle aches
_____	_____	Back pain	_____	_____	Muscle pain
Neurologic:					
_____	_____	Numbness	_____	_____	Weakness/paralysis
_____	_____	Tremors	_____	_____	Seizures
Psychiatric:					
_____	_____	Depression	_____	_____	Anxiety/panic attacks

_____ _____

Patient Signature Date

We request that you bring all of your current medications (actual bottles please) so a correct list can be made for your chart. If you cannot, make a complete, accurate list of your current medications. Use the table below if necessary.

Medication	Dose	Times per day	Length of time used	Prescribing Physician

STOP-BANG Questionnaire

What is Obstructive Sleep Apnea (OSA)?

It is when your breathing stops or slows down while you are sleeping.

If you snore loudly or gasp for air when you sleep, or you are always tired, you may have OSA.

OSA is often present with other diseases. If OSA is overlooked, it could be bad for your health.

- 43 million Americans currently have OSA
- 50% of patients with diabetes have OSA
- 30% of patients with high blood pressure have OSA

Complete the questionnaire below to know if you are at risk of OSA.

Patient Information	
Name:	
Male/Female (M/F):	Age (years):
Height: _____Feet _____Inches	Body mass index (BMI) (office staff can calculate):
Weight (pounds):	Neck or collar size (in inches, office staff can measure):

STOP-BANG	**YES**	**NO**
Do you **S**NORE loudly (eg, louder than talking or loud enough to be heard through closed doors)?		
Do you often feel **T**IRED, fatigued or sleepy during the day?		
Has anyone **O**BSERVED that you have stopped breathing while sleeping?		
Do you have or are you being treated for high blood **P**RESSURE?		
BMI more than 35 kg/m^2?		
Are you more than 50 years of **A**GE?		
Is your **N**ECK 17 inches or greater for men (15 inches for women)?		
Male **G**ENDER?		

YES to 3 or more questions means you are at an increased risk.

PATIENT REGISTRATION FORM

Date:_____

SSN _____ Sex _____ Employment Status ☐ Employed ☐ Disabled ☐ Self Employed ☐ Retired ☐ Unemployed ☐ Student

Name:

First _____ Employer _____

Middle _____ Employer phone _____

Last _____ Birth Date _____

Preferred Name _____ Suffix _____ Marital Status _____ Language _____

Race _____ Ethnicity: ☐Latino/Hispanic ☐Not Hispanic or Latino ☐Other ☐Decline to Answer

Address _____ City _____ Home Phone _____

_____ State _____ ♦Mobile Phone _____

Zip _____ Work Phone _____

☒ Email _____

✓ Preferred phone for **voice** calls (select one)	☐ Home ☐ Mobile ☐ Work
Preferred contact method for automated appointment reminders (select one or more)	☐ Voice (preferred phone selected above ✓) ☐ Text (enter mobile phone above ♦) ☐ Email (enter email address above ☒) ☐ Do Not Remind Me
Patient Portal Access (please select one):	
☐ Please email an invitation to the patient portal (email address above ☒)	☐ I decline access to the patient portal

Referred By _____ Phone _____ Fax _____

Address _____
Street City State Zip+4

Primary Care Physician _____ Phone _____ Fax _____

Address _____
Street City State Zip+4

List other physicians you are currently seeing _____

Are you currently residing in a skilled nursing facility? Yes No If yes, name of facility _____

Notify in case of emergency:

Name _____ Phone _____ Relationship _____

Address _____
Street City State Zip+4

Pharmacy _____ Phone _____

Have you signed a: Living Will: Yes No DNR (Do Not Resuscitate): Yes No (Please provide a copy)

Durable Power of Attorney: Yes No Date signed:_____ (Please provide a copy)

Are you currently using a DME (Durable Medical Equipment) company? Yes No

If yes, which one? _____

If no, who does your insurance company require you to use? _____

Who does your insurance company require you to use for: Lab _____ X-ray _____

Is this a work-related illness/injury? Yes No Date of illness/injury _____ Date last worked _____

Cause of accident, if any _____

I hereby authorize release of my medical records from_____to Texas Pulmonary & Critical Care Consultants, PA. This authorization expires upon written notice from patient/patient representative.

_____ _____

Signature of Patient or Responsible Party Date

FINANCIAL POLICY

PRIMARY INSURANCE POLICY:

Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Insured's DOB _____ Ins Start Date _____
Relationship to Patient _____ SSN _____ Sex _____

SECONDARY INSURANCE POLICY:

Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Insured's DOB _____ Ins Start Date _____
Relationship to Patient _____ SSN _____ Sex _____

Responsible Party Name _____ Phone _____ Relationship _____
Address _____
Street City State Zip+4

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. Full payment or copayment (if applicable) is due at the time of service. We accept cash, check, Visa, MasterCard, Discover or American Express. We are not responsible for misinformation given by your insurance company. You will be refunded any over-payments or billed for any balance after the claim processes.

Regarding Insurance – We cannot bill your insurance company unless you give us your insurance information. If we are nonparticipating with your insurance, and they have not paid the balance within 90 days, the balance will be transferred to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable and necessary under the Medicare Program and/or other medical insurance. These charges will be your responsibility. Our office makes every effort to obtain referral authorizations from the Primary Care offices for patients on HMOs. Should we not be able to obtain a referral, charges will be your responsibility.

Appeals – You appoint Texas Pulmonary & Critical Care Consultants, P.A. and/or Sleep Consultants, Inc. to act as your authorized representative in requesting an appeal from your insurance plan in the event of denial of services/denial of payment. You agree that if the payment denial is overturned on appeal, the plan's payment should be paid directly to Texas Pulmonary/Sleep Consultants, and you direct the plan to do so in that event.

Out of Network Billing – The physicians may not be participating providers with your insurance plan and, if not, benefits may be reduced and/or your portion may be applied to your out-of-network deductible.

_____ _____
Signature of Patient or Responsible Party Date

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's 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.

_____ _____
Signature of Patient or Personal Representative Date

A copy of our Notice of Privacy Practices will be provided at your request.

Texas Pulmonary & Critical Care Consultants, PA

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Texas Pulmonary & Critical Care Consultants, PA, must have my consent, therefore I authorize Texas Pulmonary & Critical Care Consultants, PA to disclose my PHI as described in the provided forms to the recipients listed below:

Description of the information to be disclosed (check all that apply):

☐All Procedures ☐Test Results ☐Appointments ☐Other ☐Surgeries ☐Billing/Account information

Name(s) of the person(s) authorized to obtain the above-mentioned information (e.g. family members and other specified person(s), physician other than your referring doctor).

Name:_____Relationship:_____

Name:_____Relationship:_____

Patient's Contact Information:

I authorize Texas Pulmonary & Critical Care Consultants, PA to contact me at the following number with results or questions:

Home_____ Cell_____ Work_____

May we leave a detailed message on your answering machine or voicemail?

Yes☐ No☐ Failure to check one of these boxes may delay results

By Patient: (printed name) _____ DOB: _____

Patient Signature: _____ Date:_____

Or Patient's Representative (print name, sign and describe authority)

_____ Date:_____

By signing this HIPAA Patient Acknowledgement form, you acknowledge and authorize that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. You understand that your records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that you have the right to revoke this authorization at any time, provided you do so in writing; that you have been given the opportunity to ask questions; that you have received a copy of the signed authorization; that you may inspect a copy of your PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to you or your treatment upon receipt of this signed authorization; and that you may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

Advanced Practice Provider Consent

In addition to our Board-Certified physicians, this facility has on staff advanced practice providers to assist in the delivery of pulmonary care.

These advanced practice providers are not physicians. They have received advanced education and training in the provision of health care. Each can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

I have read the above and hereby consent to the services of an advanced practice provider for my health care needs.

I understand that at any time I can refuse to see the advanced practice provider and request to see a physician.

_____ _____

Name Date

_____

Signature