PATIENT INFORMATION

Patient Legal Name (Last, first, middle) _____

DOB: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow/Widower

Race:_____ Ethnicity:_____ ☐ Decline

Patients Home Address: _____

City: _____ State: _____ Zip: _____

Phone (Home):_____Cell phone: _____ Text? ☐ Y ☐ N

Email address: _____

Primary Care Physician: _____

Employer: _____ Emp. Address: _____

City: _____ State: ____ Zip: _____ Employer Phone: _____

EMERGENCY CONTACT

Name: _____ Email: _____

Home phone: _____ Cell: _____

Street Address: _____ City: _____ State: ____ Zip: _____

Relationship to Patient: _____

PRIMARY INSURANCE HOLDER / PERSON RESPONSIBLE FOR BILL

☐ Check if same as above

Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone (Home): _____ Cell:_____

Street Address: _____ City: _____ State: _____

Email: _____ Relationship to patient: _____

PRIMARY INSURANCE HOLDER / PERSON RESPONSIBLE FOR BILL (cont.)

Employer: _____ Employer Address: _____

City: _____ State: ____ Zip: _____ Phone: _____

INSURANCE INFORMATION

☐Not Insured/Self Pay

Primary Insurance Provider: _____ Member ID:_____

Effective Date: _____ Group No. _____

Secondary Insurance Provider: _____ Member ID:_____

Effective Date: _____ Group No. _____

Tertiary Insurance Provider: _____ Member ID:_____

Effective Date: _____ Group No. _____

PRIMARY CARE/REASON FOR VISIT

Referring Provider: _____Primary Care Provider: _____

Reason for your visit today:

_____

Have you recently been hospitalized, to an Emergency Room or Urgent Care? ☐Yes ☐ No

If yes, When: _____ Where: _____

Any recent testing completed:

☐ Chest / Sinus X-ray When: _____ Where: _____

☐ Chest / Sinus CT When: _____ Where: _____

☐ Labs/Bloodwork When: _____ Where: _____

☐ PET Scan When: _____ Where: _____

☐ Ultrasound When: _____ Where: _____

☐ Sleep Study When: _____ Where: _____

SOCIAL HISTORY:

Do you use tobacco: ☐ Yes ☐ No ☐ Former Date quit: _____

Type: ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Chew ☐ Vape

Overall daily use: _____ Packs/pipes/ can / per day Total # years used: _____

Do you drink alcohol? ☐ Yes ☐ No ☐ Former Type of alcohol: _____

How many beers/glasses/drinks? ____How often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Yearly

Do you use recreational drugs: ☐ Yes ☐ No If so, type and how often: _____

Do you exercise: ☐ Yes ☐ No Type of exercise: _____ How often: _____

Occupation: _____ Pets: _____

VACCINES:

Pneumonia: ☐ Yes ☐ No Date: _____ Flu: ☐ Yes ☐ No Date: _____

COVID-19: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson Date(s): _____

FAMILY HISTORY: Please check to indicate history of the following:

Breathing History	Father	Mother	Brother / Sister
Alpha 1 Antitrypsin			
Asthma			
COPD			
Emphysema			
Pulmonary Fibrosis			
Pulmonary Hypertension			
Sarcoidosis			
Sleep Apnea			

Other History	Father	Mother	Brother / Sister
Coronary Artery Disease			
Hypertension			
Congestive Heart Failure			
Blood Clots / DVT's			
Diabetes			
Lupus			
Rheumatoid Arthritis			
Lung Cancer			
Colon Cancer			
Other cancer			

Past Surgical / Procedure History:

_____

_____

PERSONAL MEDICAL HISTORY

Pulmonary			Cardiovascular		
Allergies	Y	N	Congestive Heart Failure	Y	N
Alpha 1 Antitrypsin	Y	N	Blood Clots / DVT	Y	N
Asthma	Y	N	Coronary Artery Disease	Y	N
Asbestosis	Y	N	Heart Attach (MI)	Y	N
COPD	Y	N	Hypertension (HTN)	Y	N
Recurrent Bronchitis	Y	N	Atrial Fibrillation	Y	N
Emphysema	Y	N	Elevated Cholesterol	Y	N
Pulmonary Embolism	Y	N	Chest Pain / Angina	Y	N
Pneumonia	Y	N	Heart Murmur's / Valvular Disease	Y	N
Pulmonary Fibrosis	Y	N	Stroke	Y	N
Sarcoidosis	Y	N	Anemia	Y	N
Sleep Apnea	Y	N	Neurologic / Psychological		
COVID–19 Pneumonia	Y	N	Depression	Y	N
Gastrointestinal			Anxiety	Y	N
Acid Reflux (GERD)	Y	N	Bipolar Disorder	Y	N
Hepatitis, Type - C B A	Y	N	Insomnia	Y	N
Peptic Ulcer Diseases (PUD)	Y	N	Restless Leg Syndrome	Y	N
Inflammatory Bowel Disorder (IBD)	Y	N	Dementia	Y	N
Metabolic / Rheumatologic			Other		
Diabetes – Type 1 Type 2	Y	N	Cancer – Type:	Y	N
Hyperthyroidism	Y	N	HIV / AIDS	Y	N
Hypothyroidism	Y	N	Tuberculosis	Y	N
Lupus	Y	N	Immunoglobulin Deficiency	Y	N
Rheumatoid Arthritis	Y	N	Fever	Y	N
Musculoskeletal			Chills	Y	N
Osteoarthritis	Y	N	Night Sweat	Y	N
Fibromyalgia	Y	N	Weight Change	Y	N
Additional Medical History:					

Preferred Pharmacy _____

Location _____Phone (_____)_____

Any allergies to medications: □ Yes □ No □ Unknown

If so what Medication / Reaction _____

_____

_____

PLEASE LIST ALL PRESCRIBED AND OVER THE COUNTER MEDICATIONS AND VITAMINS AND SUPPLEMENTS

Medication Name	Strength mg, mcg, etc.	How often 1 X day, 2 X day, etc.	Reason for taking (Heart, blood pressure, etc.)

Epworth Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these activities recently, try to work out how they would affect you. Use the following 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			
	0	1	2	3
Sitting and reading				
Watching TV				
Sitting, inactive in a public place (theatre, meeting, etc)				
As a passenger in a car for an hour without break				
Lying down to rest in the afternoon when circumstances permit				
Sitting and talking to someone				
Sitting quietly after a lunch without alcohol				
In a car, while stopped for a few minutes in traffic				
Total				

Stop-Bang Patient Questionnaire

Question		Yes	No
Snoring	Do you Snore Loudly (loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)?		
Tired	Do you often feel Tired, Fatigued, or Sleepy during the daytime (such as falling asleep during driving or talking to someone)?		
Observed	Has anyone Observed you Stop Breathing or Choking/Gasping during your sleep ?		
Pressure	Do you have or are being treated for High Blood Pressure ?		
Body	Body Mass Index more than 35 kg/m^2?		
Age	Age older than 50?		
Neck	Large Neck size		
Gender	Are you male?		

OSA - Low Risk: Yes to 0 - 2 questions OSA - Intermediate Risk: Yes to 3 - 4 questions OSA - High Risk: Yes to 5 - 8 questions or Yes to 2 or more of 4 STOP questions + male gender or Yes to 2 or more of 4 STOP questions + BMI > 35kg/m^2 or Yes to 2 or more of 4 STOP questions + neck circumference 16 inches / 40cm

Total

Sleep-Related Breathing Disorders Screening Form

It is important for you to be as accurate as possible in answering the following questions. The purpose of this questionnaire is to get a total picture of your background and the nature of your present problem. Please complete these questions as thoroughly as you can. This information will be held in the strictest of confidence.

Describe your main problem(s) in your own words, including when and how this began and what treatment you have received for this in the past:	

Sleep History

Do you experience any of the following?

Snoring	Insomnia	Leg Cramps	Stopping Breathing	Excessive Daytime Sleepiness

What time do you go to sleep?	
How long does it take you to fall asleep?	
What time do you wake up on the weekdays? On the weekends?	
How many times do you wake up during the night?	

Question	Yes	No
Do you have feelings of depression/anxiety?		
Do you have drop attacks during the day?		
Do you have hallucinations upon falling asleep or upon waking?		
Do you have crawling sensations in your legs?		
Do you work split shifts or variable shifts?		
Do you usually drink caffeine within two hours of going to bed?		
Awaken from sleep short of breath or gasping for air?		
Awaken at night with heartburn, belching or cough?		
Snore?		
Sweat excessively at night?		
Notice your heart pounding or beating irregularly during the night?		
Fall asleep during the day?		
Fall asleep or lose muscle tone when laughing or crying?		
Feel unable to move (paralyzed) when waking or falling asleep?		
Experience vivid dreamlike scenes upon awakening or falling asleep?		
Remember your dreams?		
Kick or have body jerks during the night?		
Experience crawling and aching feelings in your legs?		

Please rate your breathlessness on a scale from 0-4. Read description below.

Grade	Description of Breathlessness
0	I only get breathless with strenuous exercise
1	I get short of breath when hurrying on level ground or walking up a slight hill
2	On level ground, I walk slower than people of the same age because of breathlessness, or have to stop for breath when walking at my own pace.
3	I stop for breath after walking about 100 yards or after a few minutes on level ground
4	I am too breathless to leave the house or I am breathless when dressing

HOW IS YOUR COPD? TAKE THE COPD ASSSESSMENT TEST

This questionnaire will help you and your healthcare professional measure the impact COPD (Chronic Obstructive Pulmonary Disease) is having on your health and well being and daily life. Your answers, and the test score, can be used by you and your healthcare professional to help improve the management of your COPD and get the greatest benefit from treatment.

For each item below, circle the number that best describes you currently from 1-6 on the scale. Be sure to only select one response for each question. Example, if you are more happy than sad, circle a number from 1-3. If you are more sad than happy, circle a number from 4-6.

Example: I am very happy	1 2 3 4 5 6	I am very sad	SCORE
I never cough	1 2 3 4 5 6	I cough all the time	
I have no phlegm (mucus) in my chest at all	1 2 3 4 5 6	My chest is completely full of phlegm (mucus)	
My chest does not feel tight at all	1 2 3 4 5 6	My chest feels very tight	
When I walk up a hill or one flight of stairs, I am not breathless	1 2 3 4 5 6	When I walk up a hill or one flight of stairs, I am very breathless	
I am not limited doing any activities at home	1 2 3 4 5 6	I am very limited doing activities at home	
I am confident leaving my home despite my lung condition	1 2 3 4 5 6	I am not all confident leaving my home because of my lung condition	
I sleep soundly	1 2 3 4 5 6	I don't sleep soundly because of my lung condition	
I have lots of energy	1 2 3 4 5 6	I have no energy at all	
		TOTAL SCORE	

Due to the Health Information Portability and Accounting Act (HIPAA) of 1996, the following information must be filled out by each patient annually*.

Please initial each statement at your discretion

_____ I authorize Texas Pulmonary Institute to release and receive my medical or insurance information as necessary to process my medical claims and coordination or manage my healthcare.

_____ In the event of a family member or caregiver attends my office visit and is in the exam room at the time of my evaluation and/or treatment, I give Texas Pulmonary Institute and its physician, providers, or employees my permission to discuss freely my condition, treatment, diagnosis, or pregnancy with that person.

Patient Contact Numbers:

Home: _____ Mobile: _____

Work: _____ Other: _____

May we leave a message at one or more of the numbers listed above regarding appointments and test or lab results?

: ☐ Yes : ☐ No

: ☐ Home : ☐Mobile : ☐Work : ☐Other : ☐All of the above

With whom may we discuss or release information about your care, treatment, diagnosis or pregnancy?

Name:_____Relationship:_____Number:_____

Name:_____Relationship:_____Number:_____

Name:_____Relationship:_____Number:_____

Patient Signature: _____ Date: _____

Personal Representative/Witness Name: _____

Personal Representative/Witness Signature:_____

Relationship: _____ Date: _____

Please read and initial each statement to confirm understanding of the authorizations/consent listed below.

_____ I voluntarily consent to the rendering of medical care, treatment and diagnosis, including such diagnostic, therapeutic or medical procedures to be performed by my attending physician, his or her designee, or assistants as is necessary in his or her judgment.

_____ I understand that treatment may involve risk. I understand that emergency or major procedures will not be performed on me until I have had the opportunity to discuss such procedures and the risks associated to my satisfaction with my physician or other health care provider and have consented to such procedure. Further, I understand that medical, nursing and other health care personnel may participate in my care and treatment as part of procedure.

_____ I understand that Texas Pulmonary Institute will keep records that contain my medical, personal and other information related to my diagnosis, care, and treatment in electronic and paper format.

_____ I hereby assign to Texas Pulmonary Institute the right to all health insurance benefits otherwise payable to me, and I authorize Medicare and/or medical insurance benefits to be paid directly to Texas Pulmonary Institute. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

_____ I understand that Texas Pulmonary Institute may release any information about me, my health, the health services provided to me, or payment for my health services, that may be necessary for claim processing

____ I authorize Texas Pulmonary Institute to request my medical information including complete medical records, test results, and insurance information from medical professionals that I have received treatment including my referring physician/practitioner, primary care physician, specialists, and/or medical care institutions that may be necessary to improve coordination of care

____ I authorize Texas Pulmonary Institute to release my medical information including complete medical records, test results, and insurance information to medical professionals including my referring physician/practitioner, primary care physician, and/or medical care institutions that I may be referred to for treatment to improve coordination of care

_____ I understand that insurance may not pay the full amount of my charges and I acknowledge that I am financially responsible and agree to pay my bill for non-covered services, as well as any deductibles, copays, or co-insurance. If I am uninsured, I agree to assume full financial responsibility for payment of all charges.

My signature below constitutes my acknowledgement that I have read and understood the above information, and that I agree to this consent of treatment, payment and medical release as described herein.

Patient Signature_____Date_____

Personal Representative/Witness Name: _____
Personal Representative/Witness Signature:_____
Relationship: _____ Date: _____

Texas Pulmonary Institute

No Show, Late and Cancellation Policy

Effective 12/01/2022

"No Show" shall mean any patient who *fails to arrive* for a scheduled appointment. **"Same Day Cancellation"** shall mean any patient who cancels an appointment *less than 24 hours* before their scheduled appointment. **"Late Arrival"** shall mean any patient who arrives at the clinic *15 minutes after* the expected arrival time for the scheduled appointment.

Policy

It is the policy of the practice to monitor and manage appointment no-shows and late cancellations. It is our goal is to provide excellent care to each patient in a timely manner. If it is necessary to cancel an appointment, patients are required **to call or leave a message at least 24 hours** before their appointment time. Notification allows the practice to better utilize appointments for other patients in need of prompt medical care.

Procedure

A patient is notified of the appointment "No-Show, Late, & Cancellation Policy" at the time of scheduling. This policy can and will be provided in writing to patients at their request.

Failure to provide 24 hours' notice will result in a $50 charge being billed to the patient account.

Established patients

Appointment must be cancelled at least 24 hours prior to the scheduled appointment time. In the event a patient arrives late as defined by "late arrival" to their appointment and cannot be seen by the provider on the same day, they will be rescheduled for a future clinic visit, if available. If appointments are not yet available for their provider, a reminder will be placed for the patient to call to make a future appointment once the schedule opens. In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from Texas Pulmonary Institute. The patient's chart is reviewed, and dismissals are determined by a physician only, no exceptions, in accordance with the TPI policy.

New patients

Appointment must be cancelled at least 24 hours prior to scheduled appointment time. In the event of a no-show, Texas Pulmonary Institute may require a new referral sent from the referring physician. In the event a patient arrives late as defined by "late arrival" to their appointment, the Texas Pulmonary Institute reserves the right to request a new referral sent from the referring physician. In the event of three (3) documented "same-day cancellations," the patient may be

subject to dismissal from Texas Pulmonary Institute. The patient's chart is reviewed, and dismissals are determined by a physician only, no exceptions, in accordance with the TPI policy.

Please read and initial in statement to confirm understanding of fees you may be responsible for while receiving care at Texas Pulmonary Institute.

____ I read and understand that cancellation less than 24 hours before my appointment or a no show is subject to a fee of $50.

Patient Documentation and Records Requests

We understand that many circumstances and other providers may ask for documentation for our office in the form of disability paperwork, records requests, unemployment or workman's compensation documents and the related. We will be happy to accommodate these requests, but we require **a 48-72 hour processing time for completion and a fee of $30.**

While we will always do our best to complete these quickly, please do not expect same day service, and make any adjustments accordingly.

____ I understand that outside forms provided to the medical professionals at Texas Pulmonary Institute to complete included but no limited to work release and disability forms require a 48-72 hour processing time. Fee of $30 to be collected once forms are completed.

Returned Check Fees

Texas Pulmonary Institute reserves the right to charge a $30 fee on any returned personal checks. Once we receive a returned check, we will no longer accept personal checks for a form of payment on your account.

____ I understand that a returned personal check is associated with a fee of $30 and if a personal check is returned for non-payment I will be unable to secure payment with TPI using personal checks.

I,_____ , authorize *Texas Pulmonary Institute* to charge my patient account for the fee associated with items listed above. I understand that I will be responsible for paying the balance of these charges prior to any scheduled visits.

Patient Signature: _____Date: _____