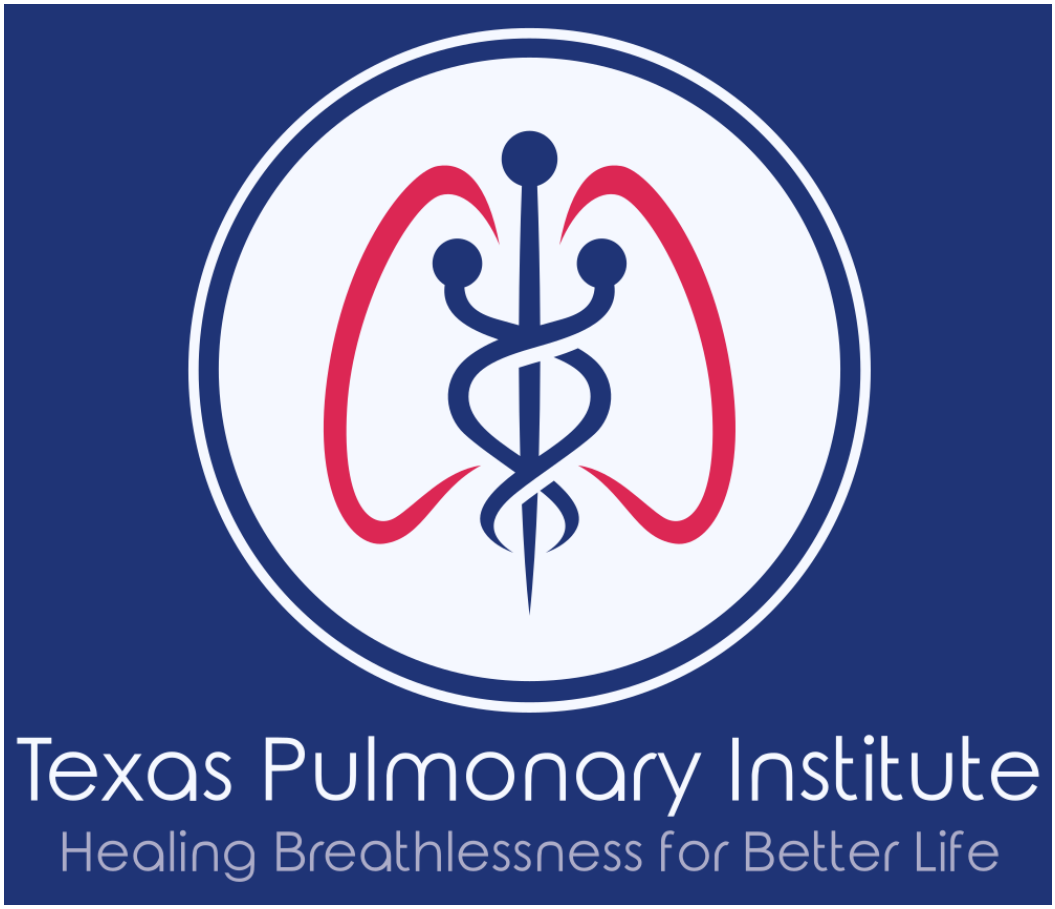
Texas Pulmonary Institute
Healing Breathlessness for Better Life

NAME:

WELCOME TO THE TEXAS PULMONARY INSTITUTE (TPI)

Hello,

Thank YOU for choosing the Texas Pulmonary Institute (TPI)! On behalf of our providers, clinicians, and staff I would like to welcome you for being a part of the TPI family. We are committed to provide you the same level of care we envision for our loved ones. As an independent organization, the TPI dedicated all its resources to improve the lives of the Southeast Texas community through various services.

With **SERVICE** and **HEALING** being our utmost values, our mission is to **"HEAL BREATHLESSNESS"** so our patients can have the opportunity for "a Better Life". Your **INDIVIDUALIZED PLAN OF CARE** is developed after thorough review of your clinical symptoms, medical records, and comprehensive assessment of your pulmonary function testing and other respiratory testing. This plan is developed after you visit with our clinicians and staff.

To expedite the new patient registration process, please be sure to arrive at least 15-30 minutes early or complete this new patient packet prior to your appointment.

Please bring the following with you to your scheduled appointment:

1. New Patient Packet (**THIS PACKET**),
2. All active insurance and prescription cards,
3. Driver's License or Identification Card,
4. A form of payment for your copay/coinsurance. For your convenience we accept:
    - Credit Cards: Visa, MasterCard, American Express, Discover
    - Cash
    - Check
5. List of medications you are currently taking including vitamins.
6. Any medical records from referring physician(s) including labs and imaging.

We look forward to serving you at Texas Pulmonary Institute. If you must cancel or reschedule, please give the office at least a 24 hour notice.

Respectfully,

Texas Pulmonary Institute
Patient Service Management
Direct Number (Call or Text): (409) 401 – 5864 (LUNG) | E-Mail: Info@TexasPulmonaryInstitute.org

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NAME: ……

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Patient Legal Name (Last, first, middle) _____

DOB: _____ Soc. Security No: _____

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

Race:_____ Ethnicity:_____ Decline:_____

Patients Home Address: _____

City: _____ State: _____ Zip: _____

Phone (Home):_____ Cell phone: _____

Email address: _____

Employer: _____ Emp. Address: _____

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

Do you have an advance directive?_____ If so, please provide a copy.

Do you have a medical power of attorney?_____ If so, who? _____

Spouse Name:_____ DOB:_____

Phone Number:_____ Employer:_____

EMERGENCY CONTACT (Other than Spouse)

Name: _____ Email: _____

Home phone: _____ Cell: _____

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

Relationship to Patient: _____

PRIMARY INSURANCE HOLDER / GUARANTOR

☐ Check if same as patient

Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone (Home): _____ Cell:_____

Street Address: _____ City: _____ State: _____

Email: _____ Relationship to patient: _____

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NAME: .....

Employer: _____ Employer Address: _____

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

Primary Carrier:_____ ID Number:_____

Group:_____ Address:_____

Secondary Carrier:_____ ID Number:_____

Group:_____ Address:_____

MEDICAL HISTORY FORM

Referring Provider: _____ Primary Care Provider: _____

Other specialists that you see:_____

Reason for seeking care: _____

_____

Have you recently been hospitalized, sought emergency care or urgent care? ☐Yes ☐ No

When: _____ Where: _____

Any recent testing completed:

☐ Chest X-ray When: _____Where: _____

☐ Chest CT When: _____Where: _____

☐ Other Imaging _____ When: _____Where: _____

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

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

Overall daily use: _____ Packs/pipes/ can / 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: _____

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NAME: ……

VACCINATION:

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

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

Shingles: ☐ Yes ☐ No Date: _____ RSV: ☐ Yes ☐ No Date: _____

FAMILY HISTORY:

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

	Father	Mother	Brother / Sister
Coronary Artery Disease			
Hypertension			
Congestive Heart Failure			
Blood Clots / DVTs			
Diabetes			
Lupus			
Rheumatoid Arthritis			
Lung Cancer			
Colon Cancer			

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NAME: ……

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 Attack (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
Pulmonary Hypertension	Y	N	Swelling	Y	N
Pneumonia	Y	N	Heart Murmur / 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:					
Past Surgical / Procedure History:					

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NAME: ……

MEDICATION LIST

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.)	**Who Prescribes?** Name of Doctor

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NAME: .....

SLEEP-RELATED BREATHING DISORDERS QUESTIONNAIRE

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 (theater, 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 years old?		
Neck	Neck Circumference size (inches)		
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**	

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NAME: ……

FUNCTIONAL IMPACT OF RESPIRATORY DISORDER

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 ground level
4	I am too breathless to leave the house or I am breathless when dressing

This questionnaire will help you and your healthcare professional measure the impact of your respiratory symptoms on your health, well-being and daily life. Your answers (*overall test score*) can help you and your healthcare professional to improve the management of your respiratory condition(s) and get the greatest benefit from treatment plan.

FOR EACH ITEM BELOW, PLACE A MARK (X) IN THE BOX THAT BEST DESCRIBES YOU CURRENTLY. BE SURE TO ONLY SELECT ONE RESPONSE FOR EACH QUESTION

LEAST SEVERE SYMPTOM	SEVERITY OF SYMPTOMS 1	2	3	4	5	6	MOST SEVERE SYMPTOM	SCORE
I am very happy	1	2	3	4	5	6	I am very sad	
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	
Walking up a hill or one flight of stair 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								

NOTES:

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NAME: ……

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 gain understanding of your background and the nature of your present problem. Please complete these questions as thoroughly as you can.

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?		

Patient Signature: _____ Date: _____

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NAME: ……

AUTHORIZATION FOR TREATMENT, RELEASE & REQUEST OF MEDICAL RECORDS

INFORMED CONSENT FORM

(PAGE ONE)

In compliance with 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: _____ **Work: _____**

Mobile: _____ **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:_____

_____ 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 the 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 understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result or outcome of the treatments, or examinations of the providers of Texas Pulmonary Institute or its designees,

_____ 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,

Signature: _____

Personal Representative/Witness Name: _____

Personal Representative/Witness Signature: _____

Relationship: _____ Date: _____

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NAME: .....

INFORMED CONSENT FORM

(Page Two)

_____ 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 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,

_____ This facility may staff and use nurse practitioners or physician assistants to assist in the delivery of pulmonology care. A nurse practitioner or physician assistant have both received advanced education and training in the provision of healthcare. I consent to the services of a nurse practitioner or physician assistant. I understand that at any time I can refuse to see a nurse practitioner or physician assistant and can request to see the physician,

_____ 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, and

_____ I agree that all copayments, coinsurances, or remaining deductibles due are due at the time of services are rendered or promptly upon billing. Therefore, I do hereby voluntarily consent to medical treatment and/or diagnostic testing under the providers of Texas Pulmonary Institute, their assistants, or designees as is necessary in their professional judgment.

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.

Signature: _____

Personal Representative/Witness Name: _____

Personal Representative/Witness Signature: _____

Relationship: _____ Date: _____

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NAME: ……

FEES NOT BILLABLE TO INSURANCE

*All major healthcare insurance plans and are accepted by our providers and vendors. For certain services that healthcare plans have not defined or does not provide any coverage, the patient is legally responsible for the costs described below. Below please review and initial each statement to confirm understanding of fees you **MIGHT** be responsible for:*

GENERAL PATIENT SERVICES

_____ I understand that ***cancellation within 24 hours before or failure to attend any of my appointments*** is subject to a fee of **$25**.

_____ I understand that outside forms provided to the medical professionals at the Texas Pulmonary Institute (TPI) including but not limited to work disability forms require **up to 72 hour processing time**. Fees of **$25 per page completed** by our clinicians at the Texas Pulmonary Institute, **not to exceed $250** will be collected at the time of the forms being submitted.

_____ I understand that TPI provides electronic version of my records ***(via email or electronic fax)*** at ***NO additional cost***.

_____ I understand that TPI charges ***NO additional / hidden fees*** for printing ONE copy of my test or imaging studies.

SLEEP MEDICINE SERVICES

_____ I understand the Home-Based Sleep devices are expensive (*$2,500 per testing unit*). I acknowledge that I am solely responsible to safely return the equipment back to the Texas Pulmonary Institute offices. Each night delay in returning this equipment, **penalty** is **$50 per unit per night**.

_____ I understand there is a processing, training, and education fee of **$50** for using the reusable Home-Based Sleep Study Testing Equipment. *This fee is for the sleep technician's efforts and does not considered a reimbursement to your physician.*

_____ I understand there is a convenience fees of **$125** for using the disposable Home-Based Sleep Study Testing Equipment. This is to cover the additional cost of equipment and training by the technicians, in-person or over the phone.

_____ I understand that **no additional / hidden costs** is applied for the professional / medical services covered by your medical insurance plan.

The amounts disclosed above applies to all our patients with exception of:

- ⇨ *Our sisters and brothers in uniform, veterans, and law-enforcement officers and their first-degree relatives*
- ⇨ *The traditional Medicare and Medicaid beneficiaries*

CREDIT CARD INFORMATION	☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX
Card Holder Name (*as shown on card*):	
Card Number:	Expiration Date (mm/yy):
Credit Card Holder ZIP Code:	Credit Cardholder Security Code:
Credit Card Holder Signature:	

To ensure payment is collected the following credit card on file will be billed for in case of any of the above items (namely, processing outside forms – not the medical records, returned personal checks, no show OR cancellation less than 24 hour from the appointment, and Training & Preparation fee for the Home-Based Sleep Study. This credit card on file will only be used for this purpose and you will be notified prior to processing fee. I,_____, authorize the Texas Pulmonary Institute to charge my credit card above for the fee associated with items listed above. I understand that my information will be saved to file for future transactions on my account, within the scope defined above. The Texas Pulmonary Institute will NOT share this information with any third party, marketing, or any other agency.

Patient Signature: _____

Date: _____

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NAME: ……

MEDICAL RECORDS REQUEST FORM

Texas Pulmonary Institute
Healing Breathlessness for Better Life

DR. ROOZBEH SHARIF

2300 Hwy 365 Ste. 150, Nederland, TX 77627
Phone: 409-401-LUNG (5864) | Fax: 409-344-8600

To: Medical Records Department
Healthcare Facility: _____
Phone: _____ | Fax: _____

Our mutual patient, _____ , has authorized our office to obtain a copy of the following medical records from your office:

- 0 Clinical Notes
- 0 Radiographic studies (CT, MRI, X-ray, US, …)
- 0 Any Anesthesiology and Surgery report
- 0 Cardiac Evaluations (EKG, Echo, etc)
- 0 ALL MEDICAL RECORDS
- 0 Laboratory studies
- 0 Procedure Details
- 0 Respiratory / Pulmonary Studies
- 0 Pathology & Cytology studies

In case of any imaging studies, please provide a CD of the images along with the records.

PATIENT INFORMATION

First Name
Last Name
Date of Birth
Social Security Number
Address :
Phone Number

Medical Record Number (if available):

Patient Signature: _____
Date: _____

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