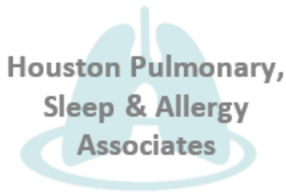

New Patient Registration

Physician Referred By: ______________________ Primary Care Physician (First & Last Name): ________________________

Reason for Visit: ____

Patient Information

Last: _________________________ First: _________________________ Middle Initial: _____ Date of Birth: ___________

Gender: ☐ Male ☐ Female ☐ Other Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Home Address: ____

City: __________________________ State: ______ Zip: __________

Home #: _______________________ Cell #: ______________________

Email: ____

Required for access to our Patient Portal to request refills, make appointments, send messages to provider, schedule Telehealth appointment, etc

Not required. For reporting purposes only

Race:
- ☐ Asian
- ☐ Black or African American
- ☐ Declined to Specify
- ☐ Other: ____________
- ☐ White

Ethnicity:
- ☐ Declined to Specify
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other: ____________

Employer: ____

Occupation: ____

Pharmacy Name: ______________________________________ Pharmacy Phone #: ________________________________

Emergency Contact Information

Name: __________________________________ Relation: _______________________ Phone #: _____________________

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).

Name: __________________________________ Relation: _______________________ Phone #: _____________________

Name: __________________________________ Relation: _______________________ Phone #: _____________________

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, Sleep & Allergy 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.

Patient Name: ____________________________ Signature: ____________________________ Date: _________________

Notice of Privacy Practices

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.

Patient Name: ____________________________ Signature: ____________________________ Date: ________________

Houston Pulmonary, Sleep & Allergy Associates

Updated Financial and Billing Policies

1. You are ultimately responsible for knowing what your insurance plan does and does not cover. This includes in-network/out-of-network benefits, out of pocket, co-payment, co-insurance, deductible, prior authorizations, referrals, etc.
2. Be prepared to show your photo identification and insurance card at every visit.
3. It is your responsibility to make certain that a valid referral is on file should your insurance require one. If there is not a valid referral on file at the time of service, we reserve the right to reschedule your appointment.
4. 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.
5. Once your benefits have been determined, payments of any co-pays, co-insurance, deductible, and fees are required at the time services are rendered.
6. Once your insurance company has processed a claim, any balance determined by your insurance company to be "patient's responsibility" and/or "non-covered service", will be your responsibility.
7. 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, Revele (formally GroupOne), at 800-893-3557 for further explanation.
8. Failure to provide current insurance information to our office and/or reply to insurance's request for additional information may result in the entire bill being your responsibility.
9. Once a payment deemed patient responsibility has not been made on your account after three months, you may be sent to collection agency.
10. For Self-Pay patients, full payment for your visit and any testing (allergy testing, serum, allergy shots, pulmonary function test, spirometry, 6-minute walk, etc.) is expected at the time services are rendered.
11. Any outstanding balance owed to our office is also due, unless payment arrangements have been made in advance with our office.
12. 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.
13. 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.
14. A $25 fee will be incurred if you do not cancel or reschedule your appointment with at least a 4-hour notice prior to the scheduled appointment time.
15. There will be a $35 fee for all returned checks.
16. There will be a $20 fee for paperwork completion, including but not limited to, FMLA, disability, life insurance, and school physicals. Payment is due prior to completion of the forms.
17. Fees for medical and billing records will be charged per the current allowable set by the Texas Medical Board. Payment is due prior to the processing of the request.

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 accordingly.
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. Controlled substances 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.

By signing below, I acknowledge that I have read and understood all the above policy updates.

Patient Name (please print): ______________________________ Date of Birth: ______________

Signature: ______________________________________ Date: __________________

Current Medications

NAME	DOSAGE	FREQUENCY	REASON

Date of Last Influenza Vaccination: _________　　**Date of Last Pneumonia Vaccination: _________**

Past Medical History – *Do you have a history of any of the following conditions? Check all that apply.*

- ☐ Hypertension
- ☐ Diabetes
- ☐ COPD
- ☐ Asthma
- ☐ OSA
- ☐ Pulmonary Embolism
- ☐ Deep Vein Thrombosis
- ☐ Atrial Fibrillation
- ☐ Congestive Heart Failure
- ☐ Heart Disease
- ☐ Stroke
- ☐ Acid Reflux
- ☐ Emphysema
- ☐ Nasal Allergies

Allergies to Medications/Foods/Environmentals

NAME	REACTION

Surgical History (Not Including Pregnancies)

NAME	PROCEDURE

Hospital Admissions (Not Including Pregnancies)

NAME	REASON FOR ADMISSION

Family History – If any relative listed below has suffered any of the following, please put a check in the box corresponding to the family member and the diagnosis.

FAMILY MEMBER	OSA	COPD	LUNG CANCER	ASTHMA	EMPHYSEMA	STROKE	N/A
Mother	☐	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐	☐

Social History

Tobacco Use

☐ Current Smoker When did you start smoking? ______________

How many cigarettes a day do you smoke?

☐ 5 or less ☐ 6-10 ☐ 11-20 ☐ 21-30 ☐ 31 or more

☐ Former Smoker When did you start smoking? _____________ When did you quit smoking? _____________

Alcohol Use

Did you have a drink containing alcohol within the past year? ☐ Yes ☐ No

How often did you have a drink containing alcohol in the past year?

☐ Never ☐ Monthly or less ☐ 2-4 times a month ☐ 2-3 times a week ☐ 4 or more times a week

How many drinks did you have on a typical day when you were drinking in the past year?

☐ 1-2 drinks ☐ 3-4 drinks ☐ 5-6 drinks ☐ 7-9 drinks ☐ 10 or more drinks

How often did you have 6 or more drinks on one occasion in the past year?

☐Never ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily or almost daily

Drug Use

Have you used drugs other than those for medical reasons in the past 12 months? ☐ Yes ☐ No

If yes, what substance? ___________________

Current Symptoms/Problems

General:	YES	NO
Fevers	☐	☐
Fatigue	☐	☐
Generalized Body Aches	☐	☐
Tiredness	☐	☐
HEENT:		
Headaches	☐	☐
Nasal Drainage	☐	☐
Nasal Congestion	☐	☐
Nose Bleeding	☐	☐
Eyes:		
Itchy eyes	☐	☐
Drainage	☐	☐
Double Vision	☐	☐

Sleep:	YES	NO
Snoring	☐	☐
Waking Up with Difficulty Breathing	☐	☐
Difficulty Falling Asleep	☐	☐
Excessive Daytime Sleepiness	☐	☐
Interrupted Sleep	☐	☐
Genitourinary:		
Increased Urinary Frequency	☐	☐
Pain While Urinating	☐	☐
Blood in Urine	☐	☐
Musculoskeletal:		
Joint Pains	☐	☐
Joint Stiffness	☐	☐
Muscle Pains	☐	☐

Respiratory:	YES	NO
Cough	☐	☐
Chest Congestion	☐	☐
Difficulty Breathing at Rest	☐	☐
Difficulty Breathing on Exertion	☐	☐
Coughing Up Blood	☐	☐
Heart:		
Chest Pain at Rest	☐	☐
Chest Pain on Exertion	☐	☐
Dizziness	☐	☐
Heart Beating Fast	☐	☐
Passing Out	☐	☐
Gastrointestinal:		
Abdominal Pain	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐

Nervous:	YES	NO
Weakness of Arms or Legs	☐	☐
Restless Feeling in Legs	☐	☐
Endocrine:		
Increased Thirst	☐	☐
Increased Appetite	☐	☐
Intolerance to Heat or Cold	☐	☐
Psychiatric:		
Feeling Depressed	☐	☐
Feeling Anxious	☐	☐
Vascular:		
Bruises Easily	☐	☐
Excessive Bleeding on Minor Cuts	☐	☐
Skin:		
Rashes	☐	☐
Itching	☐	☐