North Houston Respiratory Consultants

T.H. Jayaram, M.D., F.C.C.P F.A. Rakla, M.D., F.C.C.P S.R. Alim, M.D.

Demographics			
First Name:		Last Name:	
DOB:		SS#:	
Address:			
City:		State:	Zip:
Home Phone:		Mobile Phone:	
Employer:		Work:	
Marital Status:	Married Single	Widowed Divorced	Email:

Emergency Contact(s)		
Name:	Relation:	Phone:
Name:	Relation:	Phone:

Medical Insurance (Exactly as printed on Insurance Card)		
Primary Insurance:	Member ID:	
Group Number:	Policy Holder: Self Spouse Child	
Policy Holder:	SS#	DOB:
Secondary Insurance:	Member ID:	
Group Number:	Policy Holder: Self Spouse Child	
Policy Holder:	SS#	DOB:
Tertiary Insurance:	Member ID:	
Group Number:	Policy Holder: Self Spouse Child	
Policy Holder:	SS#	DOB:

Physicans:	
Primary Care Physican:	Phone:
Referring Physican:	Phone:

Pharmacy:	
Pharmacy:	Phone:
Address:	

Reasons for today's Visit
Why are you here to see a pulmonary (lung) doctor?

To access the patient portal please copy the link below:

https://mycw38.eclinicalweb.com/portal4306/jsp/login.jsp

I, understand, certify that I (or my dependent) have insurance coverage as indicated above & directly to North Houston Respiratory Consultants of Houston all insurance benefits, If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the use of this signature of all insurance submissions. I have received, read & understand all documents given to me in regards to HIPPA rights as a patient. If the patient is a minor, I consent to evaluation and treatment. Disclaimer for Quote of Benefits: "A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service." If the quote of benefits was given in error the patient will be liable for all services rendered.

Disclaimer for Insurance Liability for Payment: Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures pre-authorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service. In those cases the patient will be fully responsible for all services rendered.

Signature: ______________________ Date: ______________________

Have you taken any aspirin, ibuprofen or arthritis medicine in the last two weeks? ________________
If so when? ________________________ Do you bruise easily? ____________________________

Drug Allergies: ____

____

Current Medications **Dose** **Frequency**

____

____

____

____

____

____

Medical Illnesses:

____

____

____

____

____

Surgical Procedures: **Date:**

____

____

____

____

Hospitalizations: **Date:**

____

____

____

____

Have you ever had problems with anesthesia? ____Yes ____No
Reaction: ____________________________________

Family History

Family Member	Medical Illnesses	Alive (Yes/No)/Age	Age at Death
Father			
Mother			
Grandparents (maternal)			
Grandparents (paternal)			
Sister (s)			
Brother (s)			

Do you have children? ___Yes ___ No Son(s)____ Daughter(s) ____

Review of Systems

Are you currently having, or have you had problems with: (check all that apply)

General well-being
- __ Fever
- __ Weight Loss (>10lbs)
- __ Excess fatigue
- __Recurrent Nausea/Vomit
- __ Night Sweats

Eyes
- __ Wear Glasses
- Date of last exam___
- __ Infections
- __ Injuries
- __ Glaucoma
- __ Cataracts
- __ Blurred vision
- __ Trouble focusing
- __ Recent change in vision

Ears, Nose, Mouth and Throat
- __Wear hearing Aids
- Date of last exam ____
- __ Hearing loss
- __ Ear Infection
- __ Pressure in ears
- __ Ringing in ears
- __ Pain in ears
- __ balance disturbance
- __ Itching in ears
- __ Dizziness
- __ Nasal Congestion
- __ Nasal drainage
- __ Nosebleeds
- __ Sinus Problems
- __ Sinus Infection
- __ Sinus Headaches
- __ Throat Infections
- __ Difficulty swallowing
- __ Lip or mouth sores
- __ Sore Throats

Respiratory
- __ Chronic cough
- __ Emphysema
- __ Bronchitis
- __ Asthma
- __ COPD
- __ Shortness of Breath
- __ Oxygen use at home
- __ Pneumonia
- __ Lung cancer
- __ Tuberculosis
- __ Blood in Saliva
- Date of last chest X-ray____

Cardiovascular
- __ Chest pain
- Date of last EKG __
- __Heart attack
- __ High Blood Pressure
- __ Low Blood Pressure
- __ Irregular heartbeat
- __ Heart murmur
- __ Arm and leg swelling
- __ High Cholesterol

Gastrointestinal
- __ Blood in vomit
- __ Indigestion
- __ Nausea/Vomiting
- __ Jaundice
- __ Abdominal pain
- __ Change in bowel habits
- __ Ulcers or Gastritis
- __ Colon, liver, stomach cancer
- __ Hepatitis

Hematologic
- __ Anemia
- __ Hemophilia
- __ Easy Bleeding/bruising
- __ Swollen glands

Genitourinary
- __Urinary tract infect.
- __ Painful urination
- __ Blood in urine
- __ Difficulty urinating
- __ Incontinence
- __ Kidney stones
- __ Prostate Cancer
- __ Endometriosis
- __ Uterine, ovarian or cervical cancer

Neurological
- __ Disorientation
- __ Fainting/blacking out
- __ Light headedness
- __ Seizures
- __ Stroke
- __Mini stroke
- __ Memory problems
- __ Concentration problems
- __ Speech problems
- __ Facial weakness/spasms
- __ Muscle weakness
- __ Coordination problems
- __ Uncontrolled shaking
- __ Headache
- __ Migraine

Endocrine
- __ Diabetes
- __ Hormone problems
- __ Low blood sugar
- __ Thyroid disease
- __ Increased appetite
- __ Excessive thirst
- __ Excessive urination
- __ Temperature intolerance
- __Pituitary gland problems
- __ Bleeding tendencies

Immunologic
- __Environmental allergies
- __ Hay Fever
- __ Food allergies
- __ Immune system problems
- __ Connective tissue disease
- __ Frequent colds/infections

Skin
- __ Eczema or psoriasis
- __ Dermatitis
- __ Dry or scaling skin
- __ Rashes
- __ Changes in skin color
- __ Changes in moles
- __ Skin Cancer
- __ Breast pain or swelling
- Date of last Mammogram_____

Musculoskeletal
- __ Broken bones list:______________
- __ Arm or leg weakness
- __ Joint pain or swelling
- __ Back pain
- __ Arthritis

Psychiatric
- __ Anxiety
- __ Depression
- __ Manic/Depression
- __ Schizophrenia
- __ Considering suicide/homicide
- __ Panic attacks
- __ Sudden mood swings
- __ Emotional difficulties
- __ Insomnia
- __ Other psychiatric problems
- __ Under psychiatric care
- __ Desiring psychiatric care

The above information is accurate to the best of my knowledge.

_______________________________ Patient Signature

_______________________________ Date

Social History

Are you presently working or going to school full or part time? ______________________________

Employer / School: ____

Have you ever been a smoker in your life time? ______ If no, are you currently or have you been exposed to second hand smoke? _____________ If yes, how many years were you a smoker? _____
Cigars? ____ Pipe? _____ Chewing tobacco? _____
Cigarettes per day? ______ **When did you quit?** _______
Do you currently smoke? ___________ If yes, how many per day? _______________

Do you drink alcohol? ______ Yes ______ No
Is it ______ Social ______ Heavy ______Prior addiction

Do you take or have you taken recreational drugs? _____ Yes _____No _____Prior addiction

Do you have difficulty Sleeping?
____ Never ____Often ____ Sometimes ____ Getting to sleep ____ Staying awake

Does anyone complain that you snore? ____ Yes ____No

Do you stop breathing at night? ____Yes ____No

Do you wake up tired in the morning? ____Yes ____No

Do you fall asleep in the daytime? ____ Yes ____No

Do you have night terrors? ____ Yes ____No

Do you kick in your sleep? ____Yes ____No

Has it been witnessed you swing your arms in your sleep? ____Yes ____No

Do you grind your teeth while sleeping? ____Yes ____ No

Caffeine intake: ____ per day

Do you exercise? ____Yes ____No Type/Frequency:_________________________________

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)?

____

Have you ever been diagnosed with Aids or Hepatitis? If so, please explain.

____

Have you had a recent Chest X-ray, CT scan, recent blood work, or any other labs pertinent to today's visit? If you answered yes, please have all of these records with you before your first visit.

____ _________________________
Signature Date

HIPAA Notice of Privacy Practices

North Houston Respiratory Consultants, P.A.
9950 Memorial, Ste 102, Humble, TX 77338
(281)446-6803

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected heath information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health- related benefits and services that may be of interest to you.

We may use or disclose your protected health information in the following situations without your authorization. These situations include, as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers' compensation, inmates, and other required uses and disclosures. Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. **You may revoke the authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

<u>YOU'RE RIGHTS</u>

The following are statements of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information – This means you may ask us not to use or disclose any part of your protected health information and by law we must comply. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. By law, you may not request that we restrict the disclosure of your PHI for treatment purposes.

You have the right to request to receive confidential communications – You have the right to request confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You have the right to request an amendment to your protected health information – If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provided you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures – You have the right to receive an accounting of all disclosures except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or six years prior to the date of this request.

You have the right to obtain a paper copy of this notice may from us even if you have agreed to receive the notice electronically. We reserve the right to change the terms of this notice and we will notify you of such changes on the following appointment. We will also make available copies of our new notice if you wish to obtain one.

<u>COMPLAINTS</u>

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying out Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgement" form. Please note that by signing the Acknowledgement form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

ACKNOWLEDGEMENT OF OUR NOTICES OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of North Houston Respiratory Consultants, P.A. Notice of Privacy Practices.

By signing below I am "only" giving acknowledgement that I have received or have had an opportunity to receive the Notice of our Privacy Practices.

____ ____________________

Patient Name (Type or Print) **Date**

____

Signature

NORTH HOUSTON RESPIRATORY CONSULTANTS
SLEEP LAB

THE EPWORTH SLEEPINESS SCALE

Name: ____ Date:___________________

Sex: Female____ Male____ Age: __________

How Likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected 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

Situations:	**Chance of dozing**
Sitting and Reading	______________
Watching TV	______________
Sitting, inactive in a public place (e.g., a theater or a meeting)	______________
Lying down to rest in the afternoon when circumstances permit	______________
Sitting and talking to someone	______________
Sitting quietly after lunch without alcohol	______________
In a car while stopped for a few minutes in the traffic	______________
As a passenger in a car for an hour without a break	_______________
TOTAL:	_______________

CAT Assessment

For each item below, place a **X** in the box that best describes you currently. Be sure to only select one response for each question.

Example: I am very happy **0 X 2 3 4 5** I am very sad **Score**

	0	1	2	3	4	5		Score
I never cough	0	1	2	3	4	5	I cough all the time	
I have no phlegm (mucus) in my chest at all	0	1	2	3	4	5	My chest is completely full of phlegm (mucus)	
My chest does not feel tight at all	0	1	2	3	4	5	My chest feels very tight	
When I walk up a hill or one flight of stairs I am not breathless	0	1	2	3	4	5	When I walk up a hill or one flight of stairs I am very breathless	
I am not limited doing any activities at home	0	1	2	3	4	5	I am very limited doing activities at home	
I am confident leaving my home despite my lung condition	0	1	2	3	4	5	I am not at all confident leaving my home because of my lung condition	
I sleep soundly	0	1	2	3	4	5	I don't sleep soundly because of my lung condition	
I have lots of energy	0	1	2	3	4	5	I have no energy at all	

Total Score ____

Modified MRC Dyspnea Scale

DATE:________________________________

PT NAME:____

DOB:______________________

PLEASE CHECK THE BOX THAT APPLIES TO YOU (ONE BOX ONLY) (GRADES 0-4)	
mMRC Grade 0. I only get breathless with strenuous exercise.	
mMRC Grade 1. I get short of breath when hurrying on the level or walking up a slight hill.	
mMRC Grade 2. I walk slower than people of the same age on the level because of breathlessness, or I have to stop for breath when walking on my own pace on the level.	
mMRC Grade 3. I stop for breath after walking about 100 meters or after a few minutes on the level.	
mMRC Grade 4. I am too breathless to leave the house or I am breathless when dressing or undressing.	

DME /Sleep Study Questions

Do you have a CPAP/Bipap machine already?______YES / NO__________

How old is this machine? ________________________________

What Company Provided the Machine?___________________________

If an initial Sleep Study done in our office is not approved by the insurance company, a home sleep study may be required by your insurance company. Would you feel comfortable assembling and setting up a self-monitored sleep study.

Yes /No

Please explain:

____

____

What's the name of the doctor who referred for your sleep studies?
(Name and Telephone Number)____

What year was your diagnostic study done? ______________________________

What facility was your sleep study done?________________________________

We will need a copy of your first and second night sleep study.

We will need to sign a medical release of information form before we can obtain any records.

Notice:

We will attempt to obtain your information within 24 hours if the information is not available and not obtainable please note that a new sleep study will be needed and can be provided within a week here in our facility. DME (durable medical equipment) companies ask for this information before they can supply or resupply items.

Name:(Printed)

_______________________________ Date:________________

Signature:________________________

North Houston Respiratory Consultants, P.A.

T.H. Jayaram, M.D., F.C.C.P   F.A. Rakla, M.D., F.C.C.P   S.R. Alim, M.D.

Sleep Questionnaire

Patient Name: ________________________ Date of Birth: ______________

Weight: __________________ Height: ____________________

1. Main sleep complaints check all that apply:
   - __ Loud or disturbing snoring
   - __ I've been told I stop breathing when I sleep
   - __ I am tired and sleepy during the day
   - __ I wake up gasping for air
   - __ I fall asleep unintentionally
   - __ I can't fall asleep or stay asleep
   - __ My limbs jerk or kick at night
   - __ I have unwanted behavior during sleep.
     Explain: ____
   - __ Other: ____

2. How long have you had a sleep problem? ______________________________
3. Have you ever had a sleep study? If so, when? __________________________
4. Are you currently on CPAP or BIPAP therapy? If yes, what is the current pressure and mask type? ____
5. Have you gained or lose weight recently? How much? ___________________
6. What time do you usually:

	Week day	Weekend
Go to bed?	______________	______________
Wake up?	______________	______________

7. Do you take naps during the day? ____ Yes ____ NO If yes, how many?_____
   How long do you nap? ___________________

8. Do you work rotating shifts? ___Yes ____ No
9. Do you have trouble falling asleep? ___ Yes ____ No
10. Do you have trouble staying asleep? ___ Yes ____ No
11. Do you have trouble falling back to sleep once awakened? ____Yes ____ No
12. Do you lie in bed with racing/repetitive thoughts? ___ Yes ____ No

13. Do you take medications to help you fall asleep? ____ Yes ____ No
14. Do you take stimulants during the day to help you stay awake? ____Yes ____No
15. Do you suffer from pain that interferes with your sleep? ____Yes ____No

16. Have you ever been told that you snore? ____Yes ____No
17. Have you ever been told that you stop breathing in your sleep? ____Yes ____No
18. Do you wake yourself form snoring, or from choking/gasping for air? ____Yes ____No
19. Do you suffer from indigestion/heartburn/reflux disease? ____Yes____No

20. Do you ever awaken suddenly feeling short or breath? ____Yes ____No
21. Do you wake up with dry mouth or sore throat? ____Yes ____No
22. Do you suffer from morning headaches? ____Yes ____No
23. Do you sweat at night? ____Yes ____No
24. Do you feel refreshed and well rested upon wakening? Yes No

25. Do you experience leg discomfort such as a creepy-crawly or achy sensation that compels you to move your legs or get up and walk? ___Yes___No

26. Do your arms or legs jerk/kick in your sleep? ___Yes___No

27. Do you grind your teeth while you sleep? ___Yes___No

28. Do you have frequent nightmares? ___Yes___No

29. Have you ever walked or talked in your sleep? Yes___No

30. Have you ever injured yourself or a bed-partner acting out your dreams while sleeping? ___Yes___No

31. Do you experience vivid-like dreams soon after falling asleep or close to waking up? Yes___No

32. Have you ever found yourself unable to move or paralyzed for a short time upon falling asleep or awakening? ___Yes___No

33. Have you ever experienced sudden muscle weakness during vigorous laughter when angry? Yes___No

34. Have you ever experience sleep attacks, or sudden onset of severe drowsiness? ___Yes___No

35. Do you have or are you currently being treated for:

___High Blood Pressure	___Asthma	___ Angina	___Emphysema/COPD
___Thyroid disease	___Heart Attack	Stroke	___Seizures
___Congestive heart failure	___Frequent urination	Diabetes	___Depression
___Anxiety	___ Drug/alcohol problems	___Chronic Pain	
___Bipolar disorder	___Acid reflux/ heartburn	___Chronic nasal congestion	
___ Irregular heart rhythm			

36. Please list any other medical problems:

Patient Signature: ______________________________ Date: __________________________

NORTH HOUSTON RESPIRATORY CONSULTANTS, P.A.

Respiratory Diseases and Critical Care

Phone: 281-446-6803
Fax: 281-446-0449

T.H. Jayaram, M.D., F.C.C.P. F.A. Rakla, M.D., F.C.C.P. S.R. Alim, M.D.

I, ________________________________ whose signature appears below, authorize North Houston Respiratory Consultants, P.A. and its affiliated providers to view my external prescription history via the RX eligibility hub service.

I understand that prescription history from multiple other unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

MY SIGNATURE CERIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

________________________________ DATE: ____________________

PATIENT

________________________________ DATE: ____________________

WITNESS

9950 Memorial, Suite 102
Humble, TX 77338

22999 Hwy 59 N. West Tower, Ste 201
Kingwood, TX 77339