Texas Multi-Specialty Group

New Patient Registration

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

Reason for Visit: _____

Patient Information

Last: _____ First: _____ Middle Initial: _____ DOB: _____

Gender: ☐ Male ☐ Female ☐ Other SS#: _____

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, etc.

Not required. For reporting purposes only

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

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

Employer: _____ Occupation: _____

Pharmacy Name & Cross Streets: _____ Pharmacy Phone #: _____

Emergency Contact Information

Name: _____ Relation: _____ Phone #: _____

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 Texas Multi-Specialty Group, 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: _____

Texas Multi-Specialty Group

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 your appointment, you will be responsible for the complete charge, or you may 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 department at 281-955-0338, option 7, 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 a 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 will be asked to reschedule.
14. **Failure to cancel your appointment within 48 hours prior to your scheduled appointment will result in a no-show fee automatically applied to your account. The no-show fee amounts are as follows:**
    New Patient & New Hospital Follow-up: $75, PFT & Established Follow-up: $75, Allergy Testing: $75, Established Follow-up: $25
15. There will be a $35 fee for all returned checks.
16. **There will be a $25 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.

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. All other maintenance medications require a 3-6 month follow up appointment for consideration on therapeutic regimen and necessary blood work.
8. 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: _____

I. Current Medications – *Please list your current medications/supplements below. If you already have a list of medications, please give your list to our receptionist and proceed to Section II.*

NAME	DOSAGE	FREQUENCY	REASON
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

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

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

III. Allergies to Medications/Foods

NAME	REACTION
_____	_____
_____	_____
_____	_____

IV. Surgical History (Not Including Pregnancies)

MONTH/YEAR	PROCEDURE
_____	_____
_____	_____
_____	_____

V. Hospital Admissions (Not Including Pregnancies)

MONTH/YEAR	REASON	HOSPITAL NAME/LOCATION
_____	_____	_____
_____	_____	_____
_____	_____	_____

VI. 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	☐	☐	☐	☐	☐	☐	☐

VII. Social History

Tobacco Use

☐ Non-Smoker ☐ 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? _____

VIII. Current Symptoms/Problems – *Check all that apply.*

General:
☐ Fevers
☐ Fatigue
☐ Generalized Body Aches
☐ Tiredness

HEENT:
☐ Headaches
☐ Nasal Drainage
☐ Nasal Congestion
☐ Nose Bleeding

Eyes:
☐ Itchy Eyes
☐ Drainage
☐ Double Vision

Respiratory:
☐ Cough
☐ Chest Congestion
☐ Difficulty Breathing at Rest
☐ Difficulty Breathing on Exertion
☐ Coughing up blood

Cardiovascular:
☐ Chest Pain at Rest
☐ Chest Pain on Exertion
☐ Dizziness
☐ Heart Beating Fast (Palpitations)
☐ Passing Out

Gastrointestinal:
☐ Abdominal Pain
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Constipation

Sleep:
☐ Snoring
☐ Waking Up with Difficulty Breathing
☐ Difficulty Falling Asleep
☐ Excessive Daytime Sleepiness
☐ Interrupted Sleep

Nervous:
☐ Weakness of Arms or Legs
☐ Restless Feeling in Leg

Musculoskeletal:
☐ Joint Pains
☐ Joint Stiffness

Genitourinary:
☐ Increased Urine Frequency
☐ Pain While Urinating
☐ Blood in Urine

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

Texas Multi-Specialty Group

Authorization for Release of Health Information

Patient Name: _____ **Date of Birth:** _____

Address: _____ **Phone:** _____

I hereby authorize Texas Multi-Specialty Group to:

☐ Release To ☐ Receive From

Person/Organization Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

Purpose of Disclosure: *(Choose only one option below)*

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Legal Purposes
- ☐ Insurance
- ☐ Other: _____

Information to be disclosed:

☐ All health information	☐ Discharge Summary	☐ Lab/Pathology Reports	☐ Billing Records
☐ Physician Orders	☐ Consultations	☐ Pulmonary Studies (PFT)	☐ Other: _____
☐ Progress Notes	☐ Op/Procedure Reports	☐ EKG/Cardiology Reports	_____
☐ History/Physical Exam	☐ Radiology/Imaging	☐ Sleep Studies	_____

Initials are required to release the following information:

_____ Drug, Alcohol, or Substance Abuse Records

_____ Genetic Information (including Genetic Test Results)

_____ HIV/AIDS Test Results/Treatment

Treatment dates *(required):* _____

Please fax records to 281-469-0741

This authorization is valid for one year after I, or my personal representative, signs this form. I have the right to revoke this authorization in writing any time to the Privacy Office, except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless above-named facility and its parent company from all liability and damages resulting from the lawful release of my protected health information.

_____ _____

Signature of Patient or Personal Representative **Date**

_____

Printed Name of Patient or Personal Representative

If you are a Personal Representative signing on behalf of the patient, please indicate your relationship to the patient:

☐ Parent	☐ Legal Guardian	☐ Executor or Person Representative
☐ Power of Attorney	☐ Other: _____	

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