Patient Registration & Demographic Form

Please complete this form entirely. You will also need to bring your photo ID and insurance card with you to your appointment.

Patient Information

Patient's Name: (Last) _____(First)_____(M)_____

Sex:_____ Age:_____ Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Address: _____ City/State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Email:_____ Contact Preference _____

Preferred Language:_____ Race: _____ Ethnicity: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced Primary Care Doctor: _____

Referring Doctor: _____ How did you hear about us? _____

Emergency Contact: Name _____ Phone#:_____

Employer:_____ Phone # _____

Pharmacy Name/Address/Phone: _____

Guarantor (if other than patient)

Name: _____ Relationship:_____ DOB _____

Address_____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Insurance Information (if you present your insurance card you may omit this section)

Primary Insurance: _____ PPO or HMO? ID/Member # _____

Subscriber's Name: _____ DOB: _____/_____/_____ SS #: _____-_____-_____

Group # _____ Claims Address / Phone # _____

Secondary Insurance: _____ PPO or HMO? ID/Member # _____

Subscriber's Name: _____ DOB: _____/_____/_____ SS #: _____-_____-_____

Group # _____ Claims Address / Phone # _____

I acknowledge the information I provided above is true and correct.

X _____ _____ _____/_____/_____

Signature Relationship Date

General Practice Policies

Texas Sleep Medicine

The information provided in this document explains what you can expect as a patient of Texas Sleep Medicine and outlines your responsibilities. Please familiarize yourself with the entire document. A copy will be provided to you. A member of our staff is available to answer your questions. Thank you for placing your trust and confidence with Texas Sleep Medicine.

Appointments: Please arrive prior to your appointment time. Patients arriving late may be asked to reschedule. You will be asked to confirm your demographic and insurance information each time you visit. An appointment reminder will be communicated with you 3 days prior to your appointment. Confirming your appointment is required.

Appointment Cancellations / No Shows: We understand unexpected things happen. Please be courteous and contact the office 48 hours in advance should you be unable to keep your scheduled appointment. Without prior advance notice to the office **you will be charged a $100 fee for missed office visits, $125 fee for missed sleep studies and a $200 fee for missed multiple sleep latency tests.** A pattern of multiple missed appointments is considered being noncompliant with your healthcare and may be cause for dismissal from the practice.

Financial Responsibility: All applicable fees, deductibles, coinsurance and copays are collected at the time of service. Balances billed to the patient are due within 30 days of the statement date. Past due balances are subject to collection activity and associated fees. A $35 fee will be charged to your account for checks returned by your bank. You, or your guarantor, are financially responsible for all charges relating to healthcare services received. Please contact our insurance coordinator in advance with any questions regarding insurance and billing at 512-440-5757 option 6.

Insurance Referrals: Most HMO's and some insurance plans require the patient to obtain a referral from their primary care physician to be treated by a specialist. In this instance, Texas Sleep Medicine must receive the referral prior to scheduling an appointment.

Medical Staff: The care you receive will always remain under the direct supervision of Ashwin Gowda, MD, Board Certified in Sleep Medicine. Participating in the care of every patient are nurse practitioners and clinical nurse specialists who have completed advanced graduate level education and training. They work in collaboration with Dr. Gowda to diagnose and treat conditions pertaining to sleep medicine.

Communications: Our staff work closely with the providers managing your care and play an integral role in daily communications with patients. Many questions or concerns can be addressed by communicating directly with them. As an efficient means of communication with the office you will be invited via email to register with the Patient Portal. The portal is a secure way to send and receive responses as well as view test results.

Prescription Refills: Contact your pharmacy for all prescription refills. Your pharmacy will communicate with our office for all required information. Please be aware no refill requests will be completed after hours or over weekends except in case of emergency. Please allow two business days to process a request and five business days if your insurance requires a prior authorization. **You will be charged $35 in advance for staff obtaining a prior authorization.**

Additional Services: Occasionally some administrative fees will occur that are not covered by insurance. These services include but are not limited to medical records copy, depositions, completing forms, no show fees, returned check fees and medical prior authorization. You will be charged for these services should they be necessary.

Medical Compliance: A relationship of mutual respect is the basis for a proper plan of care. Patients who become noncompliant with their prescribed treatment plan may be subject to dismissal from Texas Sleep Medicine.

I acknowledge having read General Practice Polices and understand its meaning and purpose.

_____ _____

Patient Signature / Printed Name Date

Statement of Consents

Texas Sleep Medicine

- **Provide Treatment:** I authorize Texas Sleep Medicine to provide me treatment as necessary, and such treatment will be mutually agreed upon. I authorize my insurance benefits to be paid directly to Texas Sleep Medicine. I acknowledge my financial responsibility for payment of services to me including any non-covered or denied services by my insurance.

  _____
  Initials

- **Release of Information:** I have reviewed Texas Sleep Medicine's Notice of Privacy which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document. I authorize the release of information to my insurance concerning my medical condition and for the purpose of claims processing. I also authorize the release of medical information to my referring physician and / or primary care physician. This information will include diagnosis, treatment plans and services provided.

  I authorize the release of information to the following individuals until revoked by me in writing:

  _____ _____ _____
  Name Relationship Phone

  _____ _____ _____
  Name Relationship Phone

  _____
  Initials

- **Photo:** During registration I may have a photo taken and attached to my chart as a means of greater identification. I understand if I have my photo taken it will be used solely for that purpose and no other.

  _____
  Initials

- **Communication:** I understand the need for Texas Sleep Medicine to contact me regarding multiple reasons including appointments, treatment, follow up and billing issues. I wish not to restrict Texas Sleep Medicine or those operating on behalf of Texas Sleep Medicine from contacting me in all usual and customary manners. I have provided all acceptable modes of communication and contact information during registration. I will keep Texas Sleep Medicine updated should any of this information change.

  I acknowledge Texas Sleep Medicine has requested I register with the Patient Portal as a means of greater access and efficient communication. I understand this is a secure means of electronic communication that requires a password and email address to facilitate an exchange of information. I understand any electronic communication may contain personal information relating to my medical care. It is my responsibility to safeguard my password to the Patient Portal.

  _____
  Initials

I acknowledge having read Statement of Consents and understand its meaning and purpose.

_____ _____
Patient Signature / Printed Name Date