Houston Pulmonary Medicine Associates

AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

I authorize Houston Pulmonary Medicine to obtain/furnish to/from my insurance company and its representatives, any information and/or copies of all medical records, consultations, and prescriptions relating to illness.

I grant permission to view my prescription history from external sources and I authorize all permissible prescriptions to be generated and transmitted electronically. A copy of this authorization shall be effective and valid.

AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION

I authorize Houston Pulmonary Medicine to disclose any medical information regarding my illness to the following individuals:

1. _____ Relationship: _____

Telephone Number: _____

2. _____ Relationship: _____

Telephone Number: _____

_____ I do not authorize Houston Pulmonary Medicine to release any medical information to anyone other than myself.

AUTHORIZATION FOR BILLING

I authorize payment to Houston Pulmonary Medicine the insurance payments otherwise payable to me, but not to exceed my indebtedness to said doctor on the account of charges listed herein. I understand that I am responsible for any remaining balance that my insurance company does not pay.

AUTHORIZATION FOR COLLECTION EFFORTS

I understand that payment is due at the time services are rendered. I agree to pay all co-pays up front unless prior payment arrangements have been made. I also understand that if my account defaults it will be sent to a collection agency and that I will be responsible for all legal fees, court costs, and collections fees that may incur in attempt to collect payment in full. I understand that there is a $25 charge for any check that is returned from my bank.

PATIENT SIGNATURE _____

PRINT PATIENT NAME _____

DATE _____

This authorization is valid for the duration of the period that you remain a patient. A copy of this authorization shall be effective and valid. You have the right to revoke this authorization in writing or by completing a new and updated form.

HOUSTON PULMONARY MEDICINE ASSOCIATES, PA

Patient Information

Full Name: _____ DOB: _____
Last *First* *M.I.*

Address: _____
Street Address *E-Mail address*

_____
City *State* *ZIP Code*

Phone: (____) _____ Cell Phone: (____) _____

Gender: ☐ M ☐ F Social Security No.: _____ ☐ Single ☐ Married ☐ Divorced

Employer: _____

Address: _____

Work Phone: (____) _____ Occupation: _____

Race: _____ Preferred Language: _____

Health Insurance Coverage

Primary Insurance: _____ ☐ HMO ☐ PPO

ID #: _____ Group #: _____

Policy Holder: _____ Relationship to Patient: _____

SS#: _____ DOB: _____

Employer: _____

Secondary Insurance: _____ ☐ HMO ☐ PPO

ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____ SS# : _____

In case of an emergency, notify: _____ Phone: (____) _____

☐ Spouse ☐ Parent ☐ Child ☐ Caregiver ☐ Other _____

Referred By: _____ PCP Name: _____

Disclaimer and Signature

I hereby authorize payment directly to physician of benefits due me for his services as described above. I understand I am financially responsible for charges not covered by this authorization. I also hereby authorize the physician to release any information required to process this claim form.

Signature: _____ Date: _____

HOUSTON PULMONARY MEDICINE ASSOCIATES, P.A.
11920 Astoria, Suite 320 • Houston, TX, 77089 • TEL: 281-484-9369

Patient Intake Questionnaire

Name: _____ DOB:_____

Today's Date: _____

PAST ILLNESSES: (Check all that apply)

☐ Abnormal heart beat
☐ Angina/Chest pain
☐ Asthma Allergies/Hay Fever
☐ Arthritis ☐ Blood Clots
☐ Blood Problems
☐ Chronic Sinus Problems
☐ Chronic obstructive pulmonary disease
☐ Cancer (site _____)

PREVIOUS TREATMENTS:

☐ Surgery ☐ Radiation ☐ Chemotherapy
☐ Diabetes ☐ Emphysema
☐ Heartburn/GERD ☐ Heart Attack
☐ Hiatal Hernia ☐ High Blood Pressure
☐ Heart Failure ☐ HIV/AIDS
☐ Kidney Problem ☐ Liver Disease
☐ Pneumonia ☐ Pulmonary fibrosis
☐ Sarcoidosis ☐ Tuberculosis
☐ Stomach Ulcer ☐ Stroke
☐ Thyroid Problems
☐ Weight Loss Medication use
☐ Fracture (site_____)
☐ Other: _____

OPERATIONS: (Check all that apply)

☐ Appendectomy ☐ Gallbladder
☐ Heart Bypass Surgery ☐ Heart Valve Surgery
☐ Hysterectomy ☐ Joint Replacement
☐ Lung Surgery ☐ Vascular Surgery
☐ Mastectomy
☐ Inguinal Hernia Repair
☐ Other: _____

PHARMACY:

Pharmacy Name: _____
Pharmacy Phone Number: _____
Pharmacy Address:_____

SOCIAL HISTORY:

Marital Status: ☐ M ☐ S ☐ D ☐ W

Tobacco: ☐ Never Smoked
☐ Active Smoker
Years Smoked_____ Packs per Day Smoked ___
☐ Ex-Smoker
Quit _____ Years Ago
Years Smoked_____ Packs per Day Smoked ___
Exposed to second hand smoke?
☐ currently exposed ☐ never exposed
☐ previous history of exposure

Recreational Drug Use? ☐ Yes ☐ No

Alcoholic Beverages:
☐ Never ☐ Less than 1 per week
☐ 1 -5 per week ☐ Other:_____

Do you have any pets: ☐ Yes ☐ No
Type: _____ How many?: _____

Foreign travel in past year: _____

OCCUPATIONAL HISTORY:

Employment:
☐ Full time ☐ Part Time ☐ Retired
Occupation: _____
Have you ever worked with asbestos? ☐ Yes ☐ No
Exposed to fumes, dust or solvents? ☐ Yes ☐ No

MOST RECENT VACCINATIONS:

☐ Pneumonia Date: _____
☐ H1N1 Date: _____
☐ Flu vaccine Date: _____

Patient Intake Questionnaire - Page 2

FAMILY HISTORY:
Please complete the following information about your family's medical history. Please check the appropriate boxes if your family members have ever had the following conditions or check healthy if no known health problems.

FAMILY MEMBER	SEX	AGE	AGE AT DEATH (if deceased)	MAJOR HEALTH PROBLEMS
Father	M			☐ Stroke ☐ Asthma ☐ Cancer ☐ Heart Trouble ☐ COPD ☐ Emphysema ☐ Sarcoidosis ☐ Diabetes ☐ High blood pressure ☐ Pulmonary Fibrosis ☐ Tuberculosis ☐ Other: _____ ☐ Healthy, no medical conditions
Mother	F			☐ Stroke ☐ Asthma ☐ Cancer ☐ Heart Trouble ☐ COPD ☐ Emphysema ☐ Sarcoidosis ☐ Diabetes ☐ High blood pressure ☐ Pulmonary Fibrosis ☐ Tuberculosis ☐ Other: _____ ☐ Healthy, no medical conditions
Siblings	☐ M ☐ F ☐ M ☐ F ☐ M ☐ F ☐ M ☐ F ☐ M ☐ F ☐ M ☐ F ☐ M ☐ F			☐ Stroke ☐ Asthma ☐ Cancer ☐ Heart Trouble ☐ COPD ☐ Emphysema ☐ Sarcoidosis ☐ Diabetes ☐ High blood pressure ☐ Pulmonary Fibrosis ☐ Tuberculosis ☐ Other: _____ ☐ Healthy, no medical conditions
Children	☐ M ☐ F ☐ M ☐ F ☐ M ☐ F ☐ M ☐ F ☐ M ☐ F ☐ M ☐ F ☐ M ☐ F			☐ Stroke ☐ Asthma ☐ Cancer ☐ Heart Trouble ☐ COPD ☐ Emphysema ☐ Sarcoidosis ☐ Diabetes ☐ High blood pressure ☐ Pulmonary Fibrosis ☐ Tuberculosis ☐ Other: _____ ☐ Healthy, no medical conditions
Other:				

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MEDICATION ALLERGIES: _____

CURRENT MEDICATIONS:

MEDICATION	DOSE	HOW OFTEN?

Houston Pulmonary Medicine Associates, P.A.
Notice of Privacy Act

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 practice uses and discloses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive.

This notice describes our privacy practices. We may change our policies and this notice at any time and have those revised policies apply to all the protected health information we maintain. If or when we change our notice, we will post the new notice in the office where it can be seen. You can request a paper copy of this notice, or any revised notice, at any time (even if you have allowed us to communicate with you electronically). For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

A. Treatment, Payment, Health Care Operations

Treatment
We are permitted to use and disclose your medical information to those involved in your treatment. For example, the physician in this practice is a specialist. When we provide treatment we may request that your primary care physician share your medical information with us. Also, we may provide your primary care physician information about your particular condition so that he or she can appropriately treat you for other medical conditions, if any.

Payment
We are permitted to use or disclose your medical information to bill and collect payment for the services we provide to you. For example, we may complete a claim form to obtain payment from your insurer or HMO. That form will contain medical information, such as a description of the medical services provided to you, that your insurer or HMO needs to approve payment to us.

Health Care Operations
We are permitted to use or disclose your medical information for the purposes of health care operations, which are activities that support this practice and ensure that quality care is delivered.

B. Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted to disclose or use your medical information without your written authorization or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization, in writing to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or that rely on that authorization.

Public Health, Abuse or Neglect, and Health Oversight

We may disclose your medical information for public health activities. Public health activities are mandated by federal, state, or local government for the collection of information about disease, vital statistics (like births and death), or injury by a public health authority. We may disclose medical information, if authorized by law, to a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. We may disclose your medical information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using.

Because Texas law requires physicians to report child abuse or neglect, we may disclose medical information to a public agency authorized to receive reports of child abuse or neglect. Texas law also requires a person having cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation to report the information to the state, and HIPAA privacy regulations permit the disclosure of information to report abuse or neglect of elders or the disabled.

We may disclose your medical information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections, which are all government activities undertaken to monitor the health care delivery system and compliance with other laws, such as civil rights laws.

Legal Proceedings and Law Enforcement

We may disclose your medical information in the course of judicial or administrative proceedings in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.

If asked by a law enforcement official, we may disclose your medical information under limited circumstances provided:

- The information is released pursuant to legal process, such as a warrant or subpoena;
- The information pertains to a victim of crime and you are incapacitated;
- The information pertains to a person who has died under circumstances that may be related to criminal conduct;
- The information is about a victim of crime and we are unable to obtain the personôs agreement;
- The information is released because of a crime that has occurred on these premises; or
- The information is released to locate a fugitive, missing person, or suspect.

We also may release information if we believe the disclosure is necessary to prevent or lessen an imminent threat to the health or safety of a person.

Worker's Compensation

We may disclose your medical information as required by workersô compensation law.

Inmates

If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official. This release is permitted to allow the institution to provide you with medical care, to protect your health or the health and safety of others, or for the safety and security of the institution.

Military, National Security and Intelligence Activities, Protection of the President

We may disclose your medical information for specialized government functions such as separation or discharge from military service, requests as necessary by appropriate military command officers (if you are in the military), authorized national security and intelligence activities, as well as authorized activities for the provision of protective services for the president of the United States, other authorized government officials, or foreign heads of state.

Research, Organ Donation, Coroners, Medical Examiners, and Funeral Directors

When a research project and its privacy protections have been approved by an institutional review board or privacy board, we may release medical information to researchers for research purposes. We may release medical information to organ procurement organizations for the purpose of facilitating organ, eye, or tissue donation if you are a donor. Also, we may release your medical information to a coroner or medical examiner to identify a deceased person or a cause of death. Further, we may release your medical information to a funeral director when such a disclosure is necessary for the director to carry out his duties.

Required by Law

We may release your medical information when the disclosure is required by law.

C. Your Rights Under Federal Law

The U.S. Department of Health and Human Services created regulations intended to protect patient privacy as required by the Health Insurance Portability and Accountability Act (HIPAA). Those regulations create several privileges that patients may exercise. We will not retaliate against patients who exercise their HIPAA rights.

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or health care operations. We do NOT have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances.

You also may request that we limit disclosure to family members, other relatives, or close personal friends who may or may not be involves in your care.

To request a restriction, submit the following in writing: (a) the information to be restricted, (b) what kind of restriction you are requesting (i.e., on the use of information, disclosure of information, or both), and (c) to whom the limits apply. Please send the request to the address and person listed at the end of this document.

Receiving Confidential Communications by Alternative Means

You may request that we send communications of protected health information by alternative means or to an alternative location. This request must be made in writing to the person listed below. We are required to accommodate only *reasonable* requests. Please specify in your correspondence exactly how you want us to communicate with you and, if you are directing us to send it to a particular place, the contact/address information.

Inspection and Copies of Protected Health Information

You may inspect and/or copy health information that is within the designated record set, which is information that is used to make decisions about your care. Texas law requires that requests for copies be made in writing, and we ask that requests for inspection for your health information also be made in writing. Please send your request to the person listed at the end of this document.

We may ask that a narrative of that information be provided rather than copies. However, if you do not agree to our request, we will provide copies.

We can refuse to provide some of the information you ask to inspect or ask to by copies for the following reasons:

- The information is psychotherapy notes
- The information reveals the identity of a person who provided information under a promise of confidentiality.
- The information is subject to the Clinical Laboratory Improvements Amendments of 1988.
- The information has been compiled in anticipation of litigation.

We can refuse to provide access to or copies of some information for other reasons, provided that we arrange for a review of our decision on your request. Any such review will be made by another licensed health care provider who was not involved in the prior decision to deny access.

Texas law requires us to be ready to provide copies or a narrative within 15 days of your request. We will inform you when the records are ready or if we believe access should be limited. If we deny access, we will inform you in writing.

HIPAA permits us to charge a reasonable cost-based fee.

Amendment of Medical Information

You may request an amendment of your medical information if the designated record set. Any such request must be made in writing to the person listed at the end of this document. We will respond within 60 days of your request. We may refuse to allow an amendment for the following reasons:

- The information wasnôt created by this practice or the physicians in this practice.
- The information is not part of the designated record set
- The information is not available for inspection because of an appropriate denial.
- The information is accurate and complete.

Even if we refuse to allow an amendment, you are permitted to include a patient statement about the information at issue in your medical record. If we refuse to allow an amendment, we will inform you in writing.

If we approve the amendment, we will inform you in writing, allow the amendment to be made and tell others that we know have the incorrect information.

Accounting of Certain Disclosures

HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, health care operations, or made via an authorization signed by you or your representative. Please submit any request for an accounting to the person at the end of this document. Your first accounting of disclosures (within a 12-month period) will be free. For additional requests within that period we are permitted to charge for the cost of providing the list. If there is a charge we will notify you, and you may choose to withdraw or modify your request *before* any costs are incurred.

D. Appointment Reminders, Treatment Alternatives, and Other Benefits

We may contact you by (telephone, mail, or both) to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you.

E. Complaints

If you are concerned that your privacy rights have been violated, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. We will not retaliate against you for filing a complaint with us or the government.

F. Our Promise to You

We are required by law and regulation to protect the privacy of your medical information, to provide you with this notice of our privacy practices with respect to protected health information, and to abide by the terms of the notice of privacy practices in effect.

G. Questions and Contact Person for Requests

If you have any questions or want to make a request pursuant to the rights described above, please contact:

Mia Quintanilla, Privacy Officer

11920 Astoria, Suite 320

Houston, TX 77089

281-484-9369

This notice is effective 04-14-03

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this officeôs 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.

_____

Signature of Patient or Personal Representative

_____

Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representativeôs Authority