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: _____

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

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.

COMPLETION OF FORMS AND LETTERS

I understand that there is a $25 fee for review and completion of medical forms including but not limited to FMLA, long term care, life insurance, disability claims, return to work forms, etc. There is a 7 – 10 business day completion time.

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, P.A.

11920 Astoria, Suite 320 • Houston, TX 77089 • TEL: 281-484-9369

Patient Intake Questionnaire

Name: _____DOB: _____

Today's Date: _____

Local Pharmacy Information:

Pharmacy Name: _____

Pharmacy Phone Number: _____

Pharmacy Address: _____

_____

_____

Mail-in Pharmacy: _____

_____

Most Recent Vaccinations:

Flu Vaccine Date Received: _____

- ☐ PCP
- ☐ Pharmacy
- ☐ Other: _____

Pneumonia Date Received: _____

- ☐ PCP
- ☐ Pharmacy
- ☐ Other: _____

Prevnar13 Date Received: _____

- ☐ PCP
- ☐ Pharmacy
- ☐ Other: _____

Current Medications:

Medication	Dose	How Often?

Name: _____DOB: _____

Personal Medical History

- ☐ Abnormal heart beat
- ☐ Allergies/Hay Fever
- ☐ Angina/Chest Pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood Clots
- ☐ Blood Problems
- ☐ Cancer site:_____
- ☐ Chronic Sinus Problems
- ☐ COPD
- ☐ COVID-19
- ☐ Diabetes
- ☐ Emphysema
- ☐ Fracture site:_____
- ☐ Heartburn/GERD
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Hiatal Hernia
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Pneumonia
- ☐ Pulmonary Fibrosis
- ☐ Sarcoidosis
- ☐ Stomach Ulcer
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Other:
  _____
  _____
  _____
  _____

Medication Allergies: _____

_____

_____

_____

_____

_____

_____

Past Operations/Treatments

- ☐ Appendectomy
- ☐ Chemotherapy
- ☐ Gallbladder
- ☐ Heart Bypass Surgery
- ☐ Heart Valve Surgery
- ☐ Hysterectomy
- ☐ Inguinal Hernia Repair
- ☐ Joint Replacement
- ☐ Lung Surgery
- ☐ Mastectomy (R or L)
- ☐ Radiation
- ☐ Vascular Surgery
- ☐ Other:
  _____
  _____
  _____

Name: _____DOB: _____

Family History: If any blood relative has suffered any of the following, please put an 'X' in the appropriate box.

	Asthma	Cancer (Type?)	COPD/ Emphysema	Diabetes	Heart Disease	High Blood Pressure	Pulmonary Fibrosis	Stroke	Other
Father									
Mother									
Paternal Grandfather									
Paternal Grandmother									
Maternal Grandfather									
Maternal Grandmother									
Siblings									

Social History

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 If yes, what type? _____ How many? _____

Foreign travel in past year: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed

Do you have an advanced directive or living will? □ Yes □ No

Tobacco:

- □ Never smoked
- □ Ex-Smoker
  What year did you quit? _____
  How much did you smoke?_____
  How many years did you smoke? _____
- □ Active Smoker
  How many years? _____
  How many packs per day? _____
  Are you thinking about quitting? □ Yes □ No

Exposed to second hand smoke?

- □ Never exposed
- □ Currently exposed
- □ Previous history of exposure

Occupational History

Employment: □ Full Time □ Part Time □ Retired Occupation: _____

Have you ever worked with asbestos? □ Yes □ No

Were you ever exposed to fumes, dust or solvents? □ Yes □ No

Patient Name: _____ DOB: _____

EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep, need to improve your sleep hygiene and/or need to see a sleep specialist. These issues should be discussed with your physician.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze or sleep

1 = slight chance of dozing or sleeping

2 = moderate chance of dozing or sleeping

3 = high chance of dozing or sleeping

Situation	Chance of Dozing or Sleeping
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place	_____
Being a passenger in a motor vehicle for an hour or more	_____
Lying down in the afternoon	_____
Sitting and talking to someone	_____
Sitting quietly after lunch (no alcohol)	_____
Stopped for a few minutes in traffic while driving	_____
Total score	_____

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Houston Pulmonary Medicine at 281-484-9369.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

_____

Date

Houston Pulmonary Medicine Associates

COVID-19 SCREENING

_____ _____

Patient Name Date of Birth

Please check yes or no:

1. Have you or anyone in your household had any of the following symptoms in the last 21 days: sore throat, cough, chills, body aches for unknown reasons, shortness of breath for unknown reasons, loss of smell, loss of taste, fever greater than 100 degrees Fahrenheit? ☐ Yes ☐ No
2. Have you or anyone in your household been tested for COVID-19? ☐ Yes ☐ No
   If yes, date: _____ ☐ Positive ☐ Negative
3. Have you or anyone in your household visited or received treatment in a hospital, nursing home, long-term care, or other health care facility in the past 30 days?
   ☐ Yes ☐ No
4. Have you or anyone in your household traveled in the U.S. in the past 21 days?
   ☐ Yes ☐ No
5. Have you or anyone in your household traveled on a cruise ship in the last 21 days?
   ☐ Yes ☐ No
6. Are you or anyone in your household a health care provider or emergency responder?
   ☐ Yes ☐ No
7. Have you or anyone in your household cared for an individual who is in quarantine or is a presumptive positive or has tested positive for COVID-19? ☐ Yes ☐ No
8. Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19? ☐ Yes ☐ No
9. To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19? ☐ Yes ☐ No

_____ _____

Patient Signature Today's Date