TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

911C Medical Centre Drive
Arlington, Texas 76012
(817) 461-0201 (Metro)
(817) 861-3365 Fax

Joseph Austin, Jr., M.D., FCCP
Jack G. Gilbey, Jr., M.D., FCCP
Luis F. Guerra, M.D., FCCP
Tony H. Su, M.D., FCCP

Patient Name: _____

Referring Physician: _____

You have been scheduled for an initial consultation for a sleep evaluation with _____ on _____ at _____. Please arrive 15 minutes prior to the appointment. Refer to the enclosed map for directions to our facility. Below is a list of important information to assist you in preparation for this appointment.

- Please complete the paperwork within this packet prior to your appointment. Be sure that all signature blanks have been signed by yourself or your legal representative. The HIPAA privacy information is available for your review when you arrive for your appointment, if you are unfamiliar with these documents. You can be provided with a copy upon request.

- Please have your referring physician fax or send a copy with you of any recent notes and/or lab work that has resulted in this consult appointment.

- Please bring all of your current medications (in original containers), so that a correct list can be made for your chart.

- If your insurance requires a referral for specialists, please make sure your referring physician has completed the required forms and faxed it to our office prior to your appointment.

- Many patients may have sensitivity to scents due to their respiratory conditions. Please avoid the use of heavily scented body sprays, perfumes, colognes, etc.

- As a courtesy to our patients, we will file our charges to your insurance company, but we must collect all co-payments at the time of service.

- **If you cannot keep your appointment, please call us at 817-461-0201 as early as possible. Please help us serve you better by keeping all scheduled appointments.**

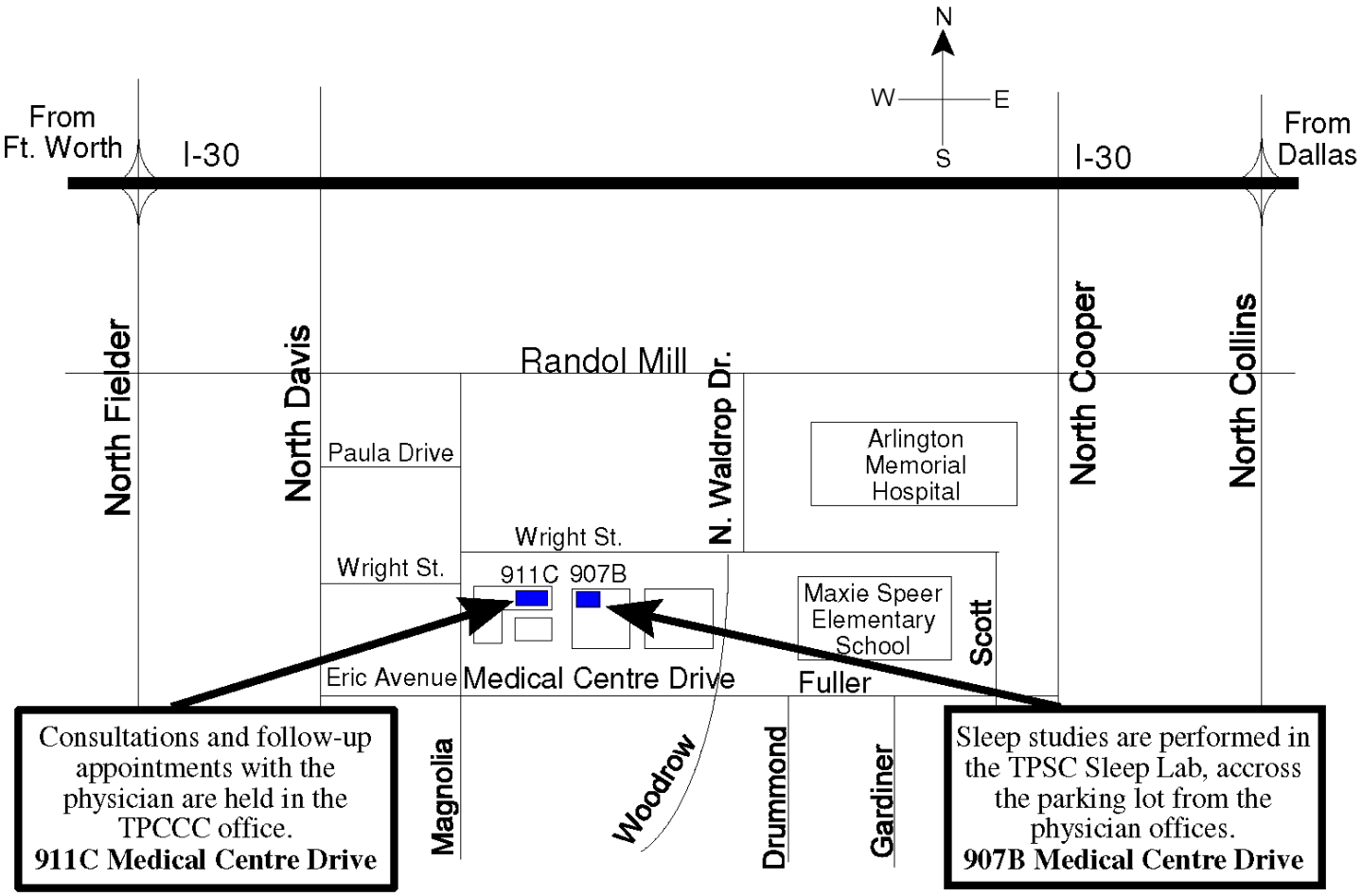
We look forward to meeting you for this first office visit. If we can assist you with questions prior to your visit, please feel free to call.

Sincerely,

Scheduling Secretary

Texas Pulmonary & Critical Care Consultants, PA
Physician Offices
911C Medical Centre Drive
Arlington, Texas 76012
(817) 461-0201

Texas Pulmonary Sleep Center
Sleep Lab
907B Medical Centre Drive
Arlington, Texas 76012
(817) 461-8772



DIRECTIONS:

From Dallas, heading west on I-30, exit Cooper Street. Turn right at the light. Proceed south on Cooper for 0.9 miles. Just past Arlington Memorial Hospital, turn right on Fuller Street. Continue 0.2 miles (Fuller Street becomes Medical Centre Drive) and follow the signs. The physician's office is in the third group of buildings on the right, and the sleep center is directly across the parking lot in the middle group of office buildings.

From Fort Worth, heading east on I-30, take the North Fielder exit. Turn right at the light and proceed 0.7 miles. Turn left on W. Randol Mill Road. Proceed east for 0.7 miles and turn right on Magnolia Street. Take the second left onto Medical Centre Drive and follow the signs. The physician's office is in the first group of buildings to your left. The sleep center is directly across the parking lot in the middle group of office buildings.

TEXAS PULMONARY SLEEP CENTER INITIAL SLEEP EVALUATION

Patient Name: _____ (first, MI, Last) Today's Date: _____

Date of Birth: _____(mm/dd/yyyy) Current Height: _____ inches Current Weight: _____ lbs.

Past year reported weight changes of _____ lbs. ☐ Loss or ☐Gain Why? _____

Previous sleep evaluation:

Name of Hospital/Sleep Center: _____

Location: _____

Approximate date of sleep study: _____

Diagnosis: _____

Previous/Current Treatments: ☐Oral Appliance ☐CPAP/BIPAP Therapy settings of: _____ cmH_2O pressure

☐ Laser or other procedure on Uvula (LAUP) ☐Mandibular Surgery ☐Uvulopalatopharyngoplasty (UPPP)

☐ Turbinate Reduction Surgery ☐Tonsillectomy ☐Adenoidectomy ☐Oxygen Therapy: _____ lpm

☐ Other Treatment (Explain): _____

If currently using CPAP/BiPAP, what company provides your equipment?_____

Approximate date you last received PAP equipment from this company: _____

If currently using oxygen, what company provides your equipment? _____

Approximate date you last received oxygen equipment from this company: _____

Please mark your primary sleep complaints:

☐Stop breathing during sleep ☐Loud Snoring ☐Wake gasping for breath

☐Difficulty falling asleep ☐Difficulty maintaining sleep ☐Unrestorative sleep

Sleepy during (check applicable): ☐Sitting ☐Talking ☐Watching TV ☐Standing

☐Riding in car ☐Driving in car ☐In theaters ☐Always

How long has this problem bothered you? ☐ <1 Month ☐ 1-3 Months ☐ 3-12 Months ☐ >1 Year

Please mark all of your medical conditions:

☐High Blood Pressure

☐COPD (Chronic Bronchitis or Emphysema)

☐Cardiac Arrythmia: _____

☐Heart Failure

☐Stroke

☐Sinusitis (chronic)

☐Deviated Septum

☐Nasal Congestion

☐Asthma

☐Reflux

☐Fibromyalgia

☐Claustrophobia

☐Depression

☐Psychiatric Condition: _____

☐Diabetes or High Blood Sugar

☐Thyroid Disease: _____

☐Seizures

☐Parkinson's Disease

☐Anxiety

☐Head Injury or previous brain surgery

☐Pain which disrupts sleep (indicate below):

Location of Pain: ☐Head ☐Neck ☐Back ☐Legs

☐Chest ☐Arms ☐Abdomen ☐Pelvis ☐Joints

☐Other: _____

PLEASE MARK ALL SYMPTOMS THAT APPLY TO YOUR SLEEP PROBLEMS:

Yes	No	Symptoms
☐	☐	Memory impairment
☐	☐	Inability to concentrate
☐	☐	Fatigue
☐	☐	Feeling sleepy or tired during the daytime
☐	☐	Wheezing or cough disruptive to sleep
☐	☐	Heartburn, sour belches, regurgitation, or indigestion disruptive to sleep
☐	☐	Frequent urination disruptive to sleep
☐	☐	Morning headaches
☐	☐	Wakes with a dry mouth
☐	☐	Wake with sore throat or hoarseness
☐	☐	Frequent arousals from sleep and cannot return to sleep
☐	☐	Wakes with sore throat and hoarseness
☐	☐	Panic attacks during sleep
☐	☐	Racing thoughts impairing sleep
☐	☐	Sudden muscle weakness when laughing, angry or emotional situations
☐	☐	Paralysis (unable to move) when just falling asleep or upon waking
☐	☐	Hallucinations (people, voices, or sounds) in the room when just falling asleep or upon waking
☐	☐	Sleep talking
☐	☐	Sleep walking
☐	☐	Nightmares
☐	☐	Acting out dreams or having colorful/vivid or violent dreams
☐	☐	Teeth grinding
☐	☐	Confusion after awakening
☐	☐	Creeping or crawling sensation in your legs before falling asleep
☐	☐	Legs or arms jerking during sleep

Reported Medications:

Do you currently take anything to help you sleep? ☐No ☐Yes What: _____

How often do you take it? ☐Nightly ☐>3 times per week ☐Weekly ☐1-3 times monthly ☐Rarely

If this is a prescription sleep aid, please list the prescribing physician: _____

Are you allergic to anything (report all medication, tape, chemical, textiles): _____

Please list your other medications:_____

_____

_____

_____

Social History:

Have you been a smoker? ☐No ☐Yes _____ packs per day for _____ years

Have you quit smoking? ☐No ☐Yes How many years ago? _____

Do you drink alcohol? ☐No ☐Yes _____ drinks per ☐day ☐week ☐month (usual frequency)

Coffee: _____ cups per day. What time is your last coffee drink prior to sleep? _____ am/pm

Tea or iced tea: _____ cups per day. What time is your last tea drink prior to sleep? _____ am/pm?

Caffeinated soda: _____ cans per day. What time is your last caffeinated soda prior to sleep? _____ am/pm

Sleep Habits:

What time do you usually go to bed? Weekdays? _____ am/pm? Weekends? _____ am/pm

How long does it take for you to fall asleep? _____ minutes

What time do you usually get up? Weekdays? _____ am/pm Weekends? _____ am/pm

How many times do you wake up while sleeping? _____ times

What is the reason you usually wake up? ☐Unknown ☐other: _____

Do you take naps during the day? ☐No ☐ If yes how often?_____ times/day. How long?_____ minutes

What time of day do you usually nap? _____ am/pm

Describe your bedroom (check all that apply): ☐Loud ☐Quiet ☐Light ☐Dark

Do you have a TV/radio in your bedroom? ☐Yes ☐No If yes, do you use a sleep timer? ☐Yes ☐No

Describe your bed (check all that apply): ☐Soft mattress ☐Hard/firm mattress ☐Just right

Do you fall asleep easier in places other than your bed? ☐ No ☐Yes If so where? _____

Do you find sleeping in a regular bed difficult? ☐ No ☐Yes Why? _____

Do you have any complaints related to your bedroom environment? ☐No ☐Yes

Please explain: _____

In contrast to just feeling tired, how likely are you to doze off or fall asleep in the following situations? If you have not done some of these things recently, try to think how they would have affected you) Use the following scale to choose the most appropriate number for each situation:

0	1	2	3
Never	Slight chance	Moderate chance	High chance

Sitting and reading	0
Watching TV	0
Sitting inactive in a public place (i.e. theatre)	0
As a passenger in a car for an hour without a break	0
Lying down to rest in the afternoon	0
Sitting and talking to someone	0
Sitting quietly after lunch without alcohol	0
In a car, while stopping for a few minutes in traffic	0

(normal: 0-7, mild: 8-11, moderate: 12-16, severe: 17-20, very severe:21-24) **Total score:** _____

Name:_____

TWO WEEK SLEEP DIARY

INSTRUCTIONS:

1. Write the date, day of the week, and type of day: Work, School, Day Off, or Vacation.
2. Put the letter "C" in the box when you have coffee, cola or tea. Put "M" when you take any medicine. Put "A" when you drink alcohol. Put "E" when you exercise.
3. Put a line (I) to show when you go to bed. Shade in the box that shows when you think you fell asleep.
4. Shade in all the boxes that show when you are asleep at night or when you take a nap during the day.
5. Leave boxes unshaded to show when you wake up at night and when you are awake during the day.

SAMPLE ENTRY BELOW: On a Monday when I worked, I jogged on my lunch break at 1 PM, had a glass of wine with dinner at 6 PM, fell asleep watching TV from 7 to 8 PM, went to bed at 10:30 PM, fell asleep around Midnight, woke up and couldn't got back to sleep at about 4 AM, went back to sleep from 5 to 7 AM, and had coffee and medicine at 7:00 in the morning.

Today's Date	Day of the week	Type of Day Work, School, Off, Vacation	Noon	1PM	2	3	4	5	6PM	7	8	9	10	11PM	Midnight	1AM	2	3	4	5	6AM	7	8	9	10	11AM
sample	Mon.	Work		E					A				I									C M				
																								week 1		
																								week 2		

PATIENT REGISTRATION FORM

Date:_____

Patient Name _____ Birth Date _____ Sex _____ SSN _____
Last First Middle

Are you currently residing in a skilled nursing facility? Yes No If yes, name of facility _____

Home Address _____
Street City State Zip+4

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred contact method for reminders (select one or more):
☐Voice message (circle preferred number above) ☐Text (cell phone above) ☐Email (below) ☐Do Not Remind Me

Email address _____ ☐ I decline access to the portal

Patient Employer _____ Employer Phone _____

Employer Address _____
Street City State Zip+4

Marital Status _____ Religious Preference _____ Patient Language _____

Race ❑American Indian or Alaskan Native ❑Asian ❑Asian Pacific American ❑Black/African American ❑Caucasian (White) ❑Hispanic ❑More Than One Race ❑Native American ❑Native Hawaiian ❑Other Race ❑Pacific Islander ❑Subcontinent Asian American ❑Unknown ❑Decline to Answer

Ethnicity ❑Latino/Hispanic ❑Other ❑Decline to Answer

Spouse's Name _____ Spouse's Employer _____

Spouse's Work Phone _____ Address _____

Referred By _____ Phone _____ Fax _____

Address _____
Street City State Zip+4

Primary Care Physician _____ Phone _____ Fax _____

Address _____
Street City State Zip+4

List other physicians you are currently seeing _____

Notify in case of emergency *(Do not list anyone who lives with you)*

Name _____ Phone _____ Pt is Contact's _____ *(relationship)*

Address _____
Street City State Zip+4

Have you signed a: Living Will: Yes No DNR (Do Not Resuscitate): Yes No (Please provide a copy)
Durable Power of Attorney: Yes No Date signed:_____ (Please provide a copy)

Pharmacy _____ Phone _____

Are you currently using a DME (Durable Medical Equipment) company? Yes No

If yes, which one? _____

If no, who does your insurance company require you to use? _____

Who does your insurance company require you to use for: Lab _____ X-ray _____

Is this a work-related illness/injury? Yes No Date of illness/injury _____ Date last worked _____

Cause of accident, if any _____

I hereby authorize release of my medical records from_____to Texas Pulmonary & Critical Care Consultants, PA. This authorization expires upon written notice from patient/patient representative.

_____ _____

Signature of Patient or Responsible Party Date

FINANCIAL POLICY

PRIMARY INSURANCE POLICY:

Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Insured's DOB _____ Ins Start Date _____
Relationship to Patient _____ SSN _____ Sex _____

SECONDARY INSURANCE POLICY:

Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Insured's DOB _____ Ins Start Date _____
Relationship to Patient _____ SSN _____ Sex _____

Responsible Party Name _____ Phone _____ Relationship _____
Address _____
Street City State Zip+4

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. Full payment or copayment (if applicable) is due at the time of service. We accept cash, check, Visa, MasterCard, Discover or American Express. We are not responsible for misinformation given by your insurance company. You will be refunded any over-payments or billed for any balance after the claim processes.

Regarding Insurance – We cannot bill your insurance company unless you give us your insurance information. If we are nonparticipating with your insurance, and they have not paid the balance within 90 days, the balance will be transferred to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable and necessary under the Medicare Program and/or other medical insurance. These charges will be your responsibility. Our office makes every effort to obtain referral authorizations from the Primary Care offices for patients on HMOs. Should we not be able to obtain a referral, charges will be your responsibility.

Appeals – You appoint Texas Pulmonary & Critical Care Consultants, P.A. and/or Sleep Consultants, Inc. to act as your authorized representative in requesting an appeal from your insurance plan in the event of denial of services/denial of payment. You agree that if the payment denial is overturned on appeal, the plan's payment should be paid directly to Texas Pulmonary/Sleep Consultants, and you direct the plan to do so in that event.

Out of Network Billing – The physicians may not be participating providers with your insurance plan and, if not, benefits may be reduced and/or your portion may be applied to your out-of-network deductible.

_____ _____
Signature of Patient or Responsible Party Date

Acknowledgment of Review of Notice of Privacy Practices

I have reviewed this office's 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

A copy of our Notice of Privacy Practices will be provided at your request.

Texas Pulmonary & Critical Care Consultants, PA

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Texas Pulmonary & Critical Care Consultants, PA, must have my consent, therefore I authorize Texas Pulmonary & Critical Care Consultants, PA to disclose my PHI as described in the provided forms to the recipients listed below:

Description of the information to be disclosed (check all that apply):

☐All Procedures ☐Test Results ☐Appointments ☐Other ☐Surgeries ☐Billing/Account information

Name(s) of the person(s) authorized to obtain the above-mentioned information. (e.g. physician other than your referring doctor, family members and other specified person/persons)

Name:_____Relationship:_____

Name:_____Relationship:_____

Patient's Contact Information:

I authorize Texas Pulmonary & Critical Care Consultants, PA to contact me at the following number with results or questions:

Home_____ Cell_____ Work_____

May we leave a detailed message on your answering machine or voicemail?

Yes☐ No☐ Failure to check one of these boxes may delay results

By Patient: (printed name) _____ DOB: _____

Patient Signature: _____ Date:_____

Or Patient's Representative (print name, sign and describe authority)

_____ Date:_____

By signing this HIPAA Patient Acknowledgement form, you acknowledge and authorize that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. You understand that your records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that you have the right to revoke this authorization at any time, provided you do so in writing; that you have been given the opportunity to ask questions; that you have received a copy of the signed authorization; that you may inspect a copy of your PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to you or your treatment upon receipt of this signed authorization; and that you may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

Advanced Practice Provider Consent

In addition to our Board-Certified physicians, this facility has on staff advanced practice providers to assist in the delivery of pulmonary care.

These advanced practice providers are not physicians. They have received advanced education and training in the provision of health care. Each can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

I have read the above and hereby consent to the services of an advanced practice provider for my health care needs.

I understand that at any time I can refuse to see the advanced practice provider and request to see a physician.

_____ _____

Name Date

_____

Signature