TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

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2000 Precinct Line Road, Suite 101
Hurst, TX 76054
(817) 284-4343, Fax (817) 590-4393

Patient Name: ____________________________________

Referring Physician: _______________________________

You have been scheduled for an initial consultation for a sleep evaluation with ______________________________on _____________________ at ________. Refer to the enclosed map for directions to our office. 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 the office as early as possible. Please help us serve you better by keeping all scheduled appointments.**

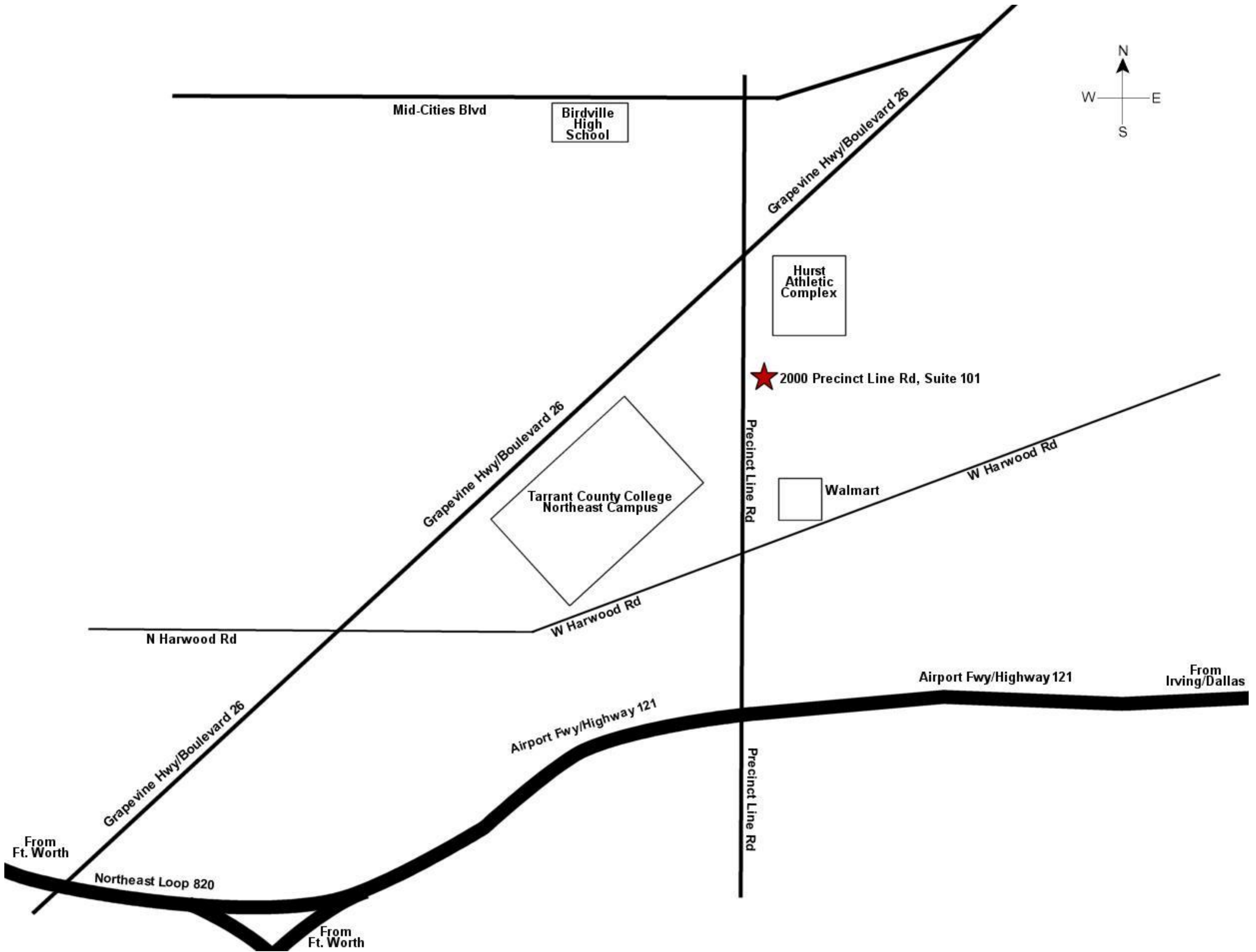
We look forward to meeting you for this first office visit. If we can assist you with questions prior to your visit, please feel free to call.

Sincerely,

Scheduling Secretary

Texas Pulmonary & Critical Care Consultants, PA

2000 Precinct Line Road, Suite 101
Hurst, TX 76054
(817) 284-4343



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 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): ____

Please mark your primary sleep complaints:

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

☐ Difficulty falling asleep ☐ Difficulty maintaining sleep ☐ Unrestorative sleep

Sleep 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: _______________________________________

Patient Name: ___________________________________

PLEASE MARK ALL SYMPTOMS THAT APPLY TO 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: ______________________________

Please list your other medications:____

____

____

____

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

Patient Name: ___________________________________

Family History:

Family History: Father alive?_____________ Mother alive?__________

Brother(s) alive?_________ Sister(s) alive ?___________

Children?_____________ How many?___________

<u>Check</u> any of the diseases that run in your family AND please note who had it:

	Mother	**Father**	**Sister**	**Brother**	**Other (explain)**
COPD					
Asthma					
Eczema					
Hay fever					
Nasal polyps					
Lung disease					
Lung cancer					
Cancer (list type)					
Breast cancer					
Colon cancer					
Skin melanoma					
Pancreatic cancer					
Heart disease					
Coronary artery disease					
High blood pressure					
Stroke					
High cholesterol					
Diabetes					
Dementia/Alzheimer's					
Blood clot to lungs					
Blood clot to leg veins					

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

Patient Name: ___________________________________

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	________
Watching TV	________
Sitting inactive in a public place (i.e. theatre)	________
As a passenger in a car for an hour without a break	________
Lying down to rest in the afternoon	________
Sitting and talking to someone	________
Sitting quietly after lunch without alcohol	________
In a car, while stopping for a few minutes in traffic	________
(normal: 0-7, mild: 8-11, moderate: 12-16, severe: 17-20, very severe:21-24) **Total score:**	________

STOP-BANG Questionnaire

What is Obstructive Sleep Apnea (OSA)?

It is when your breathing stops or slows down while you are sleeping.

If you snore loudly or gasp for air when you sleep, or you are always tired, you may have OSA.

OSA is often present with other diseases. If OSA is overlooked, it could be bad for your health.

- 43 million Americans currently have OSA
- 50% of patients with diabetes have OSA
- 30% of patients with high blood pressure have OSA

Complete the questionnaire below to know if you are at risk of OSA.

Patient Information	
Name:	
Male/Female (M/F):	Age (years):
Height: ______Feet ______Inches	Body mass index (BMI) (office staff can calculate):
Weight (pounds):	Neck or collar size (in inches, office staff can measure):

STOP-BANG	**YES**	**NO**
Do you **S**NORE loudly (eg, louder than talking or loud enough to be heard through closed doors)?		
Do you often feel **T**IRED, fatigued or sleepy during the day?		
Has anyone **O**BSERVED that you have stopped breathing while sleeping?		
Do you have or are you being treated for high blood **P**RESSURE?		
BMI more than 35 kg/m^2?		
Are you more than 50 years of **A**GE?		
Is your **N**ECK 17 inches or greater for men (16 inches for women)?		
Male **G**ENDER?		

YES to 3 or more questions means you are at high risk.

Talk with your doctor about this questionnaire. If you are at high risk of OSA, ask about the AccuSom® Home Sleep Test.

Patient Name: ______________________________

Texas Pulmonary Sleep Center

Sleep Log

Fill out days 1-5 below and days 6-10 on next page	I drank alcoholic or caffeinated beverages today: *(List type and amount)*	I took a nap today: *(List the start and end time of each nap?)*	I was awake, but resting: *(List the start and end time of each occurrence)*	I finally got out of bed this morning at:	I went to bed last night at:	Last night, I fell asleep in:	I was in bed for a total of:	Last night, my sleep quality was:	I woke up during the night: *(record number of times)*	Each awakening lasted: *(record length of each one)*	I estimate my total hours of actual sleep to be:
Example **Day: Monday** **Date: 5/19**	***If yes:*** **1 cup coffee – 8 oz** **1 can coke – 11 oz** ___________	***If yes*:** **What time?** **1-2 pm** ___________ ___________	***If yes*:** **What time?** **6-7 pm** ___________ ___________	**6:00** **PM/AM** (AM circled) ***(Circle)***	**10:00** **PM/AM** (PM circled) ***(Circle)***	**35** **Minutes**	**8.0** **Hours** ________ **Minutes**	☐ **Good** ☑ **Fair** ☐ **Poor**	**2** **Times**	**10, 5,** ___, ___, ___, ___, **Minutes**	**7** **Hours** **10** **Minutes**
Day 1 Day:_______ Date:______	*If yes:* ___________ ___________ ___________ ___________	*If yes*: What times? ___________ ___________ ___________	*If yes*: What times? ___________ ___________ ___________	_________ PM/AM *(Circle)*	_________ PM/AM *(Circle)*	_______ Minutes	_______ Hours _______ Minutes	☐ Good ☐ Fair ☐ Poor	_______ Times	___, ___, ___, ___, ___, ___, Minutes	_______ Hours _______ Minutes
Day 2 Day:_______ Date:______	*If yes:* ___________ ___________ ___________ ___________	*If yes*: What times? ___________ ___________ ___________	*If yes*: What times? ___________ ___________ ___________	_________ PM/AM *(Circle)*	_________ PM/AM *(Circle)*	_______ Minutes	_______ Hours _______ Minutes	☐ Good ☐ Fair ☐ Poor	_______ Times	___, ___, ___, ___, ___, ___, Minutes	_______ Hours _______ Minutes
Day 3 Day:_______ Date:______	*If yes:* ___________ ___________ ___________ ___________	*If yes*: What times? ___________ ___________ ___________	*If yes*: What times? ___________ ___________ ___________	_________ PM/AM *(Circle)*	_________ PM/AM *(Circle)*	_______ Minutes	_______ Hours _______ Minutes	☐ Good ☐ Fair ☐ Poor	_______ Times	___, ___, ___, ___, ___, ___, Minutes	_______ Hours _______ Minutes
Day 4 Day_______ Date_______	*If yes:* ___________ ___________ ___________ ___________	*If yes*: What times? ___________ ___________ ___________	*If yes*: What times? ___________ ___________ ___________	_________ PM/AM *(Circle)*	_________ PM/AM *(Circle)*	_______ Minutes	_______ Hours _______ Minutes	☐ Good ☐ Fair ☐ Poor	_______ Times	___, ___, ___, ___, ___, ___, Minutes	_______ Hours _______ Minutes
Day 5 Day:_______ Date:______	*If yes:* ___________ ___________ ___________ ___________	*If yes*: What times? ___________ ___________ ___________	*If yes*: What times? ___________ ___________ ___________	_________ PM/AM *(Circle)*	_________ PM/AM *(Circle)*	_______ Minutes	_______ Hours _______ Minutes	☐ Good ☐ Fair ☐ Poor	_______ Times	___, ___, ___, ___, ___, ___, Minutes	_______ Hours _______ Minutes

Patient Name: ______________________________

Texas Pulmonary Sleep Center

Sleep Log

Fill out days 6-10 below	I drank alcoholic or caffeinated beverages today: *(List type and amount)*	I took a nap today: *(List the start and end time of each nap?)*	I was awake, but resting: *(List the start and end time of each occurrence)*	I finally got out of bed this morning at:	I went to bed last night at:	Last night, I fell asleep in:	I was in bed for a total of:	Last night, my sleep quality was:	I woke up during the night: *(record number of times)*	Each awakening lasted: *(record length of each one)*	I estimate my total hours of actual sleep to be:
Example **Day: Monday** **Date: 5/19**	***If yes:*** **1 cup coffee – 8 oz** **1 can coke – 11 oz** ____________	***If yes*:** **What time?** **1-2 pm** ____________ ____________	***If yes*:** **What time?** **6-7 pm** ____________ ____________	**6:00 PM/AM (Circle)** (AM circled)	**10:00 PM/AM (Circle)** (PM circled)	**35 Minutes**	**8.0 Hours** ________ **Minutes**	☐ **Good** ☑ **Fair** ☐ **Poor**	**2 Times**	**10, 5,** ___, ___, ___, ___, **Minutes**	**7 Hours 10 Minutes**
Day 6 Day:_______ Date:_______	*If yes:* ____________ ____________ ____________ ____________	*If yes*: What times? ____________ ____________ ____________	*If yes*: What times? ____________ ____________ ____________	__________ PM/AM *(Circle)*	__________ PM/AM *(Circle)*	_______ Minutes	________ Hours ________ Minutes	☐ Good ☐ Fair ☐ Poor	______ Times	___, ___, ___, ___, ___, ___, Minutes	_______ Hours _______ Minutes
Day 7 Day:_______ Date:_______	*If yes:* ____________ ____________ ____________ ____________	*If yes*: What times? ____________ ____________ ____________	*If yes*: What times? ____________ ____________ ____________	__________ PM/AM *(Circle)*	__________ PM/AM *(Circle)*	_______ Minutes	________ Hours ________ Minutes	☐ Good ☐ Fair ☐ Poor	______ Times	___, ___, ___, ___, ___, ___, Minutes	_______ Hours _______ Minutes
Day 8 Day:_______ Date:_______	*If yes:* ____________ ____________ ____________ ____________	*If yes*: What times? ____________ ____________ ____________	*If yes*: What times? ____________ ____________ ____________	__________ PM/AM *(Circle)*	__________ PM/AM *(Circle)*	_______ Minutes	________ Hours ________ Minutes	☐ Good ☐ Fair ☐ Poor	______ Times	___, ___, ___, ___, ___, ___, Minutes	_______ Hours _______ Minutes
Day 9 Day_______ Date_______	*If yes:* ____________ ____________ ____________ ____________	*If yes*: What times? ____________ ____________ ____________	*If yes*: What times? ____________ ____________ ____________	__________ PM/AM *(Circle)*	__________ PM/AM *(Circle)*	_______ Minutes	________ Hours ________ Minutes	☐ Good ☐ Fair ☐ Poor	______ Times	___, ___, ___, ___, ___, ___, Minutes	_______ Hours _______ Minutes
Day 10 Day:_______ Date:_______	*If yes:* ____________ ____________ ____________ ____________	*If yes*: What times? ____________ ____________ ____________	*If yes*: What times? ____________ ____________ ____________	__________ PM/AM *(Circle)*	__________ PM/AM *(Circle)*	_______ Minutes	________ Hours ________ Minutes	☐ Good ☐ Fair ☐ Poor	______ Times	___, ___, ___, ___, ___, ___, Minutes	_______ Hours _______ Minutes

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.