Northeast
Pulmonary & Sleep
Associates

To: NE Pulmonary & Sleep Assoc. From: _____

Fax: (210) 655-6404 Phone: _____

Thank you for choosing NE Pulmonary & Sleep Associates and affiliated providers. In an effort to expedite your check-in process as a new patient, please complete the new patient forms before your appointment and either fax or bring them with you to your appointment.

Items to bring to your appointment:

1). New Patient Forms

2). Insurance Card(s) and Driver's License

3). Any and all recent medical records

4). Current Medications

Office Information:

NE Pulmonary & Sleep Associates
12709 Toepperwein Road, Suite 201
Live Oak, Texas 78233
Ph: (210) 655-6400 Fax: (210) 655-6404

Again, Thank you for choosing NE Pulmonary & Sleep Associates. If you have any questions please feel free to contact our office staff. We look forward to seeing you.

☐ New Patient ☐ Updated Information

Northeast Pulmonary & Sleep Associates

Patient Demographics

Patient Name: _____ Birth Date: _____/_____/_____
LAST FIRST MI

Social Security No: _____-_____-_____ Gender: ☐ Male ☐ Female

Address: _____
STREET ADDRESS CITY STATE ZIP

Home #: ____-_____-_____ Cell #: _____-_____-_____ Work #:_____-_____-_____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed Preferred Language:_____

Race: ☐ African American ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic
☐ Native Hawaiian / Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic or Latin Decent ☐ Not Hispanic or Latin Decent ☐ Do Not Wish to Report

Emergency Contact Information

Name: _____ Phone: _____-_____-_____

Release of Medical Information

(Medical Information may be released to the following individuals)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Payment Information

Form of Payment: ☐ Health Insurance ☐ Auto Insurance ☐ Workers Comp ☐ Self Pay ☐ Other

Primary Insurance:

Primary Company:_____ Insured's Name:_____

Policy #:_____ Group #:_____ Insured's Date of Birth :_____

Secondary Insurance

Secondary Company:_____ Insured's Name:_____

Policy #:_____Group #:_____ Insured's Date of Birth :_____

Self Pay Agreement

I agree to pay for medical services rendered from Northeast Pulmonary and/or affiliated providers. I understand that payment arrangements must be made prior to establishing as a new patient.

Patient Signature: _____ Date: _____

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for the office of Northeast Pulmonary and affiliated providers to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). [The office's Notice of Privacy Practices provides a more complete description of such uses and disclosures.]

I have the right to review the Notice of Privacy Practices prior to signing this consent. The office of Northeast Pulmonary and affiliated providers reserves the right to revise its Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Administrator.

With this consent, the office of Northeast Pulmonary and affiliated providers may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that may assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, the office of Northeast Pulmonary and affiliated providers may mail to my home or their alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the office of Northeast Pulmonary and affiliated providers may e-mail to my home or other alternative location any times that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that the office of Northeast Pulmonary and affiliated providers restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting that the office of Northeast Pulmonary and affiliated providers may use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, the office of Northeast Pulmonary and affiliated providers may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____
Print Patient's Name

_____
Print Name Legal Guardian

_____
Date

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION:

I authorize Northeast Pulmonary and affiliated providers to release any medical information requested by insurance companies with whom I have coverage or any public agency that may be assisting in payment of my medical care.

AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFIT:

I authorize the release of any medical information necessary to process any claim associated with Northeast Pulmonary and affiliated providers with respect to my medical care. I permit a copy of this authorization to be used in the place of the original.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize payment of benefits to be paid directly to the affiliated providers of Northeast Pulmonary. I understand that I am financially responsible for charges not covered by this assignment. I authorize refunds of overpaid insurance benefits, when my coverage is subject to coordination of benefits. In the event of default, I agree to pay all costs arising from the collection of payment, including attorney fees.

CONSENT FOR TREATMENT:

I hereby authorize the health care providers affiliated providers to perform a physical examination and to provide any medical treatment deemed necessary. This includes but not limited to all required medical examinations, echocardiograms, EKG, nuclear scans, x-rays, and/or medical / surgical procedures.

PATIENT PAYMENT RESPONSIBILITY:

I hereby agree that all applicable fees, deductibles, co-insurance, and co-payments are my responsibility and must be paid at the time services are rendered, unless payment arrangements have been made.

APPOINTMENT CANCELLATIONS:

I hereby agree to make every attempt to call the office at least 24 hours in advance of any appointment that needs to be cancelled or rescheduled.

CHANGE OF INFORMATION:

I hereby agree to provide the office any information regarding changes in my address, phone number, health benefits, or insurance information.

NOTICE OF PRIVACY PRACTICES:

Northeast Pulmonary and affiliated providers are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Signing below indicated acknowledgement of receipt of our office's Notice of Privacy Practices.

AUTHORIZED SIGNATURE:

I authorize that I have read this document and will comply with the policies listed above. I also understand and agree that Northeast Pulmonary and affiliated providers reserve the right to terminate the physician/patient relationship for non-compliance with any of the above policies.

_____	_____	_____
Patient Name (Please Print)	Date	Patient Signature

Northeast Pulmonary & Sleep Associates

New Patient Health Questionnaire

NAME: _____ Birth Date: ____/____/____ Age: _____
LAST FIRST MI

Primary Care Physician (PCP): _____

PCP Contact/ Office Phone #: _____

Referring Physician (if different from PCP): _____

Referring Physician Contact/ Office Phone # (if different from PCP): _____

Preferred Pharmacy: _____ Phone #: _____

Allergies / Sensitivity to Medications: _____

Chief Complaint for Visit: _____

PAST MEDICAL AND SURGICAL HISTORY

Please list medical illness(s) or surgeries you have ever had that required treatment or hospitalization:

Medical History	Surgical History

Northeast Pulmonary & Sleep Associates

Patient Name: _____

Birth Date: _____/_____/_____

New Patient Health Questionnaire

Social History:

Do You Live in the San Antonio Area? ☐Yes ☐No
If not, where do you live? _____
Do you live with your: ☐Children ☐Roommate ☐Significant Other
☐Spouse ☐Other Family ☐ By Yourself
How Many Children do you have? _____

What is your Occupation? _____

Have you ever been exposed to significant amount of?
- ☐ Asbestos
- ☐ Organic Dust
- ☐ Sandblasting Dust
- ☐ Toxic Chemicals or Gases

Have you ever smoked tobacco: ☐Yes ☐ No
(Please Circle) Cigar, Cigarettes, Chewable, Pipe
If yes: for how many years: _____ on an average how many packs per day _____ what year did you quit (if Applicable) _____

Do you drink Alcohol on a regular basis? ☐Yes ☐No

If yes how many? ☐Bottles of Beer ☐Glasses of Wine ☐Drinks

_____per ☐Day ☐Week ☐Month

Have you ever been exposed to person(s) infected with Tuberculosis? ☐Yes ☐No

Have you ever had a blood transfusion? ☐Yes ☐No If yes, When _____

_____

Have you ever Used Illicit Drugs? ☐Yes ☐ No if yes, what type?

_____

Do you have pets? ☐Dog(s) ☐Cat(s) ☐Bird(s)

☐Other_____

Review of Systems / Symptoms
☐ Fever
☐ Chills
☐ Night Sweats
☐ Weight Loss
☐ Shortness of Breath
☐ Cough
☐ Spit of Blood
☐ Wheezing
☐ Shortness of Breath while laying Flat
☐ Chest Pain
☐ Chest Tightness
☐ Nose Congestion / Drainage
☐ Heartbrun
☐ Nausea / Vomiting
☐ Headache
☐ Memory Problems
☐ Unsteady Gait
☐ Weakness
☐ joint Pain / Swelling
☐ Leg Swelling
☐ Skin Rash
☐ High/Low Temperature Tolerance
☐ Excessive Thirst
☐ Frequent Urination
☐ Enlarged Lymphatic Nodes
☐ Loud Snoring
☐ Daytime Sleepiness
☐ Anxiety
☐ Depression

FAMILY MEDICAL HISTORY:

Are there any health problems running in your family? ☐Father ☐Mother ☐Brother ☐Sister
☐Allergies ☐Asthma ☐Cancer ☐Emphysema
☐Heart Problems ☐Tuberculosis
☐Other Respiratory / Lung Problems (please specify) _____

_____

Others (please List below): _____

_____

_____

Reviewed by MD ☐_____ Date: _____ /_____ / _____

Northeast Pulmonary & Sleep Associates

Patient Name: ______________________________

Birth Date: _______/________/________

Medication Log

Flu Shot: ☐ YES ☐ NO	Pneumovax: ☐ YES ☐ NO

Medication / Dose / Freg	Date	Date	Date	Date	Date	Date

Nurse signature:			MD Reviewed:
Oxygen	☐ YES	☐ NO	Flow Rate:
CPAP/BIPAP	☐ YES	☐ NO	Date of Sleep Study: / /
Nebulizer	☐ YES	☐ NO	
DME Company:			

Northeast Pulmonary and Sleep Associates
12709 Toepperwein ste. 201
Live Oak, Tx 78233
(210)655-6400
Fax (210)655-6405

Policies and Procedures

We would like to welcome you to our practice. We want your visit with us to be a pleasant one. Below are our policies and procedures concerning several operational issues that will help us better manage your healthcare.

General

- Please have all paperwork sent to us thoroughly completed prior to your appointment.
- Please bring all of your medications to every appointment.
- Bring your insurance card(s) and driver's license. If you do not have your insurance card the day of your appointment, you will be required to pay for the cost of the visit at the time services are rendered.
- Copayments are due at the time services are rendered. It is your contractual obligation with your insurance carrier.
- Our regular office hours are 8:30 am - 5:00 pm Monday through Friday. We are closed daily for lunch between 12:30 pm - 1:30 pm.

Scheduling

- Please consider the need of our other patients. If you are unable to keep an appointment, please call within 24 hours of your scheduled appointment time to cancel your appointment. If you do not cancel your appointment within 24 hours and/or miss a **confirmed** appointment, you will be billed a fee of $25.00. **If you miss three appointments, we reserve the right to terminate the patient / physician relationship.**
- If you are running more than **15** minutes late for your appointment, please call to let us know of your delay. It may, in some instances, become necessary to reschedule your appointment to allow us adequate time to process your paperwork and to allow the doctor adequate time to discuss your healthcare needs without infringing upon the other appointments for the day.

Prescription Refills

- We need 72 hours to accommodate prescription refills.
- If you are using a mail-in prescription service, we will fax your prescriptions for you, but we will **NOT** mail them. We will give you a prescription to mail to your pharmacy at your convenience.
- We do **NOT** refill any medications for new patients until they are seen in the office and their healthcare is assessed by one of our providers. Also, we do **NOT** refill any medications for our existing patients that have not been seen by our provider within the past 6 months.

Test Results

- Lab, X-Ray, MRI or other types of testing require a minimum of three days to obtain results. Please give the clinical staff 3-5 days to call you with results. Please feel free to call our office if you have not been notified of your results after 5 days.

Financial Information

- For patients not covered by any insurance plans (ie. self-pay patients), we offer a private pay discount. This discount is **ONLY** extended at the time services are rendered and your account must be paid in full at that time. If we have to bill you for services, you will be billed the full amount for your treatment and no discount will be extended.
- Your insurance policy is a contract between you, your employer, and / or your insurance company. Our relationship is with you. We **cannot** become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, and secondary insurance. **Not** all services are a covered benefit of your policy.
- **Co-payments** are a contractual fee between you the patient and your insurance company. You **are required to pay** your physician at the **time services are rendered**. The physician's contract with your insurance carrier requires that we collect your co-payment at the **time services are rendered** without exception.
- A fee of $25.00 per form will be charged for any correspondence or completion of any forms. The fee is due upon delivery of the forms.
- If you need a copy of your medical record you **MUST** request a copy in writing to our office. We charge a fee of $25.00 for the first 20 pages and $.50 per page thereafter. These fees are set by the Texas Medical Board. Please call in advance if you need an estimate of the cost.

I understand and accept the policies and procedures listed above. If for any reason my insurance company should fail to pay the contractual allowable or deny any service as a non-covered benefits, I accept financial responsibility for payment of these services.

_____

Printed Name

_____ _____

Signature Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on *OCTOBER 15, 2008* and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Chris Mathis. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. *(Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)*

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: NORTHEAST PULMONARY & SLEEP ASSOCIATES PLLC

Privacy Officer: Chris Mathis

Telephone:210.655.6400 Fax:210.655.6404

E-Mail: not available

Address: 12709 TOEPPERWEIN ROAD SUITE 201 LIVE OAK TEXAS 78233