The Lung & Sleep Center of North Texas

PATIENT REGISTRATION FORM

Legal Last Name _____ Legal First Name _____ MI ____

Date of Birth _____ Age _____ Sex _____ Social Security #_____

Home Address _____City _____State ____ Zip _____

Mailing Address (If Different from Home) _____

Preferred Phone Number (circle one) Home/Cell/Work _____

Alternate Phone Number (circle one) Home/Cell/Work _____

Employer _____ Address _____

Emergency Contact Name & Relationship_____ Phone _____

Race _____ Ethnicity _____ Language _____

E-Mail Address _____ (for appt reminders & patient portal)

Pharmacy Name _____Address _____

Referring Physician & Phone Number _____

Primary Care Physician & Phone Number _____

Does the patient have active health insurance coverage (circle one) Yes/No

Primary Insurance _____Policy # _____ Group #_____

Secondary Insurance_____Policy # _____ Group #_____

Is the patient the policyholder (circle one) Yes/No ***If No: Complete Responsible Party***

Is the patient financially responsible for medical bills (circle one) Yes/No ***If No: Complete Responsible Party***

Responsible Party Information (if applicable)

Legal Last Name _____ Legal First Name _____ MI ___

Date of Birth _____ Social Security _____ Employer_____

Home Address _____City _____State ____ Zip _____

Preferred Phone (circle one) Home/Cell/Work_____

The Lung & Sleep Center of North Texas

GENERAL CONSENT FORM

Consent for Treatment. I consent for The Lung and Sleep Center of North Texas to administer treatments, tests, and/or diagnostic tests to treat my injury/illness on an outpatient basis. I acknowledge there is no guarantee as to the outcome of any treatment received. **Patient Initials: _____**

Notice of Privacy Practices. I hereby acknowledge that I have received a copy of The Lung and Sleep Center of North Texas Notice of Privacy Practices upon my request and have reviewed how my medical information will be used and disclosed. **Patient Initials: _____**

Prescription and Medical History Consent. I give The Lung and Sleep Center of North Texas full permission to access my prescription medication history and access to my medical records regarding current/past medical conditions. **Patient Initials: _____**

Medical Records Policy. To obtain medical records, complete, sign, and submit the Authorization for Release of Patient Information form to our office by mail or in person. Fees may apply. **Patient Initials: _____**

Prescription Medication Policy. It is your responsibility to notify your pharmacy when refills are necessary. The pharmacy will contact our office with the request. Approval of your refill can take up to **three business days** so please do not wait until you are out of medication. Medication refills will only be addressed during regular office hours. No prescriptions will be refilled on Saturday, Sunday or Holidays. **Patient Initials: _____**

Involvement of Others in Care. I authorize The Lung and Sleep Center to discuss my care, not limited to medical needs, treatment, and payment options with the following persons:

Name	Relationship	Phone Number

May We Contact You By Phone and Leave a Message About Your Care? On occasions when our office is unable to contact you, our staff may wish to leave you messages with personal health information. Please check the box below to indicate how you wish to receive messages:

- ☐ Leave message with medical office contact information only
- ☐ Leave message with detailed information (i.e. appointment reminder, results)
- ☐ Do not leave message (a follow up appointment will be required for communication)

Advanced Care Planning. If applicable, please provide our office with a copy of your Advance Care Plan or Surrogate Decision Maker information. **Patient Initials: _____**

Patient Name (print) _____Date of Birth _____

Signature of Patient/Representative _____Date _____

Printed Name of Patient's Representative (if applicable) _____

The Lung & Sleep Center of North Texas

PATIENT FINANCIAL RESPONSIBILITY POLICY

Co-payments, Deductibles & Co-insurance. As of January 1, 2017, all co-payments, deductibles, & co-insurance must be paid at the time of service. You cannot be billed for this unless arrangements have been made prior to your visit.

Financial Hardship & Payment Plan. If other arrangements need to be made, please speak with the receptionist **prior** to your visit.

Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. If your insurance changes, please notify us before your next visit. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be not be covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Nonpayment. Please be aware that if a balance remains unpaid without partial payments, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Assignment of Benefits. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and other health plans. I authorize any insurance company to pay benefits due directly to The Lung and Sleep Center of North Texas and to release to my insurance carrier any medical records or documents requested to secure payment. This assignment will remain in effect until revoked by me in writing.

Medicare Release & Assignment of Benefits. I authorize any holder of medical or other information about me to be released to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of this request for payment of medical insurance benefits either to myself or the party who accepts assignment.

I have read and understand the Patient Financial Responsibility Policy of The Lung and Sleep Center of North Texas and I agree to be bound by its terms. I agree that I am financially responsible for all charges.

Patient Name (print) _____Date of Birth _____

Signature of Patient/Representative _____Date _____

Printed Name of Patient's Representative (if applicable) _____

The Lung & Sleep Center of North Texas

PATIENT HEALTH QUESTIONNAIRE

Patient Name: _____Date of Visit: _____

Primary Care Provider: _____Referring Provider: _____

Reason for this visit/referral: _____

Medications: List all current medications (Dose & Frequency)

1) _____ 6) _____ 11) _____

2) _____ 7) _____ 12) _____

3) _____ 8) _____ 13) _____

4) _____ 9)_____ 14) _____

5) _____ 10) _____ 15) _____

List Any Medication Allergies:

_____

_____

List Any Medical Conditions:

_____

_____

Past Hospitalizations: Reason & Date

_____

_____

Past Surgical History: Procedure & Date

_____

_____

Other Current Physicians:

_____