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## TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

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**Joseph Austin, Jr., M.D., FCCP**  
**Jack G. Gilbey, Jr., M.D., FCCP**  
**Luis F. Guerra, M.D., FCCP**  
**Mitchell C. Kuppinger, M.D., FCCP**  
**David H. Plump, M.D., FCCP**  
**Tony H. Su, M.D., FCCP**

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

Patient Name: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

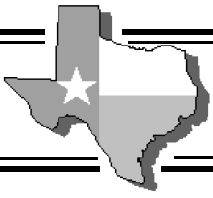
You have been scheduled for an initial consultation or hospital follow-up appointment with \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_ with a check-in time of \_\_\_\_\_. The next page of this packet is a detailed map to our facility. Below is a list of important information to assist you in preparing for this appointment.

- Please complete the enclosed packet of paperwork prior to your appointment. Be sure that all highlighted lines have a signature. The HIPAA privacy information is available in our office for your review if you are not already familiar with its contents.
- It is very important that the doctor have any old and new chest x-rays, CT chest scans or PET scans (**patient must bring the actual films** and reports) for this appointment.
- Please have your referring physician fax to our office or send with you any recent office notes and lab work.
- You must bring all of your current medications (actual bottles please) so a correct list can be made for your chart.
- New patients should plan to be in the office for a period of two hours. Patients seen in follow-up after hospitalization should plan approximately one hour for the appointment.
- If your insurance requires a referral, please make sure your referring physician has this completed and faxed to our office prior to your appointment.
- Many of our patients have sensitive respiratory conditions. Please avoid use of scented body spray, perfume, cologne, aftershave, or anything with a heavy scent.
- As a courtesy to our patients, we file charges to your insurance but all co-payments are expected at the time of service.
- **If you cannot keep your appointment, please call us at 817-461-0201 as early as possible. Unless canceled or rescheduled at least 24 hours in advance, our policy is to charge for late notification/missed appointments at the rate of \$25.00 per incident. Please help us serve you better by keeping scheduled appointments.**

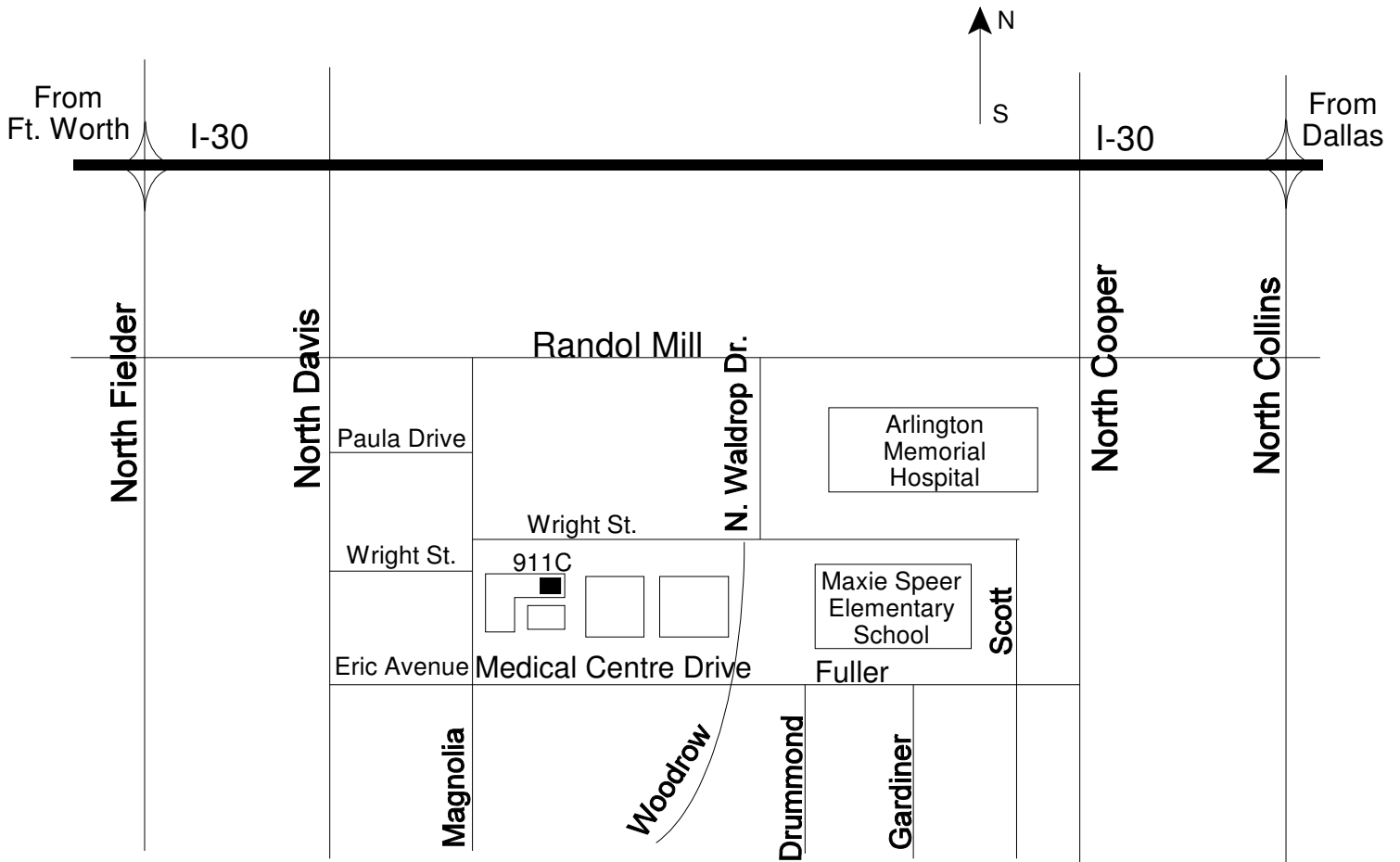
We look forward to meeting you at your first office visit. If we can assist you with questions prior to your visit, please feel free to call. You may also see our website at <http://www.texaspulmonary.com> for answers to questions you may have.

Sincerely,

Scheduling Secretary



# TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.



## DIRECTIONS:

**Heading West on I-30**, exit Cooper Street. Turn left at the light. Turn right on Fuller. Fuller Street becomes Medical Centre Drive. Our office is in the third group of office buildings.

**Heading East on I-30**, exit North Fielder. Turn right at the light. Turn left on Randol Mill. Turn right on Magnolia. Turn left on Medical Centre Drive.

PATIENT REGISTRATION FORM

Date: \_\_\_\_\_

Patient Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_\_

Are you currently residing in a skilled nursing facility? Yes No If so, name of facility \_\_\_\_\_

Home Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State Zip+4 \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_

Patient Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State Zip+4 \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_ Religious Preference: \_\_\_\_\_

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 \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State Zip \_\_\_\_\_

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? \_\_\_\_\_ Phone \_\_\_\_\_

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? Yes No Date of illness or injury \_\_\_\_\_ Date last worked \_\_\_\_\_

Cause of accident, if any \_\_\_\_\_

Only with your written request will we release information regarding your medical condition to a family member. Do you wish information to be released to a family member? Yes No

Please list family members by name and relationship to you. \_\_\_\_\_

I hereby authorize release of my medical records from \_\_\_\_\_ to the physician(s) indicated below.

Arlington - North
Joseph Austin, Jr., M.D., FCCP
Jack G. Gilbey, Jr., M.D., FCCP
Luis F. Guerra, M.D., FCCP
Mitchell C. Kuppinger, M.D., FCCP
David H. Plump, M.D., FCCP
Tony H. Su, M.D., FCCP

Bedford
Gary L. Jones, M.D., FCCP
James T. Siminski, M.D., FCCP
Donald L. Washington, Jr., M.D.

Burleson
Dereje S. Ayo, M.D.
Henry S. Cunningham, M.D., FCCP

Fort Worth - Medical District 1
John R. Burk, M.D., FACP
Stuart D. McDonald, M.D., FCCP
Kerim F. Razack, M.D., FCCP

Fort Worth - Medical District 2
Steven Q. Davis, M.D.
Roger Gleason, M.D., FCCP
John T. Pender Jr., M.D., FCCP
David S. Hernandez, M.D.

Fort Worth - Southwest
Kevin G. Connelly, M.D., FCCP
Huy X. Duong, D.O.
David Maldonado, III, M.D.

Grapevine
R. L. "Lin" Cash, Jr., M.D., FCCP
Timothy G. Schroeder, M.D., FCCP

Mansfield
John L. Tiu, M.D.

North Richland Hills
David R. Herrmann, M.D., FCCP
Madhu S. Kollipara, M.D.

Sleep Consultants, Inc.
Donald E. Watenpaugh, Ph.D.

Signature of Patient or Responsible Party

Date

## FINANCIAL POLICY

### PRIMARY INSURANCE POLICY:

Insurance Co. \_\_\_\_\_ ID No. \_\_\_\_\_ Group No. \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insured's Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_  
Claims Mailing Address \_\_\_\_\_  
\_\_\_\_\_ Phone No. \_\_\_\_\_

### SECONDARY INSURANCE POLICY:

Insurance Co. \_\_\_\_\_ ID No. \_\_\_\_\_ Group No. \_\_\_\_\_  
Name of Insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Insured's Birth Date \_\_\_\_\_ SSN \_\_\_\_\_ Sex \_\_\_\_\_  
Claims Mailing Address \_\_\_\_\_  
\_\_\_\_\_ Phone No. \_\_\_\_\_

Responsible Party Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
Street City State Zip

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. All patients must complete our Information and Insurance Form before seeing the doctor. Full payment or copayment (if applicable) is due at the time of service. We accept cash, check, Visa, MasterCard, Discover or American Express.

#### ***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.

#### ***Out of Network Billing***

The physicians may not be participating physicians with your insurance plan, and if not, benefits may be reduced as such. You will be responsible for any unpaid charges and/or balances. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's (excluding Medicare) arbitrary determination of usual and customary rates.

#### ***Missed Appointments***

Unless canceled at least 24 hours in advance, our policy is to charge for missed office and oximetry appointments at the rate of \$25.00 and a separate charge for sleep testing at the rate of \$200.00. Please help us serve you better by keeping scheduled appointments.

\_\_\_\_\_  
**Signature of Patient or Responsible Party**

\_\_\_\_\_  
Date

#### ***Research Consent***

I give permission for clinical and physiologic data from my medical records to be used for educational and research purposes. I understand that my identity and contact information (name, SS#, birth date, address, etc.) will never be attached to or processed with such data.

\_\_\_\_\_  
**Signature of Patient or Responsible Party**

\_\_\_\_\_  
Date

PATIENT HEALTH QUESTIONNAIRE  
Texas Pulmonary & Critical Care Consultants, PA

To our patients: We appreciate your cooperation in completing this pulmonary health status profile. We are committed to providing a thorough evaluation during your visits and you can participate today by answering the following questions as they pertain to your general health. (A member of our staff is available to assist you if you have difficulty completing this form.)

1. If you have any of the following symptoms, circle all that apply.

- |                      |                     |            |
|----------------------|---------------------|------------|
| cough                | snoring             | chest pain |
| wheezing             | spitting blood      | fever      |
| abnormal chest x-ray | lump                | hoarseness |
| sore throat          | shortness of breath |            |

2. Other medical illnesses:

- |                    |                        |                      |
|--------------------|------------------------|----------------------|
| arthritis          | heart disease          | anxiety              |
| kidney disease     | bleeding problems      | liver disease        |
| cancer             | seizures               | depression           |
| skin problems      | diabetes               | stomach problems     |
| fainting episodes  | thyroid disease        | AIDS/related illness |
| psychiatric/mental | nervous system disease |                      |

3. Surgical history:

List all surgeries: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

4. Past chest x-rays (list most recent first):

LOCATION	REASON	APPROX. YEAR
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Smoking history:

AGE	PACKS PER DAY	BRAND/S
20	_____	_____
30	_____	_____
40	_____	_____
50	_____	_____
60	_____	_____
70	_____	_____

Exposure to secondhand tobacco smoke:

- |             |                 |                    |
|-------------|-----------------|--------------------|
| Never _____ | Rarely _____    | Occasionally _____ |
| Often _____ | Regularly _____ |                    |

6. Occupational/Hobbies/Activities

List any jobs or activities where you were exposed routinely to chemicals, powders, dusts, or other types of hazardous materials (i.e. ceramics or remodeling).

Activity	Years of exposure	Type of hazardous exposure (i.e. powder, dust, fumes, chemicals, household cleaners)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Home environment over past ten years. Please circle all that apply.

- Dog                      Cat                      Bird                      Livestock                      Horse  
 Gas heat                      Old carpets                      Oil heat                      Central air  
 Old drapes                      Feather pillows                      Indoor insect problem  
 Home located next to high electrical power lines                      Home flooding in the past

8. Travel within the past 20 years:

Outside of local region	Foreign
_____	_____
_____	_____
_____	_____
_____	_____

9. Weight loss or gain:

AGE	WEIGHT	AGE	WEIGHT
20	_____	50	_____
30	_____	60	_____
40	_____	70	_____

10. Social activities:

Alcoholic drinks per week:

Beer \_\_\_\_\_                      Wine \_\_\_\_\_                      Mixed drinks \_\_\_\_\_  
 Hard liquor \_\_\_\_\_

Substance abuse now or in the past:

Marijuana \_\_\_\_\_                      Cocaine \_\_\_\_\_                      Narcotics \_\_\_\_\_                      Valium \_\_\_\_\_  
 LSD \_\_\_\_\_                      IV drug use \_\_\_\_\_

11. List social activities you presently enjoy:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

12. Family history (major illnesses):

Parents:

Deceased Age

Mother: \_\_\_\_\_

\_\_\_\_\_

Father: \_\_\_\_\_

\_\_\_\_\_

Brothers/Sisters:

Brothers: \_\_\_\_\_

\_\_\_\_\_

Sisters: \_\_\_\_\_

\_\_\_\_\_

Grandparents (mother's side)

Grandfather: \_\_\_\_\_

\_\_\_\_\_

Grandmother: \_\_\_\_\_

\_\_\_\_\_

Grandparents (father's side)

Grandfather: \_\_\_\_\_

\_\_\_\_\_

Grandmother: \_\_\_\_\_

\_\_\_\_\_

13. Respiratory symptoms:

Answer if you have shortness of breath.

a. When? On exertion \_\_\_\_\_

At rest \_\_\_\_\_

When lying flat \_\_\_\_\_

b. For how long? Less than 6 months \_\_\_\_\_

6 to 12 months \_\_\_\_\_

1 to 3 years \_\_\_\_\_

3 to 5 years \_\_\_\_\_

5 to 10 years \_\_\_\_\_

Greater than 10 years \_\_\_\_\_

Does shortness of breath improve most after coughing up thick sputum? Yes \_\_\_\_\_ No \_\_\_\_\_

Does shortness of breath come on suddenly? Yes \_\_\_\_\_ No \_\_\_\_\_

Is shortness of breath associated with:

drenching sweats? \_\_\_\_\_ black-outs? \_\_\_\_\_

pounding heart? \_\_\_\_\_ chest pain? \_\_\_\_\_

wheezing? \_\_\_\_\_ swollen legs? \_\_\_\_\_

fever? \_\_\_\_\_ chills? \_\_\_\_\_

nausea? \_\_\_\_\_

Cough:

How long have you had trouble with coughing?

less than 1 month \_\_\_\_\_ 1 to 2 years \_\_\_\_\_

1 to 3 months \_\_\_\_\_ more than 2 years \_\_\_\_\_

3 months to a year \_\_\_\_\_

Has your usual cough changed recently? Yes \_\_\_\_\_ No \_\_\_\_\_

Does your cough produce sputum? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, what color? (Circle one or more)

clear yellow white green

tan brown red other

How much sputum do you produce over 24 hours?

less than 2 tablespoons \_\_\_\_\_

more than 2 tablespoons \_\_\_\_\_

Chest pain:

a. When do you have chest pain?

on exertion \_\_\_\_\_ at rest \_\_\_\_\_ after meals \_\_\_\_\_

b. How long does pain last?

few seconds \_\_\_\_\_ 5 minutes \_\_\_\_\_ 15 minutes \_\_\_\_\_ one hour \_\_\_\_\_ all day \_\_\_\_\_

c. How many years have you had chest pain?

1 to 3 years \_\_\_\_\_ more than 3 years \_\_\_\_\_

d. Is the chest pain worse than at anytime before?

Yes \_\_\_\_\_ No \_\_\_\_\_

e. What, if anything, makes the pain go away?

Resting \_\_\_\_\_ Eating \_\_\_\_\_

Medications (list): \_\_\_\_\_

I certify that all information is correct and complete. If any information should change, I will notify this office immediately.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Appointment of Authorized Representative

## 1. Identifying Information

Patient's name \_\_\_\_\_

Member's name \_\_\_\_\_

Member's address \_\_\_\_\_

Member's plan identification # \_\_\_\_\_

Provider's plan identification # \_\_\_\_\_

Service not paid / not authorized by plan \_\_\_\_\_

Date(s) of service \_\_\_\_\_

**2. Appointment.** I, \_\_\_\_\_, appoint Texas Pulmonary & Critical Care Consultants, P.A. and/or Sleep Consultants, Inc. to act as my authorized representative in requesting an appeal from \_\_\_\_\_ regarding its denial of services / denial of payment.

**3. Directed payment.** I agree that if the payment denial is overturned on appeal, the plan's payment should be paid directly to my authorized representative, and direct the plan to do so in that event.

**4. Member's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**5. Witness's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

PLEASE  
DO NOT  
STAPLE  
IN THIS  
AREA

### HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (VA File #) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)		1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER		b. EMPLOYER'S NAME OR SCHOOL NAME	
11. INSURED'S POLICY GROUP OR FECA NUMBER		c. INSURANCE PLAN NAME OR PROGRAM NAME	
11. INSURED'S POLICY GROUP OR FECA NUMBER		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>	

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED <b>X</b> DATE		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED <b>X</b>	
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14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY		15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		17a. I.D. NUMBER OF REFERRING PHYSICIAN		18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY	
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.	
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		23. PRIOR AUTHORIZATION NUMBER			

24. A	DATE(S) OF SERVICE			B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F \$ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
	From	To	To										
MM DD YY	MM DD YY	MM DD YY	MM DD YY										
1													
2													
3													
4													
5													
6													

25. FEDERAL TAX I.D. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO		27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)				32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)				33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #					
SIGNED				DATE				PIN#		GRP#			

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

Texas Pulmonary & Critical Care Consultants, P.A.  
Sleep Consultants, Inc.  
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

---

Name of Patient or Personal Representative

---

Description of Personal Representative's Authority