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

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**E. Duane Dilley, M.D., FCCP**  
**Phan Nguyen, M.D.**

601 Omega Drive, Suite 206  
Arlington, TX 76014  
(817) 465-5881

Patient Name: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_

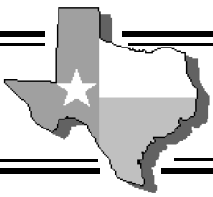
You have been scheduled for an initial consultation or hospital follow-up appointment with \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_ with a check-in time of \_\_\_\_\_. The next page of this packet is a detailed map to our facility. Below is a list of important information to assist you in preparing for 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. You need only to sign lines 12 and 13 on the "Health Insurance Claim Form". This allows us to bill your insurance and receive payment.
- 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. (New patients only – this does not apply to hospital follow-up patients.)
- Please have your referring physician fax to our office or send with you any recent office notes and lab work.
- You must bring a list of your current medications with dosage and frequency. You may bring the medication bottles if you prefer and the clinical staff can list them in 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 817-465-5881 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.

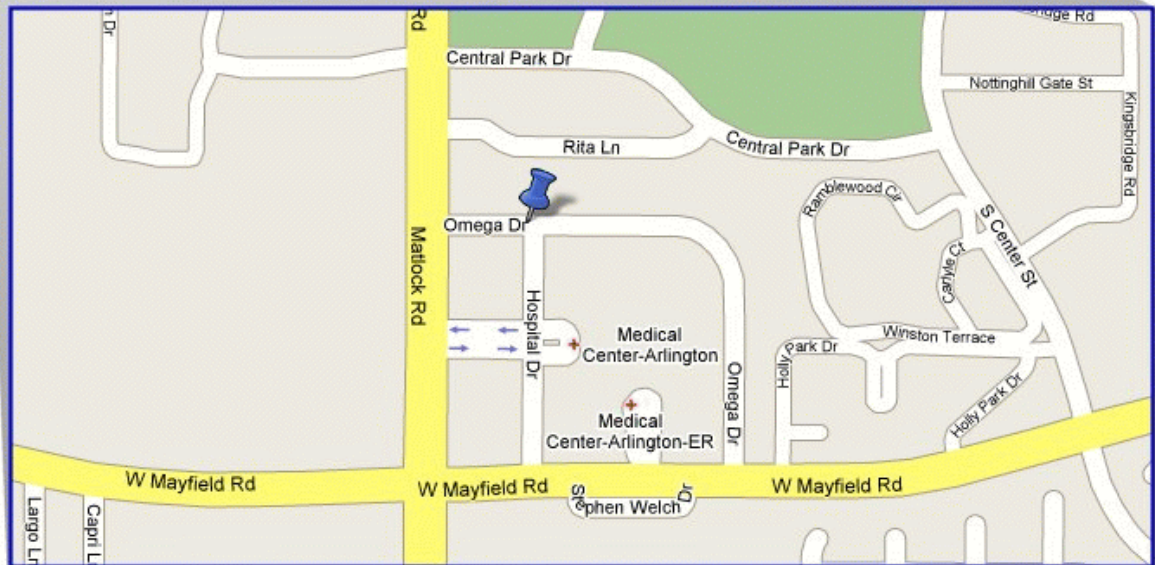
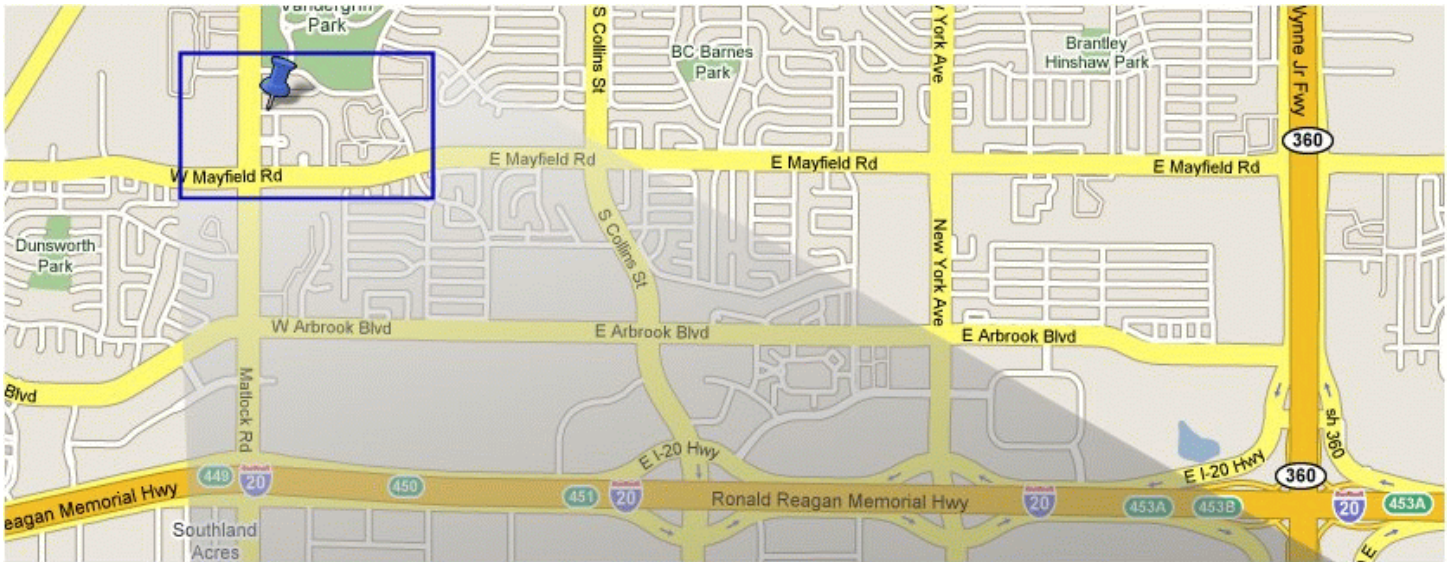
**E. Duane Dilley, M.D., FCCP**

**Phan Nguyen, M.D.**

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Arlington, TX 76014

817-465-5881



## **DIRECTIONS:**

1. Major crossroads are south I-20, and Matlock Road
2. We are north of Mayfield and east of Matlock
3. Turn east onto Omega drive. Our building is on the left-hand side.

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 \_\_\_\_\_

Email address where you would like to receive correspondence from our office \_\_\_\_\_

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
Subramanian Malaisamy, M.D., MRCP
Stuart D. McDonald, M.D., FCCP
Kerim F. Razack, M.D., FCCP

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

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

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

Mansfield
John L. Tiu, M.D., FCCP

North Richland Hills
David R. Herrmann, M.D., FCCP
T. Brad Raper, M.D.

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

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

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

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

5. Medications (prescription and nonprescription):

Name of medication	Dose	Times per day	Length of time used	Prescribing Physician

List **allergies** to:

Drugs: \_\_\_\_\_  
 Food: \_\_\_\_\_  
 Environment: \_\_\_\_\_

6. Smoking history:

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

Exposure to secondhand tobacco smoke:

Never \_\_\_\_\_ Rarely \_\_\_\_\_ Occasionally \_\_\_\_\_  
Often \_\_\_\_\_ Regularly \_\_\_\_\_

7. 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)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. 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

9. Travel within the past 20 years:

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

10. Weight loss or gain:

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

11. 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 \_\_\_\_\_



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

APPROVED OMB-0938-0008

CARRIER  
PATIENT AND INSURED INFORMATION  
PHYSICIAN OR SUPPLIER INFORMATION

### 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"/>		4. INSURED'S NAME (Last Name, First Name, Middle Initial)			
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>				7. INSURED'S ADDRESS (No., Street)					
CITY			STATE			8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>				CITY			STATE		
ZIP CODE			TELEPHONE (Include Area Code) ( )			Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>				ZIP CODE			TELEPHONE (INCLUDE AREA CODE) ( )		
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO:				11. INSURED'S POLICY GROUP OR FECA NUMBER					
a. OTHER INSURED'S POLICY OR GROUP NUMBER						a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO				a. INSURED'S DATE OF BIRTH MM DD YY				SEX M <input type="checkbox"/> F <input type="checkbox"/>	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY						b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO				b. EMPLOYER'S NAME OR SCHOOL NAME					
c. EMPLOYER'S NAME OR SCHOOL NAME						c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				c. INSURANCE PLAN NAME OR PROGRAM NAME					
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE				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 **X**

DATE

SIGNED **X**

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							

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

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

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**Signature of Patient or Personal Representative**

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Date

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Name of Patient or Personal Representative

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Description of Personal Representative's Authority