

TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

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

1604 Hospital Parkway, Suite 403
Bedford, TX 76022
817-354-9545

Patient Name: _____

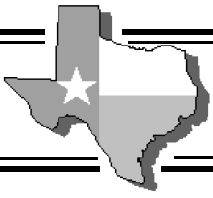
You have been scheduled for an initial consultation or hospital follow-up appointment with _____ on _____ at _____ with a check-in time of _____. The next page of this packet is a detailed map to our facility. Below is a list of important information to assist you in preparing for this appointment.

- **Paperwork:** This must be completed before your appointment. Failure to do so may necessitate rescheduling your appointment. Leave blank any questions you don't understand and we can help you. Otherwise, call our office if you have questions. If you are a new patient to our office, but we have seen you in the hospital, you are still required to fill out the paperwork completely. 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.

Health Insurance Claim Form: You need only to sign on lines 12 and 13. You do not need to complete the entire form.

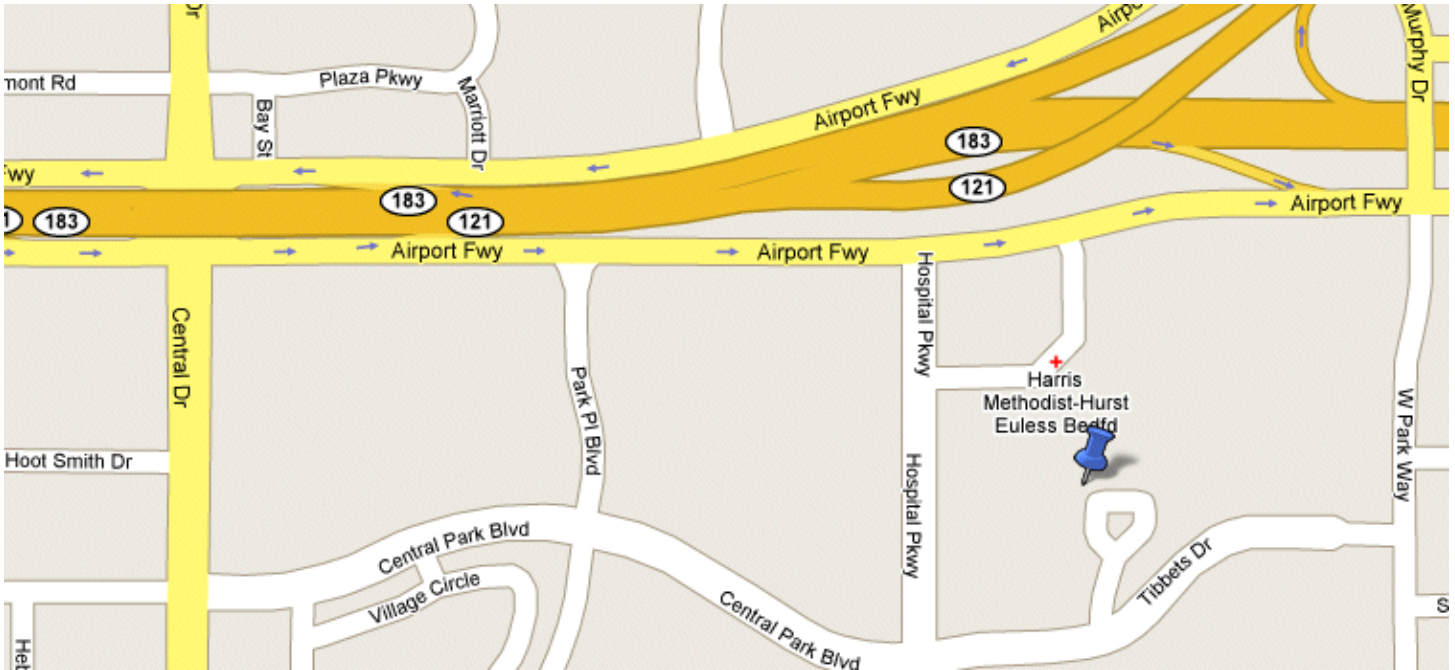
- **X-rays:**
Bring: Chest x-rays and CT scans of the chest done within the last three to six months. Must be actual films. If you have been told by your Primary Care Physician's office or an x-ray department that the films would be sent to our office, please call us and make sure the films are here, before your appointment. Failure to do so may necessitate doing another x-ray or rescheduling your appointment if the films involve CT scans.
- **Referrals:** Make sure you have requested a referral from your primary care physician if your insurance requires this. Please have your referring physician fax to our office or send with you any recent office notes and lab work.
- **Insurance cards:** We will need a copy of your insurance card and driver's license. If you have Medicaid, we need a current copy (form 3087).
- **Payment:** Co-pays are due at time of visit. As a courtesy, we will file claims to your primary and secondary insurance (we will not file a third insurance). If our physicians are not in your insurance network, you will be required to pay a minimum of 20% of your visit.
Hospital Follow-up Patients with a balance: Payment is expected at the time of your visit. Payment arrangements can be made to meet your financial needs if necessary. Please let us know.
- **Respiratory irritants:** Many of our patients have sensitive respiratory conditions. Please avoid use of scented body spray, perfume, cologne, aftershave, or anything with a heavy scent.
- **Need to reschedule?** Please call us at least 24 hours prior to your appointment if you need to cancel or reschedule. 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. Insurance does not cover this charge; it is the patient's responsibility. 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.



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DIRECTIONS:

Major crossroads are 183 (Airport Freeway), Central Dr. and Murphy Drive. We are south of 183, and east of Central Drive and West of Murphy Drive. You can get to the office from either Central or Murphy. We are located in the Professional Building of Harris Methodist Hospital next to the Emergency Room Entrance on the back side of the hospital. You'll need to go into the main entrance of the Professional Building, walk to the elevators. Once on the elevator you'll proceed to the fourth floor and then exit to the left. We are the second door on the left.

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.
Burlington
Dereje S. Ayo, M.D.
Henry S. Cunningham, 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.

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

Arlington - South
E. Duane Dilley, M.D., FCCP
Phan Nguyen, M.D.

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

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 Medical History Form

Please complete the questions on this form before your office visit.

Patient Name: _____ DOB: _____ Age: _____ Height: _____

Names of physicians now treating you: _____

Please list any surgeries you have had: _____

Please list ALL medical illnesses: _____

Please list any medication **allergies**, and what effect you experienced:

Medication: _____ Dose: _____ Reaction: _____

Medication: _____ Dose: _____ Reaction: _____

Medication: _____ Dose: _____ Reaction: _____

Medication: _____ Dose: _____ Reaction: _____

Medication: _____ Dose: _____ Reaction: _____

Please list the name, dose, and frequency of all current medication(s):

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Medication: _____ Dose: _____ Medication: _____ Dose: _____

Do you use Tobacco? Yes ___ No ___ Alcohol? Yes ___ No ___ Other? Yes ___ No ___

Family History: Father alive? Yes ___ No ___ Mother alive? Yes ___ No ___

Brother(s) alive? Yes ___ No ___ Sister(s) alive? Yes ___ No ___

Children? Yes ___ No ___ How many? _____

Do any illnesses run in your family? Yes ___ No ___ If so, what? _____

List all occupations you have had: _____

Were you exposed to chemicals or industrial dusts? _____

If so, what? _____

Do you have any pets at home? Yes ___ No ___ If so, what kind? _____

Do you have any hobbies that expose you to chemicals, industrial dusts, fumes, or animals? Yes ___ No ___

If so, please list them: _____

ONLY with your written request, we will release information regarding your medical condition to a family member.

Do you wish information to be related to a family member? Yes ___ No ___ If so, please list the family member(s)

by full name and relationship to you.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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.												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 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					
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)												22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					
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)																			
SIGNED												DATE												33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #							
																								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.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority