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

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

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

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

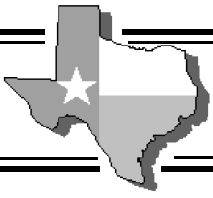
You have been scheduled for an initial consultation or hospital follow-up appointment with \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_ with a check-in time of \_\_\_\_\_. The next page of this packet is a detailed map to our facility. Below is a list of important information to assist you in preparing for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

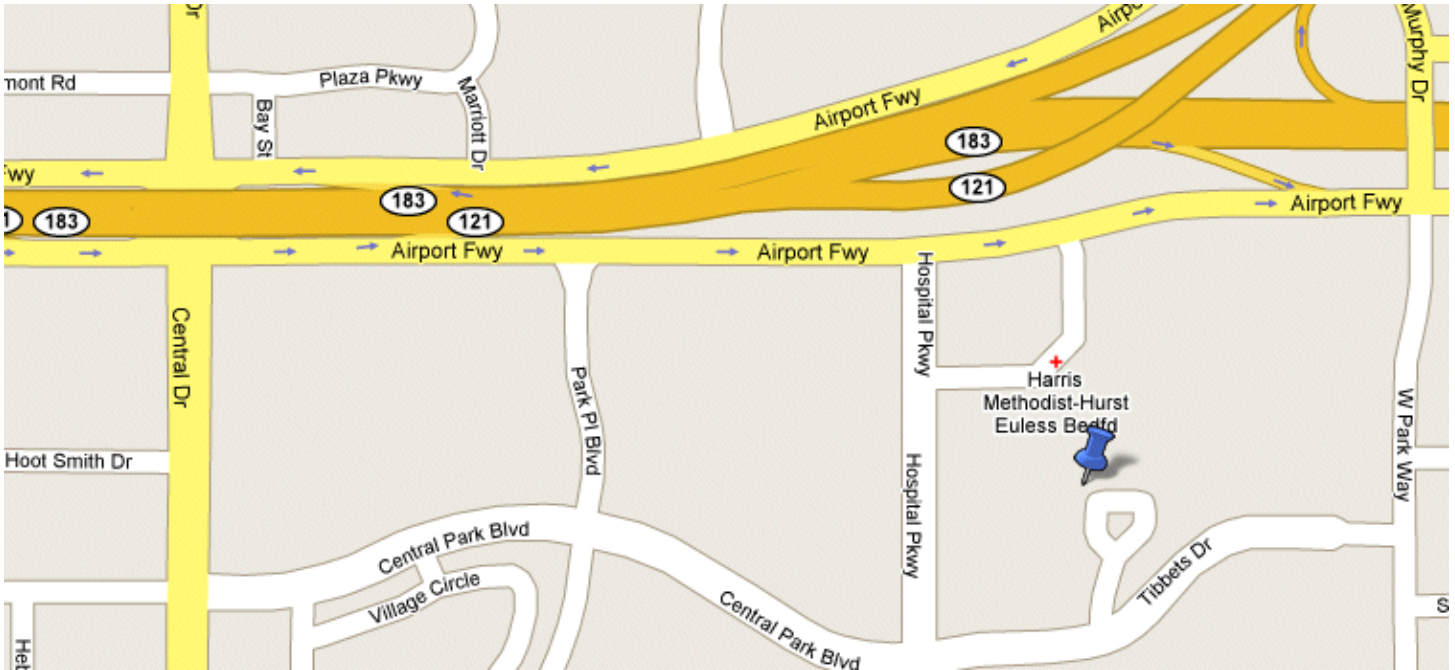
- **X-rays:**  
Bring: Chest x-rays and CT scans of the chest done within the last three to six months. Must be actual films. If you have been told by your Primary Care Physician's office or an x-ray department that the films would be sent to our office, please call us and make sure the films are here, 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 \_\_\_\_\_

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 \_\_\_\_\_

## 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: \_\_\_\_\_



**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**