

---

---

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

---

---

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

11797 S. Freeway, Suite 330  
Burleson, Texas 76028  
(817) 293-1900  
(817) 293-4930 Fax

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

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

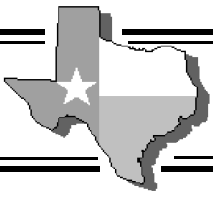
You have been scheduled for an initial consultation or hospital follow-up appointment with \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_ with a check-in time of \_\_\_\_\_. The next page of this packet is a detailed map to our facility. Below is a list of important information to assist you in preparing for 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.
- If not already done, 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 about 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 817-293-1900 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.

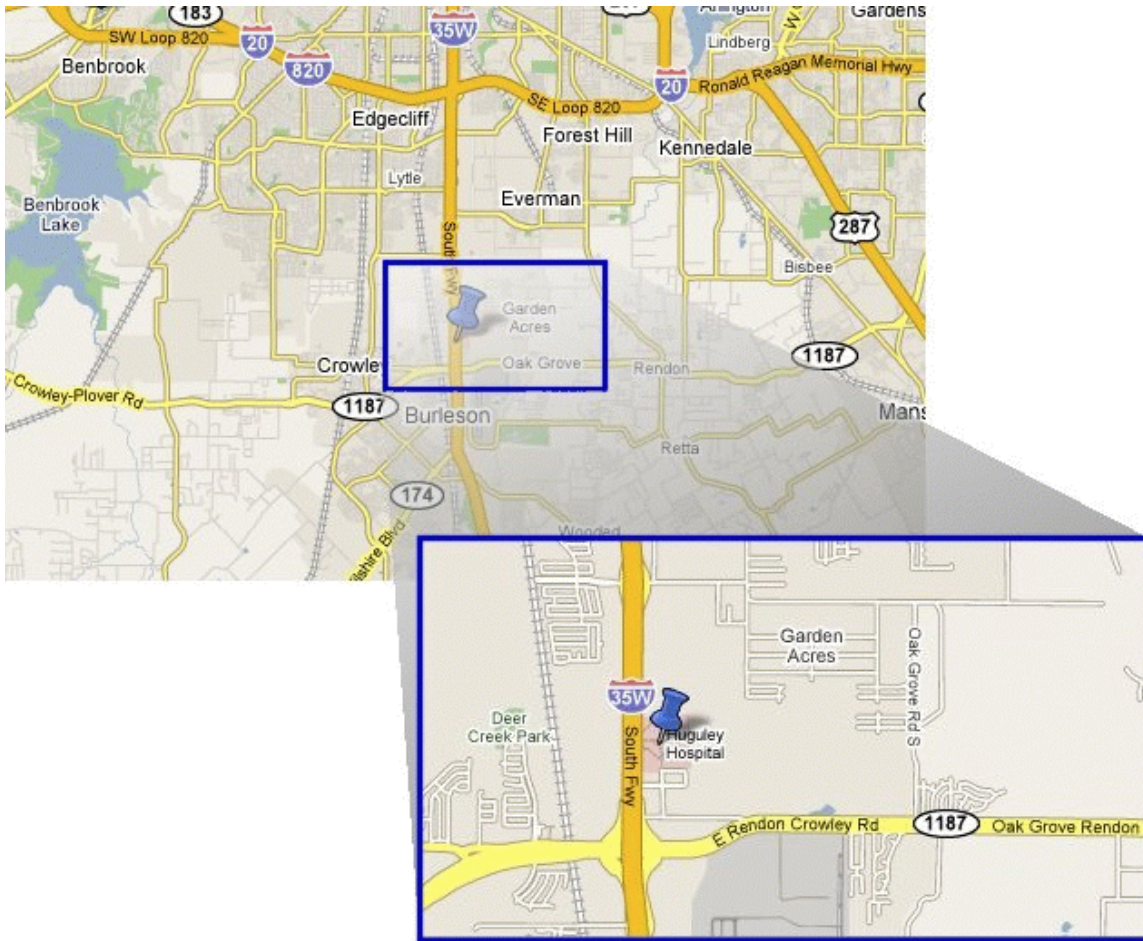
Sincerely,

Texas Pulmonary & Critical Care Consultants



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

Dereje S. Ayo, M.D.  
Henry S. Cunningham, M.D.  
11797 S. Freeway, Suite 330  
Burleson, TX 76028  
817-293-1900



## **From Fort Worth:**

Proceed to I-35W South driving toward Waco. Take Exit 39, Rendon-Crowley Road. Take a left at the stop light and proceed over the overpass and take another left at the stop light. Stay on the access road until you come to the Huguley campus on your right.

## **From Burleson or Waco:**

I-35 Northbound take Exit 39, McAllister and Rendon-Crowley Road. Stay on the access road until you come to the Huguley campus on your right.

**It is best to enter the building through the Admissions Lobby, take the elevator located off the lobby to the third floor. Turn right off the elevator and turn the corner. Office sits on the left-hand side, suite 330.**

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.
Burlison
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

# PULMONARY HEALTH QUESTIONNAIRE

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

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

## History

Brief description of present problem/complaint: \_\_\_\_\_

## Past History

Have you ever had (X = Yes answers, If NO leave blank):

- |                                       |  |   |  |
|---------------------------------------|--|---|--|
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Emphysema         | <input type="checkbox"/> Pulm fibrosis/Scarring   | <input type="checkbox"/> Cancer              |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Bronchitis        | <input type="checkbox"/> Sleep apnea              | <input type="checkbox"/> Kidney Problems     |
| <input type="checkbox"/> Pneumonia    | <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Sarcoidosis  | <input type="checkbox"/> Thyroid problems  | <input type="checkbox"/> Atrial fibrillation      | <input type="checkbox"/> GERD/Indigestion    |
| <input type="checkbox"/> Blood clots  | <input type="checkbox"/> Liver problems    | <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Seizure      | <input type="checkbox"/> HIV/AIDS          | <input type="checkbox"/> Heart attack/Angina      | <input type="checkbox"/> Arthritis           |

Date of last **Flu shot** (Influenza vaccine) \_\_\_\_\_ Date of last **Pneumonia shot** (Pneumococcal vaccine) \_\_\_\_\_

Have you had surgery?

Date: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

Date: \_\_\_\_\_ Type of surgery: \_\_\_\_\_

## Social History

**Occupation**/Describe what do you do at work: \_\_\_\_\_

**Pets:** \_\_\_\_\_

**Children:** \_\_\_\_\_

Current **smoker**? \_\_\_\_\_ If yes, **packs per day:** \_\_\_\_\_ **How many years?** \_\_\_\_\_

Past **smoker**? \_\_\_\_\_ If yes, **packs per day:** \_\_\_\_\_ **How many years?** \_\_\_\_\_

Do you drink **alcoholic beverages**? \_\_\_\_\_ If yes, how many per week? \_\_\_\_\_

Have you ever used marijuana or any other hard drug? \_\_\_\_\_

## Allergies

Are you allergic to any medications? (List/give reaction) \_\_\_\_\_

Are you allergic to anything else? \_\_\_\_\_

## Family History

Relationship	Age(s) (if living)	Age(s) at death	Illnesses/cause(s) of death
Mother			
Father			
Sisters			
Brothers			
Children			

**Review of Systems** (Please check yes or no)

Yes No

**General:**

\_\_\_\_\_ \_\_\_\_\_ Recent weight change  
\_\_\_\_\_ \_\_\_\_\_ Fever/chills  
\_\_\_\_\_ \_\_\_\_\_ Sweats  
\_\_\_\_\_ \_\_\_\_\_ Fatigue

**Skin:**

\_\_\_\_\_ \_\_\_\_\_ Skin rash

**Head/Eyes/Ears/Nose/Throat:**

\_\_\_\_\_ \_\_\_\_\_ Visual problems/changes  
\_\_\_\_\_ \_\_\_\_\_ Itchy eyes or nose  
\_\_\_\_\_ \_\_\_\_\_ Nose bleeds  
\_\_\_\_\_ \_\_\_\_\_ Hoarseness

**Respiratory:**

\_\_\_\_\_ \_\_\_\_\_ Coughing  
\_\_\_\_\_ \_\_\_\_\_ Wheezing  
\_\_\_\_\_ \_\_\_\_\_ Frequent colds or bronchitis

**Cardiovascular:**

\_\_\_\_\_ \_\_\_\_\_ Chest pain  
\_\_\_\_\_ \_\_\_\_\_ Swelling of feet/ankles  
\_\_\_\_\_ \_\_\_\_\_ Heart murmur  
\_\_\_\_\_ \_\_\_\_\_ Irregular heart beat

**Gastrointestinal:**

\_\_\_\_\_ \_\_\_\_\_ Nausea/Vomiting  
\_\_\_\_\_ \_\_\_\_\_ Vomiting blood  
\_\_\_\_\_ \_\_\_\_\_ Constipation  
\_\_\_\_\_ \_\_\_\_\_ Difficulty swallowing

**Genitourinary:**

\_\_\_\_\_ \_\_\_\_\_ Blood in urine

**Musculoskeletal:**

\_\_\_\_\_ \_\_\_\_\_ Joint pain/swelling  
\_\_\_\_\_ \_\_\_\_\_ Back pain

**Neurologic:**

\_\_\_\_\_ \_\_\_\_\_ Numbness  
\_\_\_\_\_ \_\_\_\_\_ Tremors

**Psychiatric:**

\_\_\_\_\_ \_\_\_\_\_ Depression

Yes No

\_\_\_\_\_ \_\_\_\_\_ Sleeping problems  
\_\_\_\_\_ \_\_\_\_\_ Loud snoring  
\_\_\_\_\_ \_\_\_\_\_ Morning headaches  
\_\_\_\_\_ \_\_\_\_\_ Feeling that sleep is not restful

\_\_\_\_\_ \_\_\_\_\_ Any new skin marks/spots

\_\_\_\_\_ \_\_\_\_\_ Headaches  
\_\_\_\_\_ \_\_\_\_\_ Drainage  
\_\_\_\_\_ \_\_\_\_\_ Sore Throats  
\_\_\_\_\_ \_\_\_\_\_ Sinus infections

\_\_\_\_\_ \_\_\_\_\_ Coughing up blood  
\_\_\_\_\_ \_\_\_\_\_ Coughing mucus (color \_\_\_\_\_)  
\_\_\_\_\_ \_\_\_\_\_ Shortness of breath

\_\_\_\_\_ \_\_\_\_\_ Heart attack  
\_\_\_\_\_ \_\_\_\_\_ Dizziness  
\_\_\_\_\_ \_\_\_\_\_ Shortness of breath w/walking  
\_\_\_\_\_ \_\_\_\_\_ Palpitations

\_\_\_\_\_ \_\_\_\_\_ Abdominal pain  
\_\_\_\_\_ \_\_\_\_\_ Heartburn/Indigestion  
\_\_\_\_\_ \_\_\_\_\_ Diarrhea  
\_\_\_\_\_ \_\_\_\_\_ Bloody/black stools

\_\_\_\_\_ \_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ Muscle aches  
\_\_\_\_\_ \_\_\_\_\_ Muscle pain

\_\_\_\_\_ \_\_\_\_\_ Weakness/paralysis  
\_\_\_\_\_ \_\_\_\_\_ Seizures

\_\_\_\_\_ \_\_\_\_\_ Anxiety/panic attacks

\_\_\_\_\_  
**Patient 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. 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"/>			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									

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	MM	DD	YY	MM										
1																
2																
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER				SSN EIN <input type="checkbox"/> <input type="checkbox"/>		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.  
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