



TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

Henry S. Cunningham, M.D., FCCP
Subramanian Malaisamy, M.D.

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.

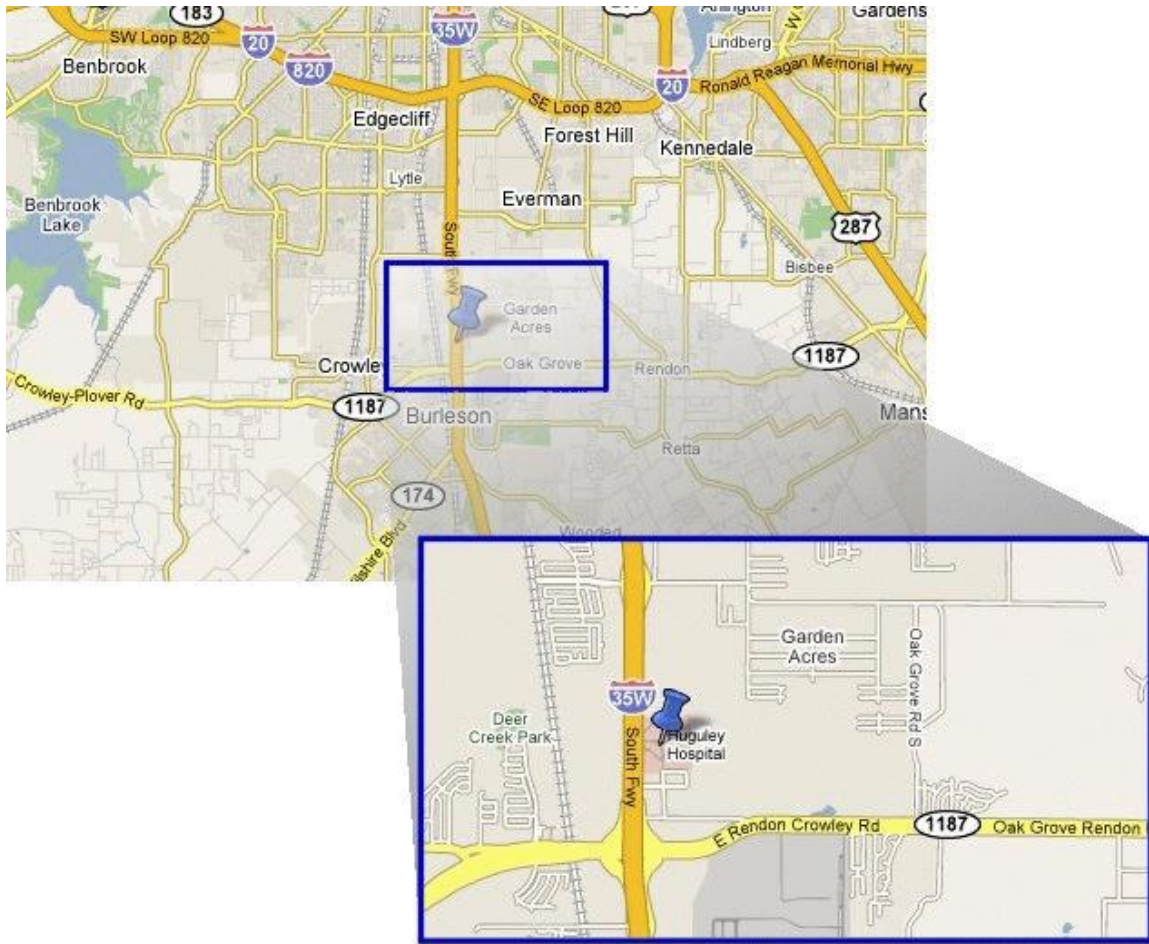
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Burleson, TX 76028

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 _____

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
Henry S. Cunningham, M.D., FCCP
Subramanian Malaisamy, M.D.

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
Harpreet S. Suri, M.D.

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.
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

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):

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

Yes No

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

Skin:

_____ _____ Skin rash

_____ _____ Any new skin marks/spots

Head/Eyes/Ears/Nose/Throat:

_____ _____ Visual problems/changes
_____ _____ Itchy eyes or nose
_____ _____ Nose bleeds
_____ _____ Hoarseness

_____ _____ Headaches
_____ _____ Drainage
_____ _____ Sore Throats
_____ _____ Sinus infections

Respiratory:

_____ _____ Coughing
_____ _____ Wheezing
_____ _____ Frequent colds or bronchitis

_____ _____ Coughing up blood
_____ _____ Coughing mucus (color _____)
_____ _____ Shortness of breath

Cardiovascular:

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

_____ _____ Heart attack
_____ _____ Dizziness
_____ _____ Shortness of breath w/walking
_____ _____ Palpitations

Gastrointestinal:

_____ _____ Nausea/Vomiting
_____ _____ Vomiting blood
_____ _____ Constipation
_____ _____ Difficulty swallowing

_____ _____ Abdominal pain
_____ _____ Heartburn/Indigestion
_____ _____ Diarrhea
_____ _____ Bloody/black stools

Genitourinary:

_____ _____ Blood in urine

Musculoskeletal:

_____ _____ Joint pain/swelling
_____ _____ Back pain

_____ _____ Muscle aches
_____ _____ Muscle pain

Neurologic:

_____ _____ Numbness
_____ _____ Tremors

_____ _____ Weakness/paralysis
_____ _____ Seizures

Psychiatric:

_____ _____ Depression

_____ _____ Anxiety/panic attacks

Patient Signature

Date

We request that you bring all of your current medications (actual bottles please) so a correct list can be made for your chart. If you cannot, make a complete, accurate list of your current medications. Use the table below if necessary.

Medication	Dose	Times per day	Length of time used	Prescribing Physician

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

CARRIER

HEALTH INSURANCE CLAIM FORM

PICA										PICA																																																											
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) ()										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										b. OTHER INSURED'S DATE OF BIRTH MM DD YY										SEX M <input type="checkbox"/> F <input type="checkbox"/>					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										c. EMPLOYER'S NAME OR SCHOOL NAME										d. INSURANCE PLAN NAME OR PROGRAM NAME										b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										b. EMPLOYER'S NAME OR SCHOOL NAME										c. INSURANCE PLAN NAME OR PROGRAM NAME									
c. EMPLOYER'S NAME OR SCHOOL 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 <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/>																																																						
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 To From MM DD YY MM DD YY										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														
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#																																							

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