

TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

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

6100 Harris Parkway, Suite 285
Fort Worth, Texas 76132
(817) 263-5864
(817) 263-3791 Fax

Patient Name: _____

Referring Physician: _____

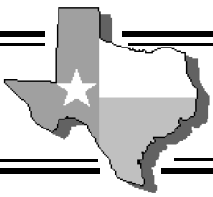
You have been scheduled for an initial consultation or hospital follow-up appointment with _____ on _____ at _____ with a check-in time of _____. The next page of this packet is a detailed map to our facility. Below is a list of important information to assist you in preparing for this appointment.

- 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 817-263-5864 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.

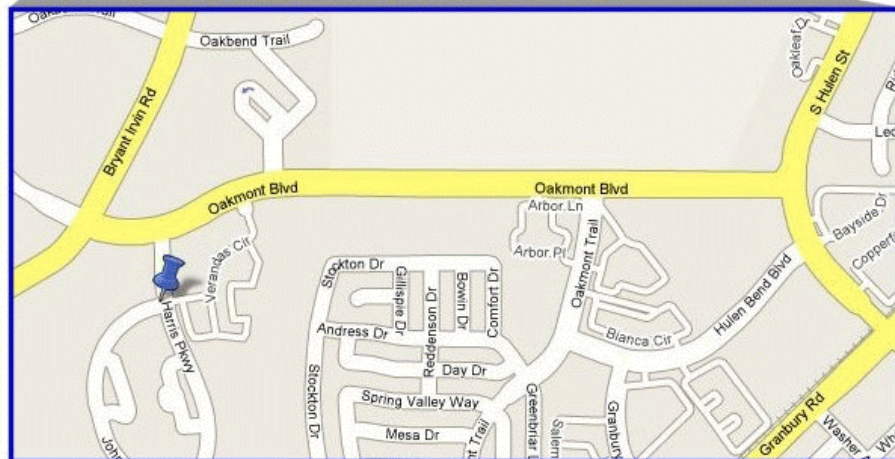
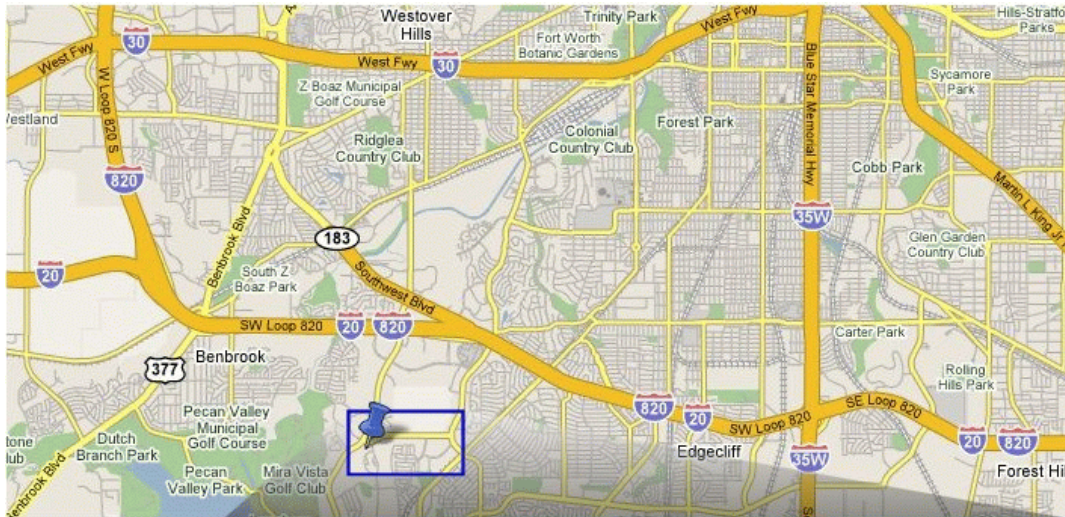
Sincerely,

Texas Pulmonary & Critical Care Consultants



TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

Dr. Kevin Connelly
Dr. Huy Duong
Dr. David Maldonado, III
6100 Harris Parkway, Suite 285
Fort Worth, Texas 76132
(817) 263-5864



From Burleson or Waco :

Proceed to I-35W North driving toward Fort Worth. Take exit (45A) to merge into I-20/820W toward Abilene. Take the Bryant Irvin Road exit. Turn left onto Bryant Irvin Rd. Go south on Bryant Irvin Rd. Turn left onto Oakmont Blvd. Turn right onto Harris Parkway. Go one block and the hospital will be on your right. Pull into the main parking lot. Follow signs to the Plaza section of the hospital. (This will be the north side of the hospital). When you enter the plaza, turn left to the bank of elevators. Take the elevator to the second floor. From the elevator, go right to suite 285. We are located on the right side at the end of the hall.

From Abilene:

Proceed to I-20E/ US80-E driving East toward Fort Worth. Continue to follow I-20 E. Take the Bryant Irvin Road exit and turn right (south) on Bryant Irvin Road. Turn left onto Oakmont Blvd. Turn right onto Harris Parkway. Go one block and the hospital will be on your right. Pull into the main parking lot. Follow signs to the Plaza section of the hospital. (This will be the north side of the hospital). When you enter the plaza, turn left to the bank of elevators. Take the elevator to the second floor. From the elevator, go right to suite 285. We are located on the right side at the end of the hall.

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

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: _____

Do you **smoke**? _____ If yes, how much? _____ Pks per day

If you quit, when and why? _____

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

Yes No

General:

<input type="checkbox"/>	<input type="checkbox"/>	Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping problems
<input type="checkbox"/>	<input type="checkbox"/>	Fever/chills	<input type="checkbox"/>	<input type="checkbox"/>	Loud snoring
<input type="checkbox"/>	<input type="checkbox"/>	Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Morning headaches
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Feeling that sleep is not restful

Skin:

<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	Any new skin marks/spots
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Head/Eyes/Ears/Nose/Throat:

<input type="checkbox"/>	<input type="checkbox"/>	Visual problems/changes	<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Itchy eyes or nose	<input type="checkbox"/>	<input type="checkbox"/>	Drainage
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throats
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Sinus infections

Respiratory:

<input type="checkbox"/>	<input type="checkbox"/>	Coughing	<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Coughing mucus (color _____)
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds or bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath

Cardiovascular:

<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of feet/ankles	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath w/ walking
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations

Gastrointestinal:

<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn/Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Bloody/black stools

Genitourinary:

<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	
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Musculoskeletal:

<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/swelling	<input type="checkbox"/>	<input type="checkbox"/>	Muscle aches
<input type="checkbox"/>	<input type="checkbox"/>	Back pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain

Neurologic:

<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Weakness/paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	Seizures

Psychiatric:

<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/panic attacks
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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"/>	
5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (Include Area Code) ()		6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street) 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:	
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>		b. AUTO ACCIDENT? PLACE (State) <input type="checkbox"/> YES <input type="checkbox"/> NO	
c. EMPLOYER'S NAME OR SCHOOL NAME		c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. RESERVED FOR LOCAL USE	
11. INSURED'S POLICY GROUP OR FECA NUMBER		a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>	
11. INSURED'S POLICY GROUP OR FECA NUMBER		b. EMPLOYER'S NAME OR SCHOOL NAME	
11. INSURED'S POLICY GROUP OR FECA NUMBER		c. INSURANCE PLAN NAME OR PROGRAM NAME	
11. INSURED'S POLICY GROUP OR FECA NUMBER		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		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	
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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	DATE(S) OF SERVICE			B	C	D	E	F	G	H	I	J	K
	From	To	To										
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#			

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