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

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John L. Tiu, M.D.  
2800 E. Broad Street, Suite 514  
Mansfield, TX 76063  
817-453-8883

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

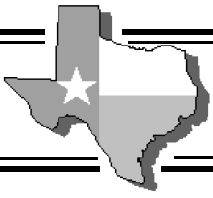
You have been scheduled for an initial consultation or hospital follow-up appointment with \_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_ with a check-in time of \_\_\_\_\_. The next page of this packet is a detailed map to our facility. Below is a list of important information to assist you in preparing for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

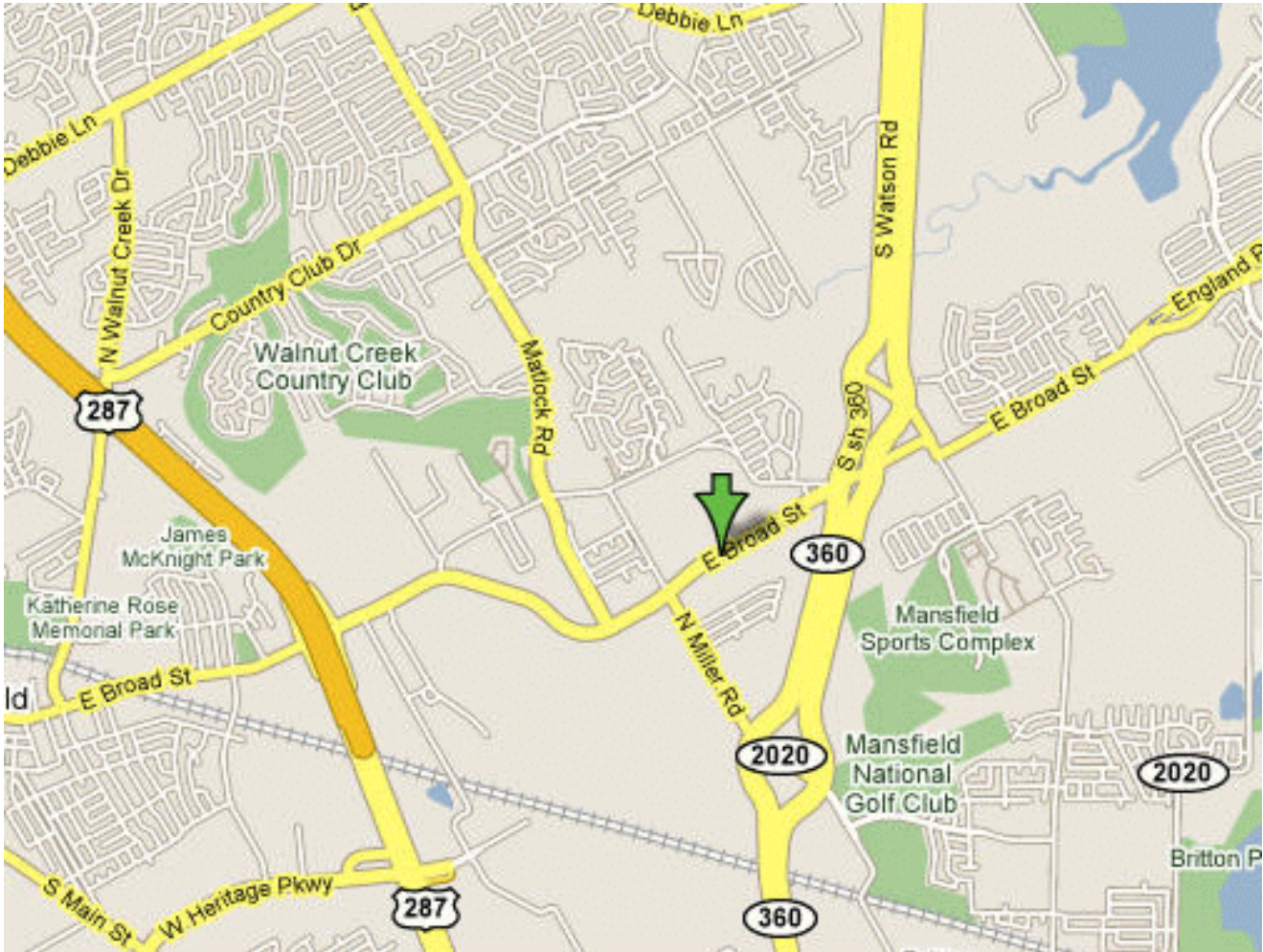
- **X-rays:** New Patients Only (this does not apply to hospital follow-up patients)  
Bring: Chest x-rays and CT scans of the chest done within the last three to six months. Must be actual films. If you have been told by your Primary Care Physician's office or an x-ray department that the films would 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. Insurance will be filed.  
Out-of-Network - depending on your insurance and benefits, you may be required to pay part or all of the charges associated with your visit.  
Hospital Follow-up Patients with a balance: Payment is expected at the time of your visit. A coupon book can be made available to you for payments if this meets your financial needs. Please let us know.
- **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 and it would have to be paid before a new appointment could be scheduled. 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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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

**PATIENT QUESTIONNAIRE:**

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

Why are you here to see the doctor today? Briefly describe your pulmonary (lung) problem. Tell when and how it began.

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

Have you ever had any pulmonary (lung) problems as a child (asthma, wheezing, shortness of breath, recurrent lung infections)? If yes, please list the problems.

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

**Respiratory symptoms:**

**Shortness of breath:**

When do you have shortness of breath?

On exertion    At rest    Both

How long has this been going on (days, weeks, months or years)? \_\_\_\_\_

If your shortness of breath happens on exertion, approximately how far can you walk or how much activity can you do before you become short of breath? \_\_\_\_\_

\_\_\_\_\_

Does shortness of breath come on suddenly?    Yes    No

What, if anything, makes the shortness of breath better or worse?

Does it improve after coughing up thick sputum?    Yes    No

Is it improved after taking any particular medications? If yes, which ones?

\_\_\_\_\_

Is it worse in any particular position (i.e.: lying down, bending over)?

\_\_\_\_\_

Is it worse after eating?    Yes    No

Is it worse with exposure to dust, fumes, cold air, other?

\_\_\_\_\_

Is the shortness of breath associated with: Circle all that apply.

Drenching sweats    Blackouts    Pounding heart    Chest pain    Wheezing  
Swollen legs    Fever    Chills    Nausea/vomiting

**Cough:**

How long have you had trouble with coughing? \_\_\_\_\_

Has your cough changed recently?    Yes    No

If yes, how has it changed? \_\_\_\_\_

Has your cough ever awakened you from sleep? If yes, how often does this occur?

\_\_\_\_\_

Does your cough produce sputum?    Yes    No

If yes, what color? (Circle one or more)

Clear    yellow    white    green    tan    brown    red    other \_\_\_\_\_

**PATIENT QUESTIONNAIRE:**

How much sputum do you produce over 24 hours?

Less than 2 tablespoons      More than 2 tablespoons

Have you ever coughed up blood? If yes, when and how much? \_\_\_\_\_

What, if anything, makes your cough better or worse?

Is it improved after taking any particular medications? If yes, which ones?

Is it worse in any particular position (i.e.: lying down, bending over)?

Is it worse after eating?    Yes    No

Is it worse with exposure to dust, fumes, cold air, other?

**Chest Pain:**

Where exactly is the chest pain located (ie: front, back, left, right)? \_\_\_\_\_

When do you have chest pain?

On exertion      At rest      After meals

How long does the pain last?

Few seconds      5 minutes      15 minutes      1 hour      All day

How long have you had chest pain?

Less than a year      1 to 3 years      More than 3 years

Is the pain increasing in frequency or intensity?    Yes    No

What, if anything, makes the pain go away?    Resting      Eating      Medication (list): \_\_\_\_\_

**Past chest x-rays:**

Location	Reason	Date (month and year)

**Review of systems:**

If you have had any of the following symptoms recently, please circle all that apply:

General:      fevers      chills      night sweats (enough to soak your shirt or sheets)  
weight loss/gain (how much? \_\_\_\_\_ In what amount of time? \_\_\_\_\_)

Head, eyes, ears, nose, throat:

itchy/watery eyes      hay fever  
post nasal drainage      bleeding nose or gums  
sore throat      hoarseness  
sinus congestion or drainage (color? \_\_\_\_\_)

Cardiovascular:    shoulder or arm pain      swelling in your legs  
shortness of breath when lying flat  
awakening at night short of breath

**PATIENT QUESTIONNAIRE:**

Pulmonary: snoring insomnia daytime sleepiness  
legs twitches/discomfort

Gastrointestinal: nausea vomiting diarrhea constipation heartburn  
reflux indigestion abdominal/stomach pain

Genitourinary: bloody urine painful urination trouble starting/stopping

Musculoskeletal: joint pain or swelling muscle pain

Hematologic: easy bleeding or bruising

Lymphatic: swelling of lymph nodes under jaw, on neck, under arms or in groin

Skin: new rashes or spots

Back: pain or swelling

Neurological: headaches seizures passing out numbness/tingling in hands or feet

**Past Medical History:**

Please list any current or past medical illnesses and hospitalizations and the approximate dates:

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

Please list all surgeries and approximate dates:

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

**Medications** (prescription and nonprescription):

Name of medication	Dose	Times per day	Length of time used	Prescribing Physician

List **allergies** to:

Drugs: \_\_\_\_\_  
Food: \_\_\_\_\_  
Environment: \_\_\_\_\_

**Social History:**

Smoking history:

How many packs per day? \_\_\_\_\_ How many years have you smoked? \_\_\_\_\_  
Have you smoked pipes or cigars? \_\_\_\_\_ When did you quit smoking? \_\_\_\_\_

**PATIENT QUESTIONNAIRE:**

Exposure to secondhand smoke: never rarely occasionally often regularly

Number of alcoholic drinks per week: \_\_\_\_\_

Illicit drug use: marijuana cocaine narcotics Valium LSD IV drug use

Have you ever had a blood transfusion? Yes No If yes, when? \_\_\_\_\_

Date of last flu shot: \_\_\_\_\_ Pneumovax: \_\_\_\_\_

Current occupation: \_\_\_\_\_

Previous occupations: \_\_\_\_\_

List any jobs, activities or hobbies where you were routinely exposed to chemicals, powders, dusts or other types of hazardous materials (i.e.: including asbestos, sandblasting and fumes)

Activity	Years of exposure	Type of hazardous exposure

Home environment in the last ten years. Circle all that apply:

- Dog Cat Bird Livestock Horses Gas heat Old carpets Central air Old drapes  
Feather pillows Indoor insect problem

Have you or anyone in your family had tuberculosis or a positive PPD skin test? Yes No  
If yes, when and what treatment was given? \_\_\_\_\_

Please list any travel in the last 20 years

Outside of local region	Foreign
_____	_____
_____	_____
_____	_____

**Family History** (include siblings, children and grandchildren; also make particular note of any diabetes, heart disease, strokes, hypertension, cancer, and asthma):

Family member	Age	Medical Problem	Or	Age	Cause of Death
Father					
Mother					
(Siblings)					
(Children)					

# 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. and/or Sleep Consultants, Inc. 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 <b>X</b> 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 <b>X</b>	
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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			

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 MM DD YY	To 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)				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.

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**Signature of Patient or Personal Representative**

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Date

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Name of Patient or Personal Representative

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Description of Personal Representative's Authority