

TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

John L. Tiu, M.D., FCCP

2800 E. Broad Street, Suite 514
Mansfield, TX 76063
(817) 453-8883

Patient Name: _____

Referring Physician: _____

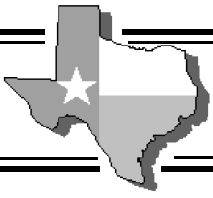
You have been scheduled for an initial consultation or hospital follow-up appointment with _____ on _____ at _____ with a check-in time of _____. The next page of this packet is a detailed map to our facility. Below is a list of important information to assist you in preparing for this appointment.

- 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. You need only to sign lines 12 and 13 on the "Health Insurance Claim Form". This allows us to bill your insurance and receive payment.
- 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. (New patients only – this does not apply to hospital follow-up patients.)
- Please have your referring physician fax to our office or send with you any recent office notes and lab work.
- You must bring a list of your current medications with dosage and frequency. You may bring the medication bottles if you prefer and the clinical staff can list them in your chart.
- New patients should plan to be in the office for a period of 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 817-465-5881 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.

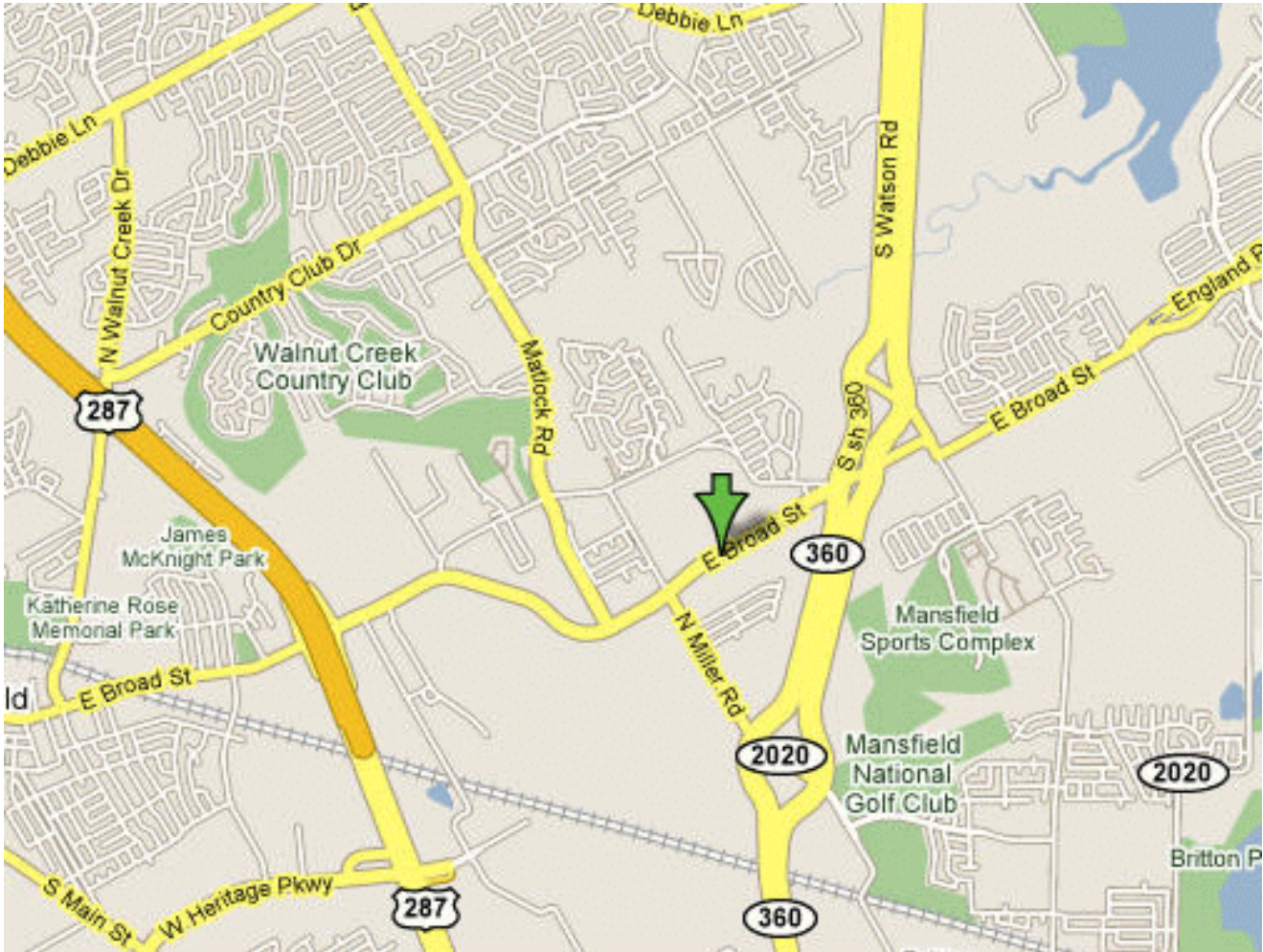
Sincerely,

Scheduling Secretary



TEXAS PULMONARY & CRITICAL CARE CONSULTANTS, P.A.

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



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 HEALTH QUESTIONNAIRE
Texas Pulmonary & Critical Care Consultants, PA

To our patients: We appreciate your cooperation in completing this pulmonary health status profile. We are committed to providing a thorough evaluation during your visits and you can participate today by answering the following questions as they pertain to your general health. (A member of our staff is available to assist you if you have difficulty completing this form.)

1. If you have any of the following symptoms, circle all that apply.
- | | | |
|----------------------|---------------------|------------|
| cough | snoring | chest pain |
| wheezing | spitting blood | fever |
| abnormal chest x-ray | lump | hoarseness |
| sore throat | shortness of breath | |

2. Other medical illnesses:
- | | | |
|--------------------|------------------------|----------------------|
| arthritis | heart disease | anxiety |
| kidney disease | bleeding problems | liver disease |
| cancer | seizures | depression |
| skin problems | diabetes | stomach problems |
| fainting episodes | thyroid disease | AIDS/related illness |
| psychiatric/mental | nervous system disease | |

3. List all surgeries: _____

4. Past chest x-rays (list most recent first):

LOCATION	REASON	APPROX. YEAR
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. Medications (prescription and nonprescription):

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

List **allergies** to:
 Drugs: _____
 Food: _____
 Environment: _____

6. Smoking history:

AGE	PACKS PER DAY	BRAND/S
20	_____	_____
30	_____	_____
40	_____	_____
50	_____	_____
60	_____	_____
70	_____	_____

Exposure to secondhand tobacco smoke:

Never _____ Rarely _____ Occasionally _____
Often _____ Regularly _____

7. Occupational/Hobbies/Activities

List any jobs or activities where you were exposed routinely to chemicals, powders, dusts, or other types of hazardous materials (i.e. ceramics or remodeling).

Activity	Years of exposure	Type of hazardous exposure (i.e. powder, dust, fumes, chemicals, household cleaners)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Home environment over past ten years. Please circle all that apply.

Dog Cat Bird Livestock Horse
Gas heat Old carpets Oil heat Central air
Old drapes Feather pillows Indoor insect problem
Home located next to high electrical power lines Home flooding in the past

9. Travel within the past 20 years:

Outside of local region	Foreign
_____	_____
_____	_____
_____	_____
_____	_____

10. Weight loss or gain:

AGE	WEIGHT	AGE	WEIGHT
20	_____	50	_____
30	_____	60	_____
40	_____	70	_____

11. Social activities:

Alcoholic drinks per week:

Beer _____ Wine _____ Mixed drinks _____
Hard liquor _____

Substance abuse now or in the past:

Marijuana _____ Cocaine _____ Narcotics _____ Valium _____
LSD _____ IV drug use _____

Has your usual cough changed recently? Yes _____ No _____

Does your cough produce sputum? Yes _____ No _____

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

clear	yellow	white	green
tan	brown	red	other

How much sputum do you produce over 24 hours?

less than 2 tablespoons _____

more than 2 tablespoons _____

Chest pain:

a. When do you have chest pain?

on exertion _____ at rest _____ after meals _____

b. How long does pain last?

few seconds _____ 5 minutes _____ 15 minutes _____ one hour _____ all day _____

c. How many years have you had chest pain?

1 to 3 years _____ more than 3 years _____

d. Is the chest pain worse than at anytime before?

Yes _____ No _____

e. What, if anything, makes the pain go away?

Resting _____ Eating _____

Medications (list): _____

I certify that all information is correct and complete. If any information should change, I will notify this office immediately.

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. 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 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			

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 EPSTD 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.

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative's Authority