Collin County Pulmonary Associates
6100 Windcom Court, Suite 102, Plano, Tx 75093
Phone: (972) 964-0170 Fax: (972) 596-8928

Welcome!

Your appointment is for __________ at _________. We hope the following information will help make your visit to our office as pleasant and efficient as possible.

Please arrive at __________ with all enclosed new patient forms completed. If you do not have the forms completed please arrive at __________ . Thank you.

If you have any questions, please do not hesitate to call us. We look forward to meeting you.

ADVANCE PREPARATIONS:

* Please, remember to bring the enclosed forms completed to your appointment and bring any lists you need as reminders of current medication, allergies and details about prior illnesses and treatments.
* Please, if at all possible, wear a loose easy to remove shirt/top.
* Please, if you have any recent lab work, x-rays, or reports from other doctors that pertain to your visit, bring them with you for our review.
* Please, as a courtesy to other patients with asthma or environmental sensitivity, **DO NOT** wear cologne or perfumes to your appointment.
* If you have personal copies of medical records, please make a separate copy to leave with us.
* If you have small children, please note that we will not provide child care or supervision while you are being tested or during your exam.

LATE ARRIVALS:

New patient appointments are our most medically involved appointments so we ask that you arrive on time to avoid rescheduling. In consideration for our other patients if you are late for your appointment, all other patients that would have followed you who do arrive on time will still be seen at the time they are scheduled. You will have the option of rescheduling or you can wait for any openings that might develop later in the schedule.

CANCELLATION:

Please notify us immediately if you are unable to keep your appointment for any reason by calling 972-964-0170 (including after hours notice by choosing phone option #1 on our voice mail).

PAYMENT:

* If your insurance requires precertification, referral from your primary care physician, co-payment any other specific requirements it is your responsibility to comply with the terms of your plan.
* If you are not sure if your insurance requires a referral, please look for the following terms on the front of your card: HMO EPO POS QPOS or if you have a primary care physician (PCP) name listed under your Id number. These all are an indication that your plan requires a referral.
* If you are not sure if we are a preferred provider under your insurance plan, please contact your insurance company prior to your appointment to verify this. We do not verify insurance prior to appointments.
* If you require a referral from your primary care physician it is your responsibility to contact your primary care physician. If you do not have a referral you can still see the doctor **only** if you agree to accept full responsibility for payment of the visit should the referral be denied.
* Please complete and sign the enclosed form so that we can file your insurance claim.
* Please bring any insurance or Medicare cards(s) so that we can make a copy.
* Please be prepared to pay your applicable co-pay, co-insurance or deductable. Such co-payments will be collected at the time of appointment check in.

RECORDS:

We are happy to send copies of your medical records to other physician's for any upcoming but we need at least 24 hours notice. We can provide you a personal copy of your chart with one week's notice. First and one copy is free.

FORMS:

We do not complete paperwork or forms for disability, work releases, medical equipment, etc initiated by another office. We can forward a copy of your medical records, if you let us know on arrival that you need documentation for this purpose.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPAA), I have certain rights to privacy regarding my medical records or protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payors.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I understand that Collin County Pulmonary Associates can change this Notice of Privacy Practices and that I may obtain a currant copy of the Notice of Privacy Practices at any time.

_____ Initial here if you want a copy of our Notice of Privacy Practices for your personal home records.

I understand that I may request in writing that you restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care options. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that unless I have made written restrictions you will proceed as though there are none.

_____ Initial here if you have provided us in compliance with HIPPA with a record of disclosures form with specific restrictions on how your protected health information is used or disclosed.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name (*printed):* ____________________

Signature: ____________________

Relationship if other than patient: ____________________

Date: ____________________

O F F I C E U S E O N L Y

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

☐ Notice of Privacy Practices given to patient as requested above

☐ Records of disclosure form received from patient and placed in chart

☐ Individual patient medical record updated with above

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Please provide the following information to help us communicate our findings to your other doctors.

Referring Physician:

Name ____

Address ____

City ____________________State ________________Zip __________

Phone ____________________ Fax ____________________

Primary Care Physician (if other than referring physician):

Name ____

Address ____

City ____________________State ________________Zip __________

Phone ____________________ Fax ____________________

Other than primary care or referring physician:

Name ____

Address ____

City ____________________State ________________Zip __________

Phone ____________________ Fax ____________________

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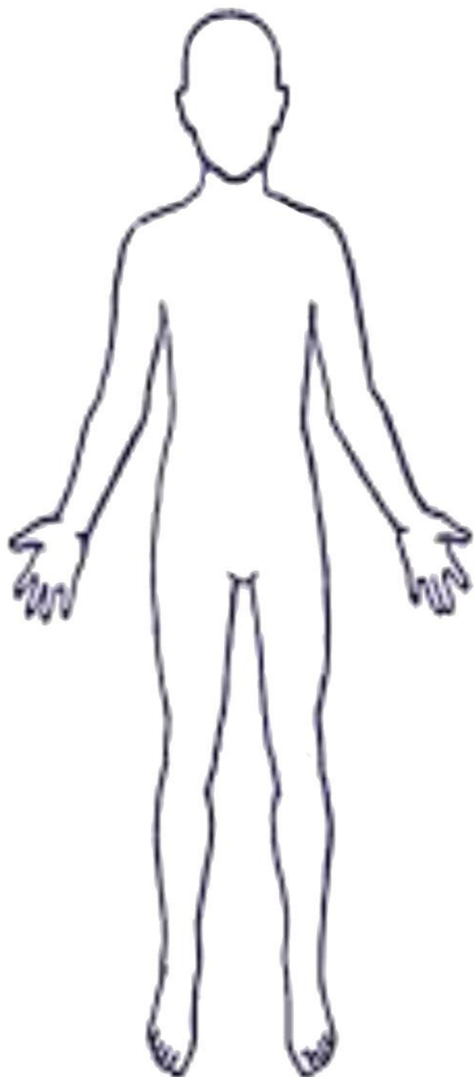
Symptom Review

Please detail any symptoms you have noted related to the reason(s) for your visit today.



Head/Neurologic ______________________________

Eyes______________________________

Ears ______________________________

Nose/Sinus ______________________________

Throat/Neck______________________________

Heart ______________________________

Lung ______________________________

Esophagus/Stomach ______________________________

Kidney/Bladder ______________________________

Colon ______________________________

Muscles ______________________________

Bones/Joints ______________________________

Skin ______________________________

General ______________________________

____
Patient Signature or Initials

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SMOKING HISTORY:

(check only one)

☐ I have **NEVER** smoked

(“NEVER” includes brief experimentation when younger, but never more than 1 pack a day and/or one or two years duration)

☐ I **QUIT** smoking

I first started smoking at ______________________________ (age)

I finally quit at ______________________________________ (age)

The **most** I ever smoked daily: circle one

<1 pack/day 1-2 pack/day >2 pack/day

☐ I **CURRENTLY** smoke

I first started smoking at ______________________________ (age)

The **most** I ever smoke daily: circle one

<1 pack/day 1-2 pack/day >2 pack/day

I have tried to quit: ____

____ (details)

PASSIVE SMOKE EXPOSURE:

(close physical proximity to smokers for more than several years)

☐ Parent/childhood

☐ Spouse

☐ Other ____ (details)

☐ I smoke cigars ____ (details)

☐ I use smokeless/chewing tobacco ____ (details)

____
Patient Signature or Initials

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FAMILY HISTORY

(CHECK APPROPRIATE BOX)

☐ ADOPTED

FATHER

☐ DECEASED CAUSE OF DEATH ______________________________ AGE______
☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ DIABETES
☐ ASTHMA ☐ EMPHYSEMA
☐ TUBERCULOSIS ☐ SINUSES/ALLERGIES
☐ CANCER____ (TYPE)
☐ OTHER ____

MOTHER

☐ DECEASED CAUSE OF DEATH ______________________________ AGE______
☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ DIABETES
☐ ASTHMA ☐ EMPHYSEMA
☐ TUBERCULOSIS ☐ SINUSES/ALLERGIES
☐ CANCER____ (TYPE)
☐ OTHER ____

SIBLINGS

☐ DECEASED CAUSE OF DEATH ______________________________ AGE______
☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ DIABETES
☐ ASTHMA ☐ EMPHYSEMA
☐ TUBERCULOSIS ☐ SINUSES/ALLERGIES
☐ CANCER____ (TYPE)
☐ OTHER ____

GRANDPARENTS

☐ DECEASED CAUSE OF DEATH ______________________________ AGE______
☐ HEART DISEASE ☐ HIGH BLOOD PRESSURE
☐ STROKE ☐ DIABETES
☐ ASTHMA ☐ EMPHYSEMA
☐ TUBERCULOSIS ☐ SINUSES/ALLERGIES
☐ CANCER____ (TYPE)
☐ OTHER ____

____
Patient Signature or Initials

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Illnesses/Medical Problems

Check ANY that apply (note: you will list surgery/operations on the next page)

Illness	Details if needed	Date(s) onset
☐ Cancer (list involved organ(s))		
☐ Depression		
☐ Stroke/TIA		
☐ Dementia/Alzheimer's		
☐ Migraines		
☐ Glaucoma		
☐ Sinusitis/Rhinitis		
☐ Thyroid Problems		
☐ Pneumonia/Bronchitis		
☐ Asthma		
☐ Emphysema		
☐ Tuberculosis		
☐ Heart Attack		
☐ Atrial Fibrillation		
☐ High Blood Pressure		
☐ Heart Failure		
☐ High Cholesterol		
☐ GERD/Reflux		
☐ Hiatal Hernia		
☐ Ulcers		
☐ Hepatitis/Liver Problems		
☐ Kidney Problems		
☐ Low Back Pain/Injury		
☐ Sciatica		
☐ Arthritis (list involved joint(s))		
☐ Diabetes		
☐ Anemia		
☐ Alcoholism		
☐ Eczema		

Other, listed above:

____

____

____

____

____

____
Patient Signature or Initials

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Operations

Check ANY that apply

Illness	Details if needed	Date(s) if you recall
☐ Cataract		
☐ R ☐ L ☐ Both		
☐ Sinus Surgery		
☐ Tonsillectomy		
☐ Disc Surgery		
☐ Cervical ☐ Lumbosacral		
☐ Breast Surgery/biopsy		
☐ Cardiac Bypass		
☐ Pacemaker/AICD		
☐ Lung Surgery/biopsy		
☐ Ulcer Surgery		
☐ Gallbladder		
☐ Appendectomy		
☐ Splenectomy		
☐ Kidney Surgery		
☐ Hernia		
☐ Hiatal ☐ Inguinal ☐ Both		
☐ Carpal Tunnel		
☐ R ☐ L ☐ Both		
☐ Bladder Surgery		
☐ Hysterectomy		
☐ Ovary Surgary		
☐ Prostate Surgery		
☐ Vasectomy		
☐ Colon Surgery		
☐ Hemorrhoidectomy		
☐ Arthroscopy(s)		
List involved joints:		

Other, not listed above:

____

____

____

____

____

____
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GENERAL HISTORY

(CHECK ALL THAT APPLY)

Current Pets

☐ Cat(s) ☐ Dog(s) ☐ Bird(s)

☐ Other ______________________________

Childhood Illness:

☐ Chicken Pox	☐ Polio	☐ Measles
☐ Whooping Cough	☐ Rheumatic Fever	☐ Mumps
☐ Asthma	☐ Scarlet Fever	☐ Pneumonia
☐ Kidney Problems	☐ Heart Murmur	☐ Mononucleosis

Adult Vaccinations

☐ Tetanus Booster *(in past 10 years)*	☐ Hepatitis B	☐ Hepatitis A	☐ Polio
☐ Measles	☐ Mumps	☐ Rubella	☐ Whooping Cough
☐ Shingle	☐ Influenza	☐ Pneumovax	☐ Prevnar

☐ OTHER ______________________________

____
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GENERAL HISTORY

When did you get your last Flu shot?

☐ Never ☐ _______ (year)

When did you get your last Pneumonia shot?

☐ Never ☐ _______ (year)

Have you ever had a TB/Tuberculosis Skin test (PPD or Tine)?

☐ Never ☐ Don't know ☐ Negative:______(year) ☐ Positive:________(year)

WORK HISTORY

Have you ever been regularly exposed in the workplace to:

☐ Asbestos ☐ Fumes ☐ Metals ☐ Chemicals

☐ Plastics ☐ Solvents ☐ Dyes ☐ Insulation

Please detail name or type of exposure and what symptoms developed:

____

____

____

Do you have a Living Will?

☐ Yes ☐ No ☐ Don't know

Do you have a Durable Power of Attorney for health care?

☐ Yes ☐ No ☐ Don't know

____
Patient Signature or Initials

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Current Medications

☐ I currently take NO medications

☐ See the current updated list I have provided today

☐ The following are my current medications (please see list below)

MEDICATION NAME	DOSE	HOW OFTEN

Medications You Are Allergic To

☐ I have NO medication allergies

☐ See the current updated list I have provided today

☐ The following are my current medication allergies (please see list below)

Medication Name

Patient Signature or Initials

DIRECTIONS:

Address:
6100 Windcom Court, Suite 102, Plano, Texas 75093

Our new location is close to Texas Health Presbyterian of Plano. From West Parker turn North onto Communications. Windcom Court is 0.6 miles to a right turn. From Spring Creek turn South onto Communications, Windcom Court is 0.8 miles. From Windhaven turn South onto Communications and Windcom Court is 0.2 miles to a left turn.

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ATTENTION: New Patients

Based on information you gave us at the time we made your new patient appointment we have requested records from your referring physician. We need a copy of important findings (report and/or actual films/tests) at the time of your office visit. Please contact your referring physician at least 48 hours prior to your appointment date to confirm they sent your records. If they have not yet sent records they can either fax them to our office or you can make arrangements with them to personally pick up the records to bring with you to your appointment. We will not be able to properly evaluate and recommend treatment options without these reports and thus will have to reschedule your appointment if you arrive and these reports are still unavailable for our review.

If your insurance requires precertification or referral from your primary care physician it is your responsibility to comply with the terms of your plan and request this from your primary care physician prior to your appointment. We can not request this for you.

We participate with most but not all insurance plans. To avoid confusion at the time of your first appointments, please call us with the name of your health insurance or fax us a copy of your card at 972-596-8928. We can let you know if we are a contracted provider under your insurance plan. However, we do not actually verify your benefits prior to your visit. Please directly contact your insurance plan in advance of your appointments if you have any questions about your coverage for your visit.

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Medication Guidelines

We have changed how we handle medication prescriptions and refill requests effective 6/01/2014. These changes are in response to Federal regulations called meaningful use and we appreciate your help and cooperation with these new guidelines:

* All pharmacy refill requests are handled by 5:00 p.m. daily Monday thru Friday. Refills requested on Saturday, Sunday and Holidays will be handled by 4:00 p.m. the next working day.

* All refill requests should come directly from your pharmacist to our office on your behalf.

*Your pharmacist will notify you if any changes are made to your prescription refill request.

*If the pharmacist tells you a refill is declined for any reason please contact the office only during our regular office hours.

*If you have not actually seen the doctor in the office or hospital within the past 12 months your refills may be declined until you contact the office during our regular office hours. This includes requests made after hours, weekends and holidays.

*If you have not actually seen the doctor in the office or hospital within the past 24 months your refills are automatically declined until you contact the office during our regular office hours. This includes requests made after hours, weekends and holidays.

*If a refill is denied by your insurance for formulary reasons and they indicate a preferred alternative choice, that selection will be automatically authorized. If you prefer instead to pay for non-formulary medications please let the pharmacist know before you accept or pay for your prescription.

*We do not do Prior Authorization approvals and/or help with denial appeals for any prescriptions written by other doctors.

* Prior authorization and appeals will only be done when your pharmacy or insurance company notifies us by phone or fax that a prior authorization is needed.

*Prior authorization and appeals require no less than 72 hours to be completed. If/when successful you only will be contacted by your pharmacy that your prescription is ready. We have no control over timing by your insurance.

*All prescriptions will always be filled with available generics unless you have previously indicated Brand Name Only.

*Prescriptions will not be approved for medications written by any other doctors.

* Prescriptions for tranquilizers, sedatives and pain medications are NEVER handled by phone after hours, weekends and holidays. The maximum quantity will always be less than or equal to 30 days at the discretion of the doctor. We do not provide refills for "lost" or otherwise unavailable medications and do not call in "early" refills for any reason.

* Prescriptions for narcotics can no longer be handled by phone or fax per the new Federal Guidelines. Handwritten prescriptions for these medications must now be hand carried to the pharmacy by the patient. These written prescriptions can take 24 hours for completion and our office will contact you once the prescription is ready to be picked up. These requests are never handled after hours, on weekends or holidays. The maximum quantity will always be less than or equal to 30 days with no additional refills at the discretion of the doctor. We do not provide "early" refills or for "lost" or otherwise unavailable medications.

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To Our Patients Who Have DME (CPAP, BIPAP, Oxygen, Nebulizer, Walkers, etc):

Healthcare is changing rapidly. This year alone there are at least 20,000 new regulations. Some of these affect your durable medical equipment (DME) particularly when it comes to renewals, repair and supplies.

Effective 6/01/2014, unless this office did the original initial order for your DME we can no longer help you with recertification paper work, supplies, renewals and repairs unless/until we have copies of the original orders and qualifying documentation done by the first ordering physician. Only you can directly contact the original healthcare provider to obtain these records. If you do not know or recall what healthcare provider initially ordered your DME please contact the company who provided you with your equipment for that name and address. When you directly contact the original provider, they will have the option of either helping you directly with your renewals, repairs and supplies or providing you with the needed records for this office.

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Patient Registration

Date of Birth ____________ Social Security ____________

Name: ____________ last ____________ first ____________ middle ☐M ☐F (gender)

Address: ____________ Street no. and name ____________ apt/lot number

____ city ____ state ____ zip ____ county ____ home ____ Fax

☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Other__________

Employer Name ____________ Work Number ____________ Cell Number ____________

☐ F/T ☐ P/T ☐Self ☐Retired ☐Student ☐Child ☐Unemployed ☐Other_______

Method of Contact: ☐Phone ☐Mail ☐Fax ☐Other__________

Ethnicity: ☐Black ☐White ☐Hispanic ☐Native American ☐Filipino ☐Chinese ☐Japanese ☐Oriental/Asian ☐Pacific Islander ☐Other________ Language__________

Guarantor (party responsible for payment) ☐Self ☐Spouse ☐Parent ☐Other__________

Name: ____________ last ____________ first ____________ date of birth ☐M ☐F (gender)

Address: ____________ Street no. and name ____________ apt/lot number

____ city ____ state ____ zip ____ county ____ home ____ Fax

Primary Insurance: ______________________________ID# ____________

Policy Holder: ☐Self ☐Spouse ☐Parent ☐Other______ Group# ____________

Name: ____________ last ____________ first ____________ date of birth ☐M ☐F (gender)

Address: ____________ Street no. and name ____________ apt/lot number

____ city ____ state ____ zip ____ county ____ home ____ Fax

Employer: ______________________________

Primary Insurance: ______________________________ID# ____________

Policy Holder: ☐Self ☐Spouse ☐Parent ☐Other______ Group# ____________

Name: ____________ last ____________ first ____________ date of birth ☐M ☐F (gender)

Address: ____________ Street no. and name ____________ apt/lot number

____ city ____ state ____ zip ____ county ____ home ____ Fax

Employer: ______________________________

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FINANCIAL POLICY STATEMENT

Payment for service is due at the time service is rendered unless payment arrangements have been approved in advance. We accept cash, checks, Visa/Master Card/Discover. There is a $30 charge for returned checks.

Please understand that you are financially responsible for paying any and all medical expenses incurred for services rendered whether or not your insurance carrier pays your claim. You are responsible for any copayment, co-insurance, deductible, non-covered or exclusions pursuant to the terms of your policy and plan benefits. If benefit payments that you assign to our office are mistakenly sent directly to you please forward them to us immediately so that your account can be properly credited and updated.

If you have insurance we will file your claim only if you assign benefits to our office by signing below. Present your current ID and current insurance card(s) at each visit. Knowing and providing your insurance benefits is your responsibility. Please contact your insurance company with any benefit questions you may have regarding your coverage. While we participate in many insurance plans, it is your responsibility to contact your insurance carrier to determine whether this office and/or doctors are participating in your insurance plan.

Referrals: If your visit requires a referral from your primary care physician it is your responsibility to call your primary care physician to obtain your referral in advance of arrival and to see that our office has a copy of your referral at the time of your visit. You can not be seen until you have obtained any required referral documentation.

A missed appointment fee is $50.00 if not canceled at least 24 hours in advance. This fee may be billed to you and not filed with your insurance carrier.

Balance for services over 60 days will be considered past due and delinquent at 90 days. Balances over 90 days may incur a $50/month rebilling fee and become subject to further collection procedures. Any collection costs are your responsibility.

Patients not responding to our phone calls and routine USPS mail who then require certified letters for contact may be directly billed for the cost of those certified mailings.

Medicare: We do accept Medicare assignment, which means that we are directly reimbursed by Medicare 80% of the approved amount minus any unmet deductible. We only bill you for the remaining 20% of the approved amount plus the part of any deductible you may still owe. If you have secondary insurance (Medigap) to help cover your 20%, we will also file this on your behalf if you agree to assign benefits to our office. We must have a copy of your current insurance card(s).

I hereby assign all medical benefits to which I am entitled, including Medicare and any other government sponsored programs, private insurance, and all other health plans to Collin County Pulmonary Associates (Tim Betz, M.D. & Timothy R. Chappell, M.D.). I understand that I am financially responsible for all charges whether or not paid by said insurance. Due to contract language between physician and insurance company, I understand that I am financially responsible for all charges deemed to be “non-covered benefit” by my insurance company even if the insurance’s Explanation of Benefits stated the procedure is a “non-covered benefit”. I hereby authorize release of any information necessary to secure payment.

I have read and understand the above information, and by my signature I agree to these terms.

Signature Acknowledgement and Agreement ______________________________

Date: ____________________

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Date ________________________

In compliance with Federal rules and regulations of meaningful use of computerized medical records we now can send prescriptions electronically. Electronic prescriptions do not include any (schedule II) medications such as narcotics, sedatives or anxiolytics, which must still be handwritten on paper.

I hereby authorize Collin County Pulmonary Associates to electronically connect to my pharmacy and/or pharmacy benefit manager for the purpose of both sending prescriptions and refills and receiving information about my medication list, allergies and my prescriptions.

I understand that this authorization is revocable at any time upon written notice to our office except to the extent that action has already been taken on this authorization. This authorization will neither change how my doctors choose my treatment nor my prescription payments or costs and health plan enrollment or benefit eligibility.

Please update the pharmacy you are using anytime you make a change. We will continue to only use the pharmacy you have provided/on file unless notified otherwise. Prescriptions electronically misdirected due to out dated pharmacy contact information in your chart are your responsibility. If your pharmacist sends us an electronic refill request we will automatically respond on the understanding that your pharmacy has your permission to electronically contact us on your behalf.

(Print Name) ____
Patient / legal representative / legal guardian

(Signature) ____
Patient / legal representative / legal guardian

Current preferred local pharmacy: ____
Name Address

☐ I choose to decline the above option of having my prescriptions handled electronically.

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PATIENT RECORD OF DISCLOSURES

In general, HIPPA privacy rules give individuals the right to request a restriction on uses and disclosures of their medical records and protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individuals home.

For your information and before you sign this disclosure, please be advised that Collin County Pulmonary Associates in the past, present and future:

- Has always required documented permission of a patient or their legal representative before releasing medical records to anyone
- Has always faxed medical records to patients only if we are first sure that the patient has direct personal control of the receiving fax machine at the time we transmit the information
- Has always called the home telephone number to contact you, unless you have specifically indicated otherwise, or we are responding back to your call from some other number
- Has always refused to release your medical or personal patient information to pharmacies and medical suppliers for their marketing or solicitation

There are NO Restrictions on disclosure of my PHI except as indicated below:

☐ Never leave a phone message at my HOME TELEPHONE number
☐ Never leave a phone message at my WORK TELEPHONE number
☐ Never correspond with me by e-mail
☐ Never mail anything to my home address
☐ Other____

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer
- I may refuse to sign this authorization and that you will not condition my treatment on me providing this authorization

I understand that it is my personal responsibility to keep my home phone number, home address, work address, and email address up to date and accurate for confidential communications of PHI. The current information you have on file today is correct and should be used unless or until I contact you with any changes.

This authorization shall remain in effect from the date signed below unless or until_______________.

Patient Name:_____________________________________Signature:___________________________

Relationship if other than patient:______________________________Date:_____________________