Collin County Pulmonary Associates
1101 Raintree Circle, Suite 100
Twin Creeks Medical, Bldg 2
Allen, Texas 75013
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 15 minutes early with all enclosed new patient forms completed. If you do not have the forms completed, please arrive 30 minutes early. 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 childcare 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 deductible. 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 physicians 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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Directions

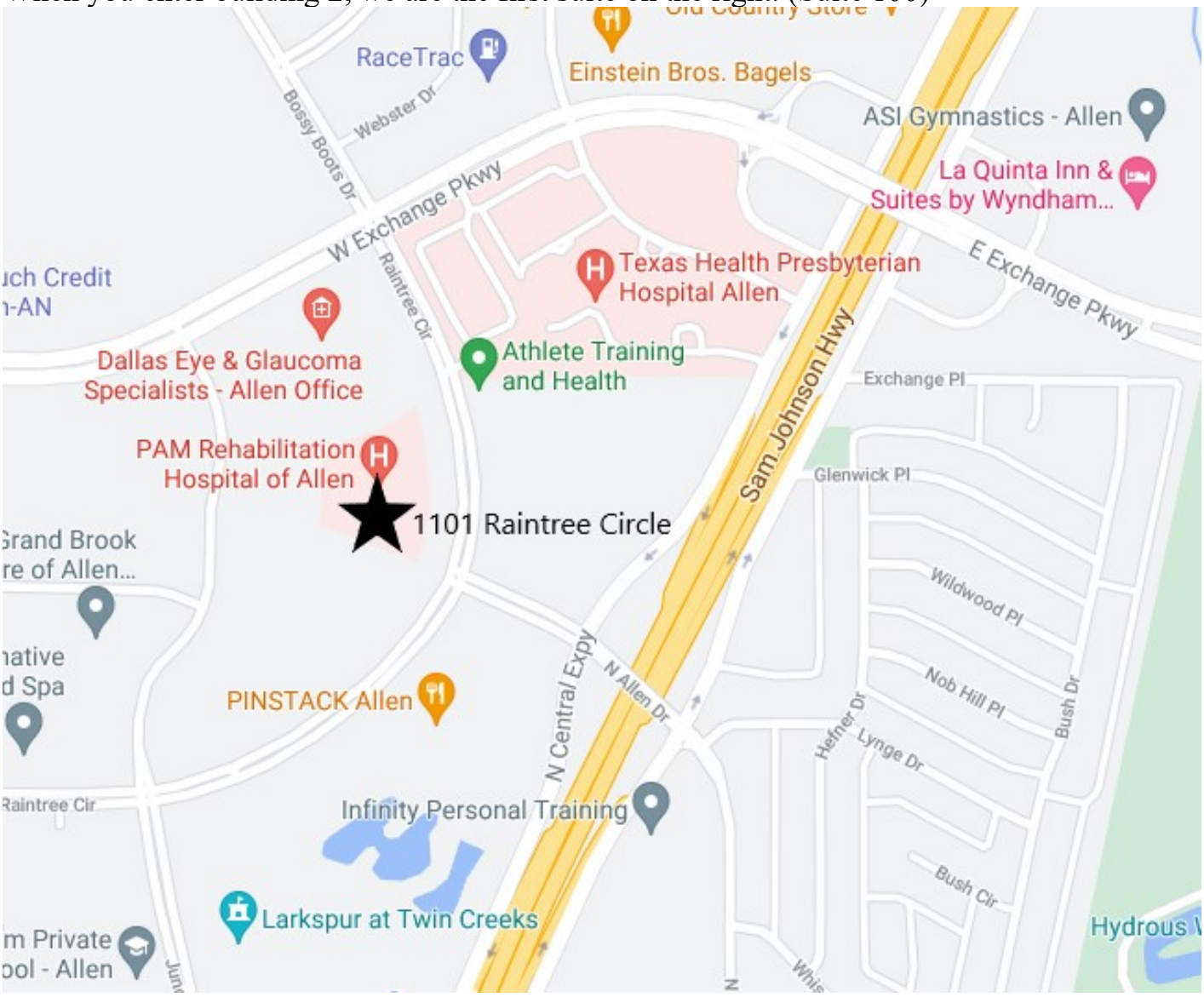
Address:

1101 Raintree Circle, Suite 100
Twin Creeks Medical, Bldg 2
Allen, TX 75013

Our new location is close to Texas Health Presbyterian Hospital of Allen. It is easily accessed from the north or south on North Central Expressway (75) using the Allen Drive exit and turning West. After the four-way stop, you drive straight into the parking lot.

If coming from Exchange Parkway (either East or West) turn South on Raintree Circle. We are in the Twin Creeks Medical Building on the West side of Raintree.

When you enter building 2, we are the first suite on the right. (Suite 100)



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Medication Guidelines

How we handle medication prescriptions and refill requests are in response to HIPP and meaningful use and we appreciate your help and cooperation with these regulations:

* All pharmacy refill requests are handled by 4:00 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 after pharmacy or insurance company notification.

*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 time delays by your insurance.

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

*Prescription refills 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 by Federal law are done electronically. 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, APAP, Oxygen, Nebulizer, Walkers, ect):

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.

Unless this office did the original initial order for your DME it is impossible to help you with recertification paperwork, 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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Date _____

In compliance with Federal rules and regulations of meaningful use of computerized medical records we now can sent prescriptions electronically.

I herby authorize Collin County Pulmonary Associates to electronically connect to my pharmacy and/or pharmacy benefit manager for the purpose of both sending prescriptions 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 doctor chooses 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 Registration

Name: (Last)_____ **(First)** _____ **(Middle)** _____

Address:_____

City: _____ **State:**_____ **Zip**: _____ **Country:** _____

Birth Date: _____ **Phone:** _____ **Work:**_____ **Fax:** _____

Contact By: *Phone* *Paper* *Fax* *Email* **Email:** _____ **Sex:** *M* *F*

Marital Status: *Single* *Married* *Divorced* *Widowed* *Separated* *Other* **SSN:** _____

Race: *Black* *Hispanic* *Native American* *Oriental/Asian* *White* *Other* **Language:** _____

Chinese *Filipino* *Native Hawaiian* *Multiracial* *Pacific Islander* *Japanese*

Employment Status: *Full-time* *Part-time* *Self-employed* *Retired* *Student* *Child* *Unemployed* *Other*

Responsible Party (Party responsible for payment) : *Self* *Spouse* *Parent* *Other*

Name: (Last)_____ **(First)** _____**(Middle)** _____

Address:_____

City: _____ **State:**_____ **Zip**: _____ **Country:** _____

Phone: _____ **Work:** _____ **Fax:** _____ **Email:** _____

Primary Insurance:_____

Insured Party: *Self* *Spouse* *Parent* *Other* **Group #:** _____ **ID #:** _____ _____

Name: (Last)_____ **(First)** _____**(Middle)** _____

Address:_____

City: _____ **State:**_____ **Zip**: _____ **Country:** _____

Phone: _____ **Work:** _____ **Fax:** _____

Secondary Insurance:_____

Insured Party: *Self* *Spouse* *Parent* *Other* **Group #:** _____ **ID #:** _____ _____

Name: (Last)_____ **(First)** _____**(Middle)** _____

Address:_____

City: _____ **State:**_____ **Zip**: _____ **Country:** _____

Phone: _____ **Work:** _____ **Fax:** _____

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FINANCIAL POLICY STATEMENT

Payment for service is due at the time service is rendered. We accept cash, checks, Visa/Master Card/Discover. There is a $40 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 you claim. You are responsible for any copayment, co-insurance, deductible, non-covered r exclusions pursuant to the terms of your policy and plan benefits. If the 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 doctor is 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 cannot 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 will 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 (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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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 individual's 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: _____

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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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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)

☐ I smoke cigars
☐ I use smokeless/chewing tobacco
☐ I vape
☐ I quit vaping_____(age)

PASSIVE SMOKE EXPOSURE:

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

☐ Parent/childhood

☐ Spouse

☐ Other _____ (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 ☐SINUSES/ALLERGIES ☐EMPHYSEMA ☐TUBERCULOSIS
☐CANCER:_____
☐OTHER:_____

PATERNAL GRANDPARENTS

GRANDFATHER ☐DECEASED CAUSE OF DEATH:_____ AGE:_____
GRANDMOTHER ☐DECEASED CAUSE OF DEATH:_____ AGE:_____
☐HEART DISEASE ☐HIGH BLOOD PRESSURE ☐STROKE ☐DIABETES
☐ASTHMA ☐SINUSES/ALLERGIES ☐EMPHYSEMA ☐TUBERCULOSIS
☐CANCER:_____
☐OTHER:_____

MOTHER

☐DECEASED CAUSE OF DEATH:_____ AGE:_____

☐HEART DISEASE ☐HIGH BLOOD PRESSURE ☐STROKE ☐DIABETES
☐ASTHMA ☐SINUSES/ALLERGIES ☐EMPHYSEMA ☐TUBERCULOSIS
☐CANCER:_____
☐OTHER:_____

MATERNAL GRANDPARENTS

GRANDFATHER ☐DECEASED CAUSE OF DEATH:_____ AGE:_____
GRANDMOTHER ☐DECEASED CAUSE OF DEATH:_____ AGE:_____
☐HEART DISEASE ☐HIGH BLOOD PRESSURE ☐STROKE ☐DIABETES
☐ASTHMA ☐SINUSES/ALLERGIES ☐EMPHYSEMA ☐TUBERCULOSIS
☐CANCER:_____
☐OTHER:_____

SIBLINGS (circle one)

SISTER / BROTHER ☐DECEASED CAUSE OF DEATH:_____ AGE:_____
SISTER / BROTHER ☐DECEASED CAUSE OF DEATH:_____ AGE:_____
SISTER / BROTHER ☐DECEASED CAUSE OF DEATH:_____ AGE:_____
SISTER / BROTHER ☐DECEASED CAUSE OF DEATH:_____ AGE:_____

☐HEART DISEASE ☐HIGH BLOOD PRESSURE ☐STROKE ☐DIABETES
☐ASTHMA ☐SINUSES/ALLERGIES ☐EMPHYSEMA ☐TUBERCULOSIS
☐CANCER:_____
☐OTHER:_____

_____
Patient Signature or Initials

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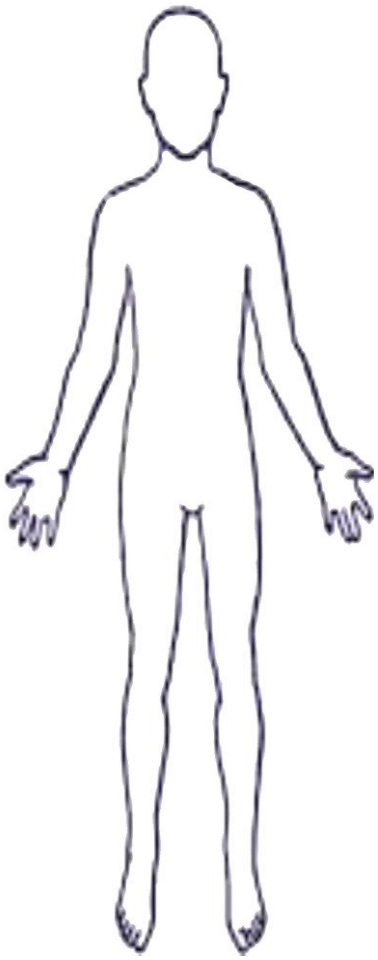
PAST MEDICAL HISTORY



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

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

Other, not listed above:

_____

_____

_____

Childhood Illness (check all that apply)

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

_____
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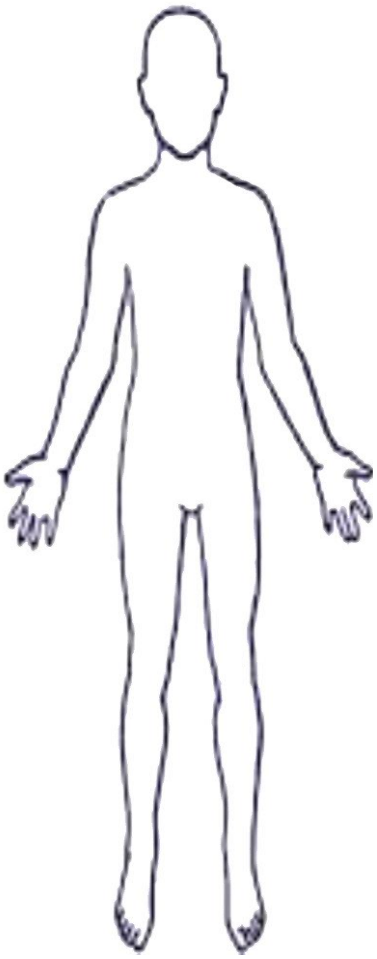
SURGICAL HISTORY

Check ANY that apply



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

Other, not listed above:

_____

_____

_____

_____

_____

_____
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VACCINATIONS

When did you get your last Flu shot?

Year: _____ ☐ Never

When did you get your last Pneumonia shot?

Year: _____ ☐ Never

Have you received the COVID vaccine?

☐ Yes ☐ No

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

☐ Never ☐ Don't Know ☐ Negative: ____(year) ☐ Positive: ____(year)

Other Adult Vaccinations:

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

☐ Other _____

_____
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GENERAL HISTORY

WORK HISTORY

Have you ever been regularly exposed in the workplace to:

☐ Asbestos ☐ Chemicals ☐ Dyes ☐ Fumes

☐ Insulation ☐ Metals ☐ Plastics ☐ Solvents

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

_____

_____

_____

CURRENT PETS

☐ Cat(s) ☐ Dog(s) ☐ Bird(s)

☐ Other _____

ADVANCED DIRECTIVES

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

Medication Allergy

☐ 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