Benbrook Medical and Sleep Center

320 Mercedes Street
Benbrook, TX 76126
817-249-7323

Pulmonary

Date: _____

Patient Information

Patient Name_____

Address: _____

_____

Telephone: Home _____Cell: _____
Social Security#_____ Email Address_____

Current Primary Care Physician:
_____ Phone Number _____

Age _____ DOB _____ Sex M_____F _____ Height: _____Weight_____

Are you? Married Separated Single Divorced Widowed

Spouse's Name: _____Contact Number:_____

Insurance Information

Primary Insurance: _____

Plan Code: Medicare Medicaid HMO PPO Military (Tricare) POS Other _____

Secondary Insurance: _____
Plan Code: Medicare Medicaid HMO PPO Military (Tricare) POS Other

Name of Insured (Guarantor): _____
Relationship to Patient: Self Spouse Parent Other_____
Guarantor's Date of Birth: _____ SSN: _____
Sex: Male Female

What Ethnic Group do you identify yourself?

_____ Black	_____ American Indian
_____ Caucasian	_____ Asian
_____ Latino	_____ Other
_____ Pacific Islander	_____ Unknown

Emergency Contact

Name: _____ Relationship: _____

Phone Number _____

Do you grant our office permission to share any medical information with any other family members? ___Yes ____No
If **YES**: Name_____ Phone Number_____
Relationship_____

Pharmacy Of Choice:_____ Phone Number _____

Medication List

If you have a current medication list please attach to this form.

Medication	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Social History

Have you ever smoked cigarettes? YES NO

Do you currently smoke cigarettes? YES NO

How many years have you smoked cigarettes?_____

How many packs of cigarettes per day have you smoked?_____

If you have quit and no longer smoke, when did you quit?_____

If you are a current smoker, have you ever quit before? YES NO

Have you ever smoked cigars? YES NO

Do you drink alcoholic beverages? YES NO

If yes, how much do or did you drink?_____

Did you ever use illicit or recreational drugs? YES NO

Do you drink caffeinated beverages? YES NO

If yes, how much?

Tea_____ Caffeinated coffee_____ Soft Drinks _____

Medical History

List of your medical diagnosis and any surgeries.

_____

_____

_____

_____

_____

_____

_____

Do you currently use supplemental oxygen? YES NO

Have you recently had a chest x-ray? YES NO

When? _____ Where _____

Have you had a CT scan of the chest recently? YES NO

When? _____ Where _____

Have you had any chest surgery? YES NO

When? _____ Where _____

Have you had a bronchoscopy? YES NO

When? _____ Where _____

Have you had a pneumonia shot? YES NO
When? _____

Have you had a skin test for tuberculosis? YES NO
When? _____ Results: Positive or Negative

Have you had a sleep study? YES NO

When? _____ Where _____

Are you currently on any PAP therapy device? YES NO

If yes what type. CPAP BiPAP ASV

Pressure: _____

Family History

Is your mother? LIVING DECEASED

Age _____ Health Conditions _____

Is your father? LIVING DECEASED

Age _____ Health Conditions _____

Do you have any brothers or sisters? YES NO

If you answered yes please fill out the following.

Age	Living or deceased	Health Conditions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have children? YES NO

If you answered yes please fill out the following.

Age	Living or deceased	Health Conditions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surgical History-

Surgical Procedure	YES	YEAR	Comments
Abdominal			
Appendectomy (appendix removal)			
Back Surgery			
Biopsy (location)			
Breast Surgery			
Colonoscopy			
Coronary Bypass			
Coronary Stent			
Cataract			
Gallbladder Removal			
Heart Surgery			
Hip Surgery			
Hysterectomy			
Knee Surgery			
Cervix Surgery			
Neck Surgery			
Ovary Removal			
Vasectomy			
Sinus Surgery			

Do you have (now) or have you had (past) any of the following conditions?
Medical History

Condition	Current	Past	Comments
Alcohol/Drug Abuse			
Allergy			
Anemia			
Anxiety			
Arthritis			
Asthma			
Bladder/Kidney Problems			
Blood Cot			
Blood Transfusion			
Breast Lump			
Cancer Breast			
Cancer Colon			
Cancer Other type			
Cancer Ovarian			
Cancer Prostate			
Cataracts			
Chicken Pox			
Colon Polyp			
COPD			
Coronary Artery Disease			
Depression			
Diabetes			
Emphysema			
Fractures (broken bones)			
Gallbladder Disease			
Reflux (heartburn/GERD)			
Glaucoma			
Gout			
Endometriosis			
Fibroids			

Condition	Current	Past	Comments
Heart Attack			
Hepatitis- Type A			
Hepatitis- Type B			
Hepatitis- Type C			
Hepatitis- Other			
High Blood Pressure			
High Cholesterol			
Hip Fracture			
Irritable Bowel Syndrome			
Kidney Disease/Failure			
Kidney Stones			
Liver Disease			
Migraine Headaches			
Osteoporosis			
Pneumonia			
Prostate Enlargement			
Seizure/Epilepsy			
Eczema			
Psoriasis			
Sleep Apnea			
Stomach Ulcer			
Stroke			
Thyroid High (overactive)			
Thyroid Low (underactive)			
Other (list)			

Benbrook Medical and Sleep Center

320 Mercedes St
Benbrook, TX 76126
Attn: Sheena Lively
(817)249-7323
BenbrookMedicalCenter@gmail.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Instruction C: Insert any special notes that apply to your entity's practices such as "we do not create or manage a hospital directory" or "we do not create or maintain psychotherapy notes at this practice."

Instruction D: The Privacy Rule requires you to describe any state or other laws that require greater limits on disclosures. For example, "We will never share any substance abuse treatment records without your written permission." Insert this type of information here. If no laws with greater limits apply to your entity, no information needs to be added.

Instruction E: If your entity provides patients with access to their health information via the Blue Button protocol, you may want to insert a reference to it here.

To leave this section blank, add a word space to delete the instructions.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective August 1, 2014

This Notice of Privacy Practices applies to the following organizations.

There are no current affiliations with OHCA's (Organized Health Care Arrangements)

Instruction H: Insert name or title of the privacy official (or other privacy contact) and his/her email address and phone number.

Name of Practice: Benbrook Medical and Sleep Center

_____ _____

Name of Patient (please print) **Date of Birth**

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Benbrook Medical Center's Notice of Privacy Practices.

_____ _____

Signature of patient or patient representative Date

Documentation of Good Faith Efforts To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

Patient refused to sign.

Patient was unable to sign or initial because:

_____

_____

The patient had a medical emergency, and an attempt to obtain the acknowledgment will be made at the next available opportunity.

Other reason (describe below):

_____

_____

_____ _____

Signature of Employee Completing Form Date

Benbrook Medical and Sleep Center
320 Mercedes St
Benbrook, TX 76126
(817)249-7323
www.BenbrookMedicalCenter.com

CONSENT TO TREATMENT: I, the undersigned, as the patient or on behalf of the patient do hereby consent to and authorize all diagnostic and therapeutic treatments considered necessary or advised in the judgment of the physician on duty. I understand that no guarantee or assurance has been made as to the results, which may be obtained.

FINANCIAL AGREEMENT: I hereby guarantee payment for services rendered by Benbrook Medical and Sleep Center. I understand that I will be held responsible for court cost, legal fees, or agency fees, which may be incurred in the collection of the account.

ASSIGNMENT OF BENEFITS: I hereby authorize all insurance companies to pay direct to Benbrook Medical and Sleep Center and any ancillary providers, any providers, any benefits and fees under my insurance policy or policies. I understand that this order does not relieve me of my obligation to pay the account. Also, any balance that is not covered or paid by the insurance company is my responsibility.

RELEASE OF MEDICAL INFORMATION: I hereby consent and authorize Benbrook Medical and Sleep Center. to release any medical information in connection with the services rendered for determination of benefits and/or collection of said benefits from my health insurance carrier.

MEDICARE BENEFICIARIES ONLY: I certify that the information given in applying for payment under Title XVII of the social Securities Act is correct. I authorize any holder of medical or other information about me to release to the social security administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made to Benbrook Medical and Sleep Center. I understand that I am responsible for health insurance deductibles and coinsurance.

MEDICARE SUPPLEMENTS: I further authorize Benbrook Medical and Sleep Center to claim and receive benefits through my Medicare Supplement that I present and place on file.
This authorization includes claims for Medigap benefits and shall remain in effect until and unless revoked in writing.

I HAVE READ THE AUTHORIZATIONS, CONSENTS, AND AGREEMENTS AND I ACCEPT THE TERMS AS DESCRIBED ABOVE.

_____ _____ _____

(SIGNATURE) **(PRINT NAME)** **(DATE)**

LETTERS

All letters to any person other those physicians will be subject to a fee of at least $25.00. Again, the exact amount will depend on the complexity of the document. Also, there is a charge for filling out and/or notarizing forms.

MEDICAL RECORDS

All information in your chart is strictly confidential and cannot be released to anyone without your written consent.

Records can be transferred to another physician upon you written request. This usually takes up to thirty days and is done in the order in which their requests are received. You may also pick up copies of any test results. We will not be able to mail, fax or give copies of your results to anyone but yourself.

Records transferred to any persons other than physicians, i.e., patients, lawyer, certain insurance companies, etc. are subject to a fee. The amount of this fee will depend on the volume of the record.

Records may take up to thirty days to be copied and mailed.

PRESCRIPTIONS OR REFILLS AFTER HOURS

Check your medications regularly and make sure that you have enough. This applies to diabetes, anti-hypertensive, arthritic medications, etc. If you do have an after hours-emergency call the above telephone number and the voice mail will direct you accordingly.

Please Allow 24 hours for prescription refill request to be processed.

REFERRALS

If you need a referral to a specialist, you will first be required to come in and see the doctor. If you see a specialist on a regular basis and he sends us consult letters requesting you return to see him/her, then we may be able to do this after the doctor has reviewed the notes and then approves the referral.

Please, do not make an appointment to see a specialist until the staff has obtained the referral for you.

Our office staff does referrals to specialists. Please allow 48-72 hours for these referrals to be processed. After processing by our office it sometimes takes another 48-72 hours to receive back an approved referral. We do referrals in the order in which they come in.

Initial_____

Pre-certs for ordered procedures are also done by the office staff when applicable. It is our intent to follow insurance regulations, if your insurance denies a pre-cert for a procedure it will be your responsibility to appeal to the next level. There is an appeal process that you can follow outlined by your plan provisions. There are certain criteria that patients have to meet in order to get tests approved. If you do not meet this criteria chances are the test will be denied.
Please do not call our office if you have questions regarding a specialist that you have been to. Many times we have not received documentation from the specialist and cannot answer your questions, instead please contact the specialist's office with any concerns.

RETURNED CHECKS
All returned checks are subject to a return check fee.

We trust that you understand the necessity for these terms, and we thank you for your cooperation. If you have any questions, do not hesitate to ask the staff or the doctor.

Please sign below, acknowledging that you have received the above information and agree to abide by the terms hereof.

SIGNED: _____ PRINT NAME: _____

DATE: _____

OUR FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. 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 is due at time of service.
We accept cash, checks, or credit card.

Regarding Insurance:

We may accept assignment of insurance benefits. However, we do require the portion responsible by the patient to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information at time of visit. We do not bill retroactively. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid the balance in full within 45 days, the balance will be automatically your responsibility and expected to be paid in full. Please be aware that some, perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding Insurance Plans where we are a participating provider:

All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating, refer to the above paragraph.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what are usual and customary rates.

Adult Patients:

Adult patients are responsible for full payment at time of service.
Minor Patients:
The adult accompanying a minor and the parents (or guardians of the minor) is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-paid.

Missed Appointments:

Unless canceled, at least 24 hours in advance, our policy is to charge $35.00 for missed appointments. Please help us serve you better by keeping your scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy.

X_____ DATE _____
(SIGNATURE OF PATIENT OR RESP. PARTY)

X_____ DATE _____
(SIGNATURE OF CO-RESP. PARTY)

THANK YOU,

BENBROOK MEDICAL AND SLEEP CENTER.