TEXAS MEDICAL & SLEEP SPECIALISTS, PLLC

REGISTRATION FORM – PEDIATRIC

(Please Print)

Referring Physician: _____ Primary Care Physician: _____

Patient's **LEGAL** Last name: _____ First: _____ Middle Initial: ____

Patient date of birth ____/____/_____ Patient Ethnicity: _____

Primary home street address: _____ Apt #: _____

City: _____ State: _____ Zip: _____ Social Security#: _____-____-_____

Primary parent email address: _____

Home phone ( ) _____ Cell phone ( ) _____ Employer phone ( ) _____

Ok to leave a voicemail at the numbers listed? Yes/No If so, preferred # ( ) _____

In case of an emergency, who should we notify: _____
Relationship to patient: _____

Is this person authorized to make medical decisions? Yes/No If not, please provide a contact that is authorized to make medical decisions:

Name: _____ Relationship to patient:_____

INSURANCE INFORMATION

Subscriber's Name: _____ Date of Birth: ____/____/_____

Subscriber's SS #: ____-____-_____ Relationship to patient: _____

Insurance Name: _____ Subscriber ID #: _____ Group #: _____

Secondary Insurance: YES / NO

Subscriber's Name: _____ Date of Birth: ____/____/_____

Subscriber's SS#: ____-____-_____ Relationship to patient: _____

Insurance Name: _____ Subscriber ID #: _____ Group #: _____

ASSIGNMENT AND RELEASE

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Texas Medical & Sleep Specialists or my insurance company to release any information required to process my claims.

_____ _____
Signature of Parent, Guardian or Responsible Party Date

_____ _____
Printed name of parent, guardian or responsible party Relationship to patient

Our Financial and Office Policies

Thank you for choosing Texas Medical & Sleep Specialists, PLLC as your healthcare provider. We are committed to providing our patients with the best available medical care. Our billing department will be available to discuss our fees and policies with you if you have any questions. We ask that all responsible parties read and sign our financial and office policies and complete the patient information form prior to seeing the physician. As you read, please initial beside each topic to indicate your understanding of our policies.

_____ 1. All co-pays, deductibles, and/or co-insurances are due at the time of service. We do not choose these fees. They are provided to our office by your insurance company when we call to verify benefits and/or the terms agreed upon by you (or your employer) and the insurance company.

_____ 2. We verify insurance benefits as a courtesy to our patients. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in your medical plan. Some insurance companies select certain services they will not cover. Please contact your insurance company if you have questions regarding your health care coverage. Texas Medical & Sleep Specialists, PLLC (TMSS) provides services that are medically necessary in the physician's professional opinion. If you are unsure if a procedure, immunization or injection is covered, please call your insurance company prior to receiving services. You are ultimately responsible for all charges that are not covered under your health care policy.
Please remember that your insurance is a contract between you (or your employer) and the insurance company. We are not a party to that contract.
It is very important that you understand the provisions of your healthcare policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of a bill or rejects your claim, any contact or explanation should be made to you, the policy holder. Reduction or rejection of any claim by your insurance company does not relieve you of your financial obligation. In the event that your insurance company pays us for a claim that you had already paid and you are due a refund, we will be happy to expedite your refund or credit your account.

_____ 3. We will collect all co-payments, deductibles or charges for non-covered services at the time upon check in. If you have a balance on your account we will ask for that payment as well. For your convenience, we accept cash, check, Visa and MasterCard.
_____ 4. **Although we accept patients with secondary Medicaid insurances as private patients, we do not bill secondary Medicaid insurances. You must complete a Medicaid form at every encounter or you cannot be seen.**
_____ 5. Some insurance companies require a referral from your primary care physician before being seen by a TMSS physician. If your appointment requires a referral from you primary care physician, that referral will need to be on file with our office before the appointment day. Please contact your primary care physician to ensure this referral is sent to our office in time for the upcoming appointment. If you are seen without a referral on file and the insurance company does not pay, you will be responsible for all charges.
_____ 6. We allow 90 days for payment of any balances that are the responsibility of the patient. If we do not receive full payment in 90 days, the account will be referred to collections. We understand that temporary financial problems may affect timely payments of your balance. We encourage you to communicate any such problems to us, so that we may assist you to keep your account in good standing.
_____ 7. Please ensure that all personal and insurance information is correct at the time of each visit. We will only bill the insurance company on file. It is not uncommon for someone to change their phone number or address and forget to inform us. This leads to fragmented communication. Please inform the receptionist if your address, phone number, or insurance information has changed (or if you anticipate that it will be changing in the near future).
_____ 8. TMSS provides a 30% discount for private pay patients. In order to receive this discount, payment must be in full at the time of service.

_____ 9a. Appointments not canceled with a 24 hour notice and any "no show" appointments will be subject to a charge of $35.00. Please note that this fee is not covered by your insurance company. We sincerely hope that we will not need to collect this fee. Rather, it is offered as an incentive to remind all of our patients and families to keep their scheduled appointments or, if unable to keep that appointment, to please reschedule more than 24 hrs in advance (and we greatly appreciate 48-72 hrs advance notice). When you reschedule your appointment several days ahead of time, this allows other patients the opportunity to be seen sooner... which they often greatly appreciate.
_____9b. Any diagnostic or therapeutic service appointments (I.E.: EEG, Rehabilitative Therapies, Endoscopy, Pulmonary Function Testing) not canceled with a 24 hour notice, will be subject to a charge of $50.00. The patient may be up to 30 minutes late for such appointment, however, a $25.00 fee will be charged and partial services may still be offered.

_____ 10. After 3 "no show" appointments we reserve the right to terminate the physician/patient relationship. A notification will be sent to the responsible party and to the referring physician. Should the physician choose not to terminate the relationship, we reserve the right to charge a $35.00 deposit for any future appointments. This deposit can be applied to any copay, co-insurance or deductible due at time of service or the deposit will cover the cost of the no show fee.

_____ 11. If you are more than 15 minutes late for your appointment, we will reschedule your appointment.
_____ 12. Any personal check returned for insufficient funds, will be charged $35.00 in addition to the amount of the check. After one instance of a returned check, all further payments will be required to be in the form of credit card, cash or money order only.
_____ 13. There is a $25.00 fee to complete any FMLA paperwork. The $25.00 fee is collected before the paperwork will be completed. Although the paperwork is long, please note that we do our best to complete this paperwork for you in a timely and efficient manner and we ask for your patience. We require 3-5 business days to complete this paperwork.
_____ 14. There is a $25.00 fee for copies of medical records not requested by another physician. The patient, parent or guardian must complete an authorization to disclose health information and the $25.00 fee will be collected before the records will be released.
_____ 15. ALL prescription refills MUST be called directly to your pharmacy. For your convenience, we transmit e-prescriptions via a secured internet network directly to participating pharmacies. You can have your pharmacy submit the refill request electronically or they may fax the request. We DO NOT accept calls directly from patients for refills. Please do not wait until you are out of medication to ask your pharmacy for a refill. **We require 2 business days to respond to a refill request. Please note that we do not process refill requests on the weekends or holidays.** The patient must have a follow-up appointment scheduled or have been seen within the last 6 months in order to have any prescriptions refilled.

_____ 16. We have adopted the following policies regarding Triplicate prescriptions (Triplicate prescriptions are for Schedule II controlled substances): All expired Triplicate prescriptions that are not filled must be returned to our office. Triplicate prescriptions must be filled within 21 days. There is a $5 fee for each triplicate prescription that is picked-up in a timely manner and a $25 fee for expired triplicate prescriptions (i.e. not picked-up in a timely manner). Triplicate prescriptions can be mail by certified mail for a fee of $25.00 in addition to the regular $5.00 refill fee.

I HAVE READ AND I UNDERSTAND THE ABOVE POLICIES

_____ _____/_____/_____

Signature of patient (or responsible party) **Date**

_____ _____

Printed name of patient (or responsible party) **Witness**

Medical History

Patient Name: _____ Date of birth: _____/_____/_____

Has the patient ever stayed overnight in the hospital? (Yes / No)
If yes, when and for what? _____
_____
_____

Has the patient ever been to the Emergency Room? (Yes / No)
If yes, when and for what? _____
_____

Previously diagnosed medical problems: _____
_____
_____

Previous surgeries: _____

ALLERGIES TO MEDICATIONS? (If yes, which medication and what happened?)

_____

Does patient have any food allergies? _____
Does patient have any environmental allergies? (Ex: pollen, oak, dust, cockroaches, pets) _____
_____

Medications (please include strength, dose, and frequency) Ex: Zyrtec (5 mg/ml) 1 teaspoon (5 ml) every night

_____
_____
_____
_____
_____
_____

Birth History

1. How many weeks pregnant was the mother at the time of birth? _____
2. How much did the infant weigh at birth? _____
3. Was child born by c-section or vaginally? _____
4. Was child a singleton, twin, or triplet? _____

NICU History

1. Did child spend any time in the NICU? _____
2. If yes, how long and which hospital? _____
   Why? _____
3. Was child diagnosed with any medical problems while in the NICU? (Yes / No)
   If so what? _____
   _____
4. Any procedures while in the NICU? _____
   If so what? _____
5. Was child on oxygen either thru a ventilator or a nasal cannula? _____
6. How many days on oxygen? _____

Specialty Questions:

1. Are the patient's immunizations up to date? _____
2. Has patient ever received Synagis injections? _____
3. When was the last **YEAR** the patient received the flu vaccine? _____
4. Has patient had allergy testing? (Yes / No) If so, where & when? _____
5. Do any of the patient caregivers work in a dusty environment? (Yes / No) _____

Other information you think we need to know? _____

Family History

Please tell us about the patient's family medical history. Do any medical problems run in the family?

Medical problems such as: (please circle all that apply)

- allergies, asthma, eczema, recurrent sinus infections, recurrent ear infections, cystic fibrosis, chronic bronchitis, emphysema, tuberculosis, or other lung diseases
- acid reflux, autoimmune diseases, HIV/AIDS, hepatitis
- high blood pressure, heart disease, heart attack, stroke, seizures, diabetes, cancer, thyroid gland problems, kidney problems, anemia, or other diseases
- snoring, sleep apnea, sleep walking, sleep talking, restless legs, periodic limb movement disorder, insomnia, SIDS, or other sleep disorders
- Other _____

If you circled any of the above, which family members?

Mother: _____ Mother's side: _____

Father: _____ Father's side: _____

Sibling(s): _____ Aunts/Uncles: _____

Cousins: _____ Others: _____

Social History

Name: _____ Date of Birth: ___/___/_____ Date: ___/___/_____

Please tell us about the patient's environment and social situation. Please bubble all that apply.

Please tell us about the patient's environment:

O house O apartment O trailer home O central A/C
O window A/C units O dehumidifier O humidifier O change air filters regularly
O hypoallergenic mattress encasement(s) O hypoallergenic pillow encasement(s)
O stuffed animals in the bedroom O carpet in the bedroom
O carpet throughout the home O mildew/mold problems in the home
O upholstered furniture O wood or leather furniture
O drapes/curtains on the windows O blinds on the windows

Does the patient drink alcohol, or is there alcohol consumption in the patient's environment?

O daily O weekly O monthly
O less than once a month O special occasions only O none

Does the patient smoke or is the patient exposed to smoke?

O Less than 1 pack per day O 1 pack per day O 1-2 packs per day
O Greater than 2 packs per day O Second hand smoke exposure
O Smoke exposure inside the home/car
O No smoke exposure

Who lives in the home with the patient?

O Mom O Dad O Both Parents O Foster Parent
O Siblings O Spouse O Children O Other

What type of work does the patient (or patient's parent(s)) do?

O Professional O Medical Field O Laboratory Work O Hard Labor
O Work in the Home O Exposure to Toxins and/or Chemicals O Other

Has the patient traveled or lived outside the United States? O Yes O No

What is the patient's (or patient's parent(s)) marital status?

O Single O Married O Divorced O Other

Is the patient exposed to pet(s) or animals? If so, how many?

O Dog(s) O Cat(s) O Bird(s) O Cattle O Horse(s) O No pet/animal(s)

Does the patient attend school?

O Elementary O Middle O High School O College
O Not in school O Involved in organized sports O Does not play sports
O Involved in extra-curricular activities

Does the patient (or patient's family) have daycare exposure? O Yes O No

Review of Systems

Name: _____ Date of Birth: ___/___/____ Today's Date: ___/___/_____

During the past few weeks, have you had any of the following symptoms? Please bubble all that apply.

CONSTITUTIONAL:
O fever O chills O night sweats
O fatigue O loss of energy O loss of appetite
O unexpected weight loss or gain O no general complaints
O problems with sleeping O snoring
O breathing difficulties O choking/gasping/snorting during sleep
O excessive sleepiness during the day O morning headaches
O dry mouth/sore throat upon wakening O difficulty falling asleep
O frequent awakening during the night O excessive movements during sleep
O other sleep difficulties O no sleeping problems

EYES:
O dry eyes O eye pain
O watery eyes O itchy eyes
O vision changes
O no eye complaints

EARS, NOSE AND MOUTH:
O nasal congestion O sinus pressure O facial pain O ear pain
O nasal discharge O nose bleeds O nasal ulcers O tooth pain
O ear discharge O dry mouth O oral ulcers O enlarged tonsils
O bad breath O postnasal drip O sore throat O no complaints
O recurrent strep throat O sensation of fluid or fullness in the ear

HEART:
O chest pain O palpitations O racing heart rate
O shortness of breath O swelling in the legs O no complaints

LUNGS:
O shortness of breath at rest O shortness of breath with normal daily activities
O shortness of breath with exercise O wheezing
O cough with sputum production O cough without sputum production
O blood tinged phlegm or coughing up blood O no lung complaints

STOMACH AND INTESTINES:
O nausea O vomiting O diarrhea O constipation
O abdominal pain O heartburn O jaundice O abdominal fullness O no complaints

GENITO-URINARY SYSTEM:
O painful urination O blood in urine O urgent or frequent urination O no complaints

PSYCHIATRIC:
O depression O anxiety O panic attacks O no complaints

MUSCLES AND JOINTS:
O joint pain O joint swelling O joint stiffness O muscle aches O muscle weakness
O no complaints

NEUROLOGICAL SYSTEM:
O headache O seizures O tremors
O vision changes O weakness O sensory changes
O difficulty with memory O no neurological problems/complaints

SKIN:
O eczema (dry/itchy skin) O rash O hives
O psoriasis O no skin complaints

HEMATOLOGICAL/LYMPHATIC SYSTEM:
O easy bruising O easy bleeding O history of blood clots (DVT) O blood clot antibody
O no complaints O swollen lymph nodes O no swollen lymph nodes

ENDOCRINE AND METABOLISM:
O heat intolerance O cold intolerance O frequent need to urinate
O always thirsty O intermittent vision changes
O problems with your thyroid O no complaints

ALLERGY/IMMUNOLOGY*:*
O anaphylaxis O angioedema
O frequent infections O no complaints

Electronic Prescriptions

We subscribe to an electronic prescription service. For your convenience, our physicians transmit e-prescriptions via a secured internet network directly to participating pharmacies. Please list your pharmacy name, address and phone number below.

Patient's Name: _____

Name of Pharmacy: _____

Pharmacy Address: _____

Pharmacy Phone #: (_____) _____ - _____

TMSS has the ability to download my pharmacy benefits and medication history through a secure internet network. This will allow my physician to prescribe medications covered by my health insurance plan and also prevent any medication allergies or duplicate prescriptions from being prescribed. By signing below, I give my permission for TMSS to download this information from the above pharmacy. **This is an OPTIONAL service provided by TMSS. If you do not wish to participate, feel free not to sign below.**

_____ _____

Patient or Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

*** If you have not received one yet, please ask for one the front desk. ***

I have received a copy of this office's Notice of Privacy Practices.

_____ ____/____/_____

Printed Name Date

_____

Signature

Thank you!

Texas Medical & Sleep Specialists

Avie Grunspan, M.D.
Joshua Rotenberg, M.D.
Sarat Susarla, M.D.
Rebekah Matos, FNP

Tarak Patel, M.D.
Kelly J. Smith, M.D.
Lesley Vernor, CPNP

PEDIATRIC PULMONOLOGY
PEDIATRIC EPILEPTOLOGY
ADULT & PEDIATRIC SLEEP MEDICINE
PEDIATRIC NEUROLOGY

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902 Frostwood, Suite 210
Houston, TX 77024
Main P: (713) 464-4107
Main F: (713) 465-4522

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the use or disclosure of information from the medical record of:
Patient Name_____DOB_____
I authorize the following individual or organization to disclose the above named individual's health information:
Name_____
Address:_____
This information may be disclosed TO and used by the following individual or organization:
Name_____
Address: _____
For the purpose of: _____
Please release the following: ____ Entire record **OR**:
____Problem List___Genetic testing information ___Medication List ___Allergies ___Progress Notes ___H&P
____X-Ray/Imaging Reports-from (date) _____ to (date)_____
____Laboratory Results-from (date) _____ to (date)_____
____Other diagnostic reports_____
____Other (specify) _____

- I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

___YES, I consent to the release of this information___NO, I do not consent to the release of this information

- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or 30 days from the date of this request.

I understand that authoring the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the office manager.

_____ _____ _____
Signature of patient/parent/guardian Date Relationship to patient

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:
I understand that my medical record may contain reports, test results and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Dr. Patel liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_____ _____
Signature of patient/parent/guardian Date

Date request completed_____ # of pages copy_____ Reviewed by _____
Charges $25.00 cash_____ check#_____ initials_____