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**

Sleep Evaluation Questionnaire

Patient Name: _____

Date of birth: _____/_____/_____

Directions

Please answer each of the following questions by writing in or choosing the best answer. This will help us know more about your family and your child.

CHILD'S INFORMATION

What are your major concerns about your child's sleep?

What things have you tried to help your child's problem?

Current Daytime Symptoms

(a) Never – does not happen **(b) Not often (less than 1 day a week)** **(c) Sometimes (1 to 2 days a week** **(d) Often (3 to 5 days a week)** **(e) Always (6 to 7 days a week)**							
1.	Trouble getting up in the morning	a	b	c	d	e	f
2.	Falls asleep in school	a	b	c	d	e	f
3.	Naps after school	a	b	c	d	e	f
4.	Daytime sleepiness	a	b	c	d	e	f
5.	Feels weak or loses control of his/her muscles with strong emotions	a	b	c	d	e	f
6.	Reports unable to move when falling asleep or upon waking	a	b	c	d	e	f
7.	Sees frightening visual images before falling asleep or upon	a	b	c	d	e	f

SLEEP HISTORY

Weekday Sleep Schedule

Write in the amount of time your child sleeps during a 24-hour period during weekdays: (add daytime and nighttime sleep)	_____ hours _____minutes
The child's usual bedtime on weekday nights :	_____:_____
The child's usual wake time on weekday mornings:	_____:_____

Weekend/Vacation Sleep Schedule

Write in the amount of time your child sleeps during a 24-hour period during weekends and vacations: (add daytime and nighttime sleep)	_____ hours _____ minutes
The child's usual bedtime on weekend/vacation nights :	_____:_____
The child's usual wake time on weekday mornings:	_____:_____

Nap Schedule

Number of days each week child takes a nap:	○ 0 ○1 ○ 2 ○3 ○4 ○ 5 ○ 6 ○ 7
If child naps, write in usual nap time(S):	Nap 1: _____: _____ a.m./p.m. to _____ : _____ a.m./p.m. Nap 2: _____ : _____ a.m./p.m. to ____ : ____a.m./p.m.

General Sleep

Does the child have a regular bedtime routine?	O yes O no
Does the child have his/her own bedroom?	O yes O no
Does the child have his/her own bed?	O yes O no
Is a parent present when your child falls asleep?	O yes O no

Child usually falls asleep in...	Child sleeps most of the night in...	Child usually wakes in the morning in...
○ own room in own bed (alone) ○ parents' room in own bed ○ parents' room in parents' bed ○ sibling's room in own bed ○ sibling's room in sibling's bed	○ own room in own bed (alone) ○ parents' room in own bed ○ parents' room in parents' bed ○ sibling's room in own bed ○ sibling's room in sibling's bed	○ own room in own bed (alone) ○ parents' room in own bed ○ parents' room in parents' bed ○ sibling's room in own bed ○ sibling's room in sibling's bed

Child is usually put to bed by: O Mother O Father O Both Parents O Self O Others

Write in the amount of time the child spends in his/her bedroom before going to sleep: minutes

Child resists going to bed?	Yes	No	**If yes,** do you think this is a problem?	Yes	No
Child has difficulty falling asleep?	Yes	No	**If yes,** do you think this is a problem?	Yes	No
Child awakens during the night?	Yes	No	**If yes,** do you think this is a problem?	Yes	No
After nighttime awakening, child has difficulty falling back to sleep?	Yes	No	**If yes**, do you think this is a problem?	Yes	No
Child is difficult to awaken in the morning?	Yes	No	**If yes,** do you think this is a problem?	Yes	No
Child is a poor sleeper?	Yes	No	**If yes,** do you think this is a problem?	Yes	No

Current Sleep Symptoms

(a) Never – does not happen
(b) Not often (less than 1 day a week)
(c) Sometimes (1 to 2 days a week
(d) Often (3 to 5 days a week)
(e) Always (6 to 7 days a week)
(f) Do not know

1	Difficulty breathing when asleep	a	b	c	d	e	f
2	Stops breathing during sleep	a	b	c	d	e	f
3	Snores	a	b	c	d	e	f
4	Restless sleep	a	b	c	d	e	f
5	Sweating when sleeping	a	b	c	d	e	f
6	Daytime sleepiness	a	b	c	d	e	f
7	Poor appetite	a	b	c	d	e	f
8	Nightmares	a	b	c	d	e	f
9	Sleepwalking	a	b	c	d	e	f
10	Sleeptalking	a	b	c	d	e	f
11	Screaming in his/her sleep	a	b	c	d	e	f
12	Kicks legs in sleep	a	b	c	d	e	f
13	Wakes up at night	a	b	c	d	e	f
14	Gets out of bed at night	a	b	c	d	e	f
15	Trouble staying in his/her bed	a	b	c	d	e	f
16	Resists going to bed at bedtime	a	b	c	d	e	f
17	Grinds his/her teeth	a	b	c	d	e	f
18	Uncomfortable feeling in his/her legs; creepy-crawly feeling	a	b	c	d	e	f
19	Wets bed	a	b	c	d	e	f

SCHOOL PERFORMANCE					
CURRENT SCHOOL PERFORMANCE (if school-aged)					
Your child's grade:					
Has your child ever repeated a grade?	○ No	○ Yes			
Is your child enrolled in any special education class?	○ No	○ Yes			
How many school days has your child missed so far this year?					
How many school days did your child miss last year?					
How many school days was your child late so far this year?					
How many school days was your child late last year?					
Child's grades this year:	○ Excellent	○ Good	○ Average	○ Poor	○ Failing
Child's grades last year:	○ Excellent	○ Good	○ Average	○ Poor	○ Failing

FAMILY'S INFORMATION

FAMILY SLEEP HISTORY

Does anyone in the family have a sleep disorder? 0 Yes 0 No

If yes, mark the disorder(s):

Insomnia	0 Mother	0 Father	0 Brother/sister	0 Grandparent
Snoring	0 Mother	0 Father	0 Brother/sister	0 Grandparent
Sleep apnea	0 Mother	0 Father	0 Brother/sister	0 Grandparent
Restless legs syndrome	0 Mother	0 Father	0 Brother/sister	0 Grandparent
Periodic limb movement disorder	0 Mother	0 Father	0 Brother/sister	0 Grandparent
Sleepwalking/sleep terrors	0 Mother	0 Father	0 Brother/sister	0 Grandparent
Sleep talking	0 Mother	0 Father	0 Brother/sister	0 Grandparent
Narcolepsy	0 Mother	0 Father	0 Brother/sister	0 Grandparent
Other:	0 Mother	0 Father	0 Brother/sister	0 Grandparent

From: Mindell JA & Owens JA (2003). *A Clinical Guide to Pediatric Sleep: Diagnosis and Management of Sleep Problems.* Philadelphia: Lippincott Williams & Wilkins.

Supported by an educational grant from Johnson's®

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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Houston, TX 77024
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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_____