TEXAS MEDICAL & SLEEP SPECIALISTS, PLLC

REGISTRATION FORM – ADULT

(Please Print)

Referring Physician: _____ Primary Care Physician: _____

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

Patient Date of birth ____/____/_____ Marital Status: M / W/ D / S Patient Ethnicity: _____

Primary home street address: _____ Apt #: _____

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

Patient email address: _____ Employer/Occupation: _____

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 <u>your responsibility</u> 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**

QUESTIONS	YES	NO	COMMENTS
Have you had sleep problems in the past?			
Have you had any sleep tests before?			
Do you snore loudly?			
Have you been told you hold your breath while sleeping?			
Do you wake up with a dry throat?			
Do you have night sweats?			
Do you need bathroom breaks after falling asleep?			
Do you wake up with headaches?			
Do you have choking spells during sleep?			
Does sleep position affect your snoring?			
Have you gained over 10 pounds in the last year?			
Do any (or did any) of your family members snore?			
Are you restless during sleep?			
Have you been told you kick or punch during sleep?			
Do you have leg discomfort relieved by movement?			
Have you had problem pregnancies? (Women)			
Do you grind your teeth at night?			
Does your spouse/family/pets affect your sleep? (circle)			
Do you worry in bed?			
Do you check the clock frequently in bed?			
Do you watch TV in bed?			
Do you play video games or work on the computer before bed?			
Do you read in bed?			
Do you get suddenly weak under extreme emotion?			
Do you ever feel paralyzed for minutes on waking?			
On falling asleep or waking, have you ever noted hallucinations?			
Would you describe your sleep as refreshing?			

Do you need a minimum amount of sleep to feel refreshed?			
Did you have sleep problems as a child?			

SLEEP TIMES	AM	PM	COMMENTS
What time do you try to go to sleep on weekdays?			
What time do you wake up on weekdays?			
What time do you try to go to sleep on weekends?			
What time do you wake up on weekends?			
What time do you take a nap, if applicable?			
Is the nap refreshing? YES / NO			

HABITS	YES	NO	AMOUNT
Do you currently smoke cigarettes/cigars/pipe?			
Do you currently chew tobacco?			
Have you quit nicotine products?			
If so, how long did you use & when did you quit?			Total years ____, Quit _____
Do you drink alcoholic beverages?			
If so, what time is your last drink?	AM	PM	
Do you drink or eat caffeine/decaf products?			
If so, what time is the last product taken?	AM	PM	
Do you use, or have you used mind altering drugs?			

DO YOU HAVE A MEDICAL HISTORY OF:	YES	NO	YEAR DIAGNOSED
High blood pressure/hypertension			
Diabetes			
Heart disease or Heart failure			
Kidney disease			

Stroke			
Obstructive lung disease or Asthma			
Heart rhythm problems			
Polycystic Ovarian disease (women)			
Depression			
Anxiety			
Chronic pain			
Reflux disease or night time heartburn			
Seizures			
Thyroid disease			
Anemia			
Fibromyalgia			
Arthritis			

PLEASE LIST SLEEP MEDICATIONS THAT HAVE FAILED AND WHY

MEDICATION NAME	WHY FAILED

MEDICAL DIAGNOSES

SURGICAL HISTORY

MEDICATION NAME - amount if known and time taken	AM	PM	BED	Other

MEDICATION ALLERGIES

NAME	*TYPE OF REACTION*

FAMILY MEDICAL HISTORY

FATHER	
MOTHER	
BROTHER	
SISTER	
SON	
DAUGHTER	
PATERNAL GRANDPARENT	
MATERNAL GRANDPARENT	

Review of Systems

Name:_____ Date of Birth:_____ 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

EARS, NOSE AND MOUTH:

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

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
sun sensitivity 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 metabolic or endocrine problems

ALLERGY/IMMUNOLOGY:

O anaphylaxis O angioedema
O no complaints O frequent infections

The Epworth Sleepiness Scale

Name: _____ Date: _____

DOB: ____/_____/_____ Height: _____ Weight: _____

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0= Never doze 1= Slight chance of dozing 2= Moderate Chance 3= High chance of dozing

Situation	**Chance of Dozing**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (e.g., theater, meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon if circumstances permitted	_____
Sitting quietly after lunch without Alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Sitting and talking to someone	_____

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

Thank you!