Pulmonary Services of North Texas
1208 Brook Ave Wichita Falls Texas 76301
Phone: 940-322-4480 Fax: 940-322-8420

Registration Information

(Please Print)

Date: _____ Home Phone _____ Cell phone: _____

Patient: _____ SS#: _____
Last name First name Middle Initial

Address: _____
Street address City State & Zip Code

Sex: ____Male ____Female Age: _____ Birthdate: _____ Marital Status: M S W D

Ethnicity ___Hispanic ___Non-Hispanic Race: _____ Preferred Language:_____

Employer: _____ Work phone: _____ Occupation: _____

Referring Physician: _____ Primary Care Physician: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Email (optional, for access to patient portal): _____

Insurance Information

Person responsible for Account: _____
Last name First name Middle Initial

Relation to Patient: _____ Birthdate: _____ SS#: _____

Address (if different than patient's): _____
Street address City State & Zip Code

Do you have Medical Insurance? _____yes ____no If yes, answer the following:

Name of Insurance company:_____

Insurance ID# : _____ Group # : _____

Name of Secondary Insurance (if any): _____

Insurance ID # : _____ Group # : _____

I, the undersigned, have insurance coverage with (name of Insurance Co.) _____(See Above)_____ and assign directly to Pulmonary Services of North Texas all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I permit a copy of this authorization to be used in place of the original and I authorize the use of this signature on all my insurance submissions.

Signature of Responsible Party: _____ Date: _____

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Photo privacy consent statement

Our physicians may request a picture of you be placed in our chart. Below is the consent for a photo to be taken.

1. I consent to have my picture taken for identification and medical documentation while at this office. I understand that this photo is part of my medical record and will be treated with the same confidentiality.
2. I release Pulmonary Services of North Texas and their successors and assigns and those acting with their permission from any responsibility of claim that may arise by reason of any exercise of the authority granted for any blurring, distortion, alteration, optical illusion that results from taking of above photo.

_____ _____

Signature Date

Notice of Privacy Practice Acknowledgement

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my 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 payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used of disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions. But, if you do agree then you hare bound to abide such restrictions.

Patient Name_____

Relationship to Patient_____

Signature_____

Date_____

HIPPA PRIVACY RESTRICTIONS

Please check all that apply.

Do not call home ____

Do not call work____

Do not leave voice message____

Do not contact by mail____

Do not contact by e-mail___

To whom can private information be shared?

_____ Relationship_____

_____ Relationship_____

_____ Relationship_____

Office Use Only

I attempted to obtain the patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgement but was unable to do so and documented below.

_____

Date Initials Reason

Pulmonary Services of North Texas
1208 Brook Ave.
Wichita Falls, Texas 76301
940-322-4480 office 940-322-8420 fax

Practice Policies

Hours of Operation

Our office hours Monday- Thursday 8:30 AM- 4:30 PM and we are closed for lunch from 12:00 PM-1:30 PM and on Friday from 8:30- 12:00 PM. Our phones will be forwarded to the answering service during lunch and at the end of the day.

Prescription and Refills

In an effort to take care of your prescription and refill needs, we ask that you have your pharmacy contact us with your request to ensure prompt and accurate refills. Please allow us 24- 48 hours to respond and approve your request. Your pharmacy will contact you when the prescription is ready for pick up.

Cancellation/ No show Policy

In order to be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to attend an appointment. We ask that you call 24 hours in advance.

A "no show" is an appointment that was not cancelled 24 hours prior to a scheduled appointment. Three no show appointments will result in dismissal from the practice.

Late Arrivals

In an effort to serve our patients in a timely manner, we request that you be on time for your scheduled appointment. In the event you are running late, please call to let us know. If you're more than five minutes late, the appointment will be rescheduled.

Contacting your provider

We understand there are times that you need to speak to your provider and or nurse during the day. However, you must realize they are seeing scheduled patients and have limited phone access during this time. If you call, please leave a detailed message with as much information as possible so we are able to address your needs appropriately. We will return your call within 24 business hours.

Non- Covered Services

We will make every possible effort to advise you of all non-covered services in advance. Medical plans have many unique stipulations. If you are not sure if a service is covered by your plan, you will need to call your insurance company in advance to see what your financial responsibility will be. It is the patients' responsibility to obtain an insurance referral when one is required. If you fail to obtain your referral, you will be financially responsible for all charges.

Online Patient Portal

We do offer online access to your medical records through our patient portal. If you wish to participate please provide the email address where you would like the invitation to be sent. If you do not have an email address you may also access the portal directly at portal.pulmonaryntx.com.

Email:

Acknowledgment of The Receipt of Pulmonary Services of North Texas Practice Policies

Name DOB Signature Date

Pulmonary Services of North Texas

Name _____ Age ____ Single Married Divorced Widowed Date _____

Occupation _____ All previous occupations _____

Birthplace _____ List all states in which you have lived _____

Education: _____ years High School _____ years College _____ years Post Graduate

Describe briefly your present medical symptoms: _____

_____

IMMUNIZATIONS: Please give year: Flu _____ Pneumonia _____

Check if any blood relative has or has had any of the following and enter relationship (Father, Mother, Sister, Brother).

	Yes	No	Relationship
Cancer of Lung	☐	☐	
Cancer of stomach, pancreas, intestines	☐	☐	
Cancer of breast	☐	☐	
Cancer of prostate	☐	☐	
Other cancer	☐	☐	
Tuberculosis	☐	☐	
Asthma	☐	☐	
Emphysema	☐	☐	
under age 50	☐	☐	

	Yes	No	Relationship
Fibrosis of lungs	☐	☐	
High blood pressure in lungs	☐	☐	
Bleeding tendencies	☐	☐	
Rheumatoid disorders	☐	☐	
Diabetes	☐	☐	
Stroke or early heart disease	☐	☐	
Heart Attack/heart failure	☐	☐	

Operations: List and indicate approximate year:

_____

_____

_____

_____

_____

PAST HISTORY (Personal)

Have you had any of the following illnesses?

	Yes	No
Angina Pectoris/ CAD	☐	☐
Heart Attack	☐	☐
Arthritis	☐	☐
High Blood Pressure	☐	☐
Anemia	☐	☐
Hay Fever	☐	☐
Asthma	☐	☐
Frequent Lung Infections	☐	☐
Emphysema	☐	☐
Diabetes	☐	☐
Cancer	☐	☐
Nervous Breakdown	☐	☐
Thyroid disease	☐	☐
Stomach Ulcers	☐	☐
Colitis	☐	☐

Hospitalizations (other than operations): List reasons and approximate dates:

_____

_____

_____

_____

Are you allergic to any medications/contrast dye?

☐ Yes ☐ No

If yes, please list (or provide list) medications and the reaction you had to them:

_____

_____

_____

_____

Do you have a living will/ Advanced care plan? Yes No

Do you have a Do Not Resuscitate (DNR) on file? Yes No

Do you have someone appointed to make decisions for you regarding your care if you are unable to? Yes No

If yes, Who? _____ Phone Number _____

Personal Habits:

Do you smoke? _____ (Never smoked_____)

_____ Cigarettes _____ Number of packs per day

_____ Cigars

_____ Pipes

How long have you been smoking? _____ Years

When did you quit smoking? _____

Have you ever been exposed to second hand smoke? _____

Have you used medication for weight loss? _____

Do you drink regularly? _____

Hard liquor _____ oz per day _____ oz per week _____oz per month

Beer _____ Per day _____ Per week _____ per month

Wine ____glasses per day _____ Per week _____ per month

Have you ever used recreational drugs?_____

Patients Signature_____

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322-4480

Medication List

Name:_____ Date: _____

Allergies (Medications): _____

Pharmacy name and phone: _____

	Name of medication and strength	Directions
1		
2		
3		
4		
5		
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