PULMONARY CARE SPECIALISTS, PA

4333 N. Josey Ln., Plaza 2, Suite 207, Carrollton 75010
972-394-2971 Fax 972-492-1261

James P. Loftin, M.D. **Melissa L. Tompkins, M.D.**

Dear New Patient;

It is **very important** that you complete the following questionnaire for the appointment you have scheduled on _____. By answering all of the questions as completely as possible before your appointment, you will save considerable time in the Doctor's office. If you do not complete this paperwork prior to your appointment, **please arrive an hour early to do so**.

When you arrive for your appointment, please present a current insurance card to the receptionist. If your insurance plan requires a referral from your Primary Care Provider, please bring it with you. **If no referral is presented, the receptionist will have to re-schedule your appointment.** If you do not know if your insurance plan requires a referral, you can call the benefits phone number on your insurance card to find out.

If you have a current chest X-Ray, please bring it with you (***Dr. Tompkins requires a chest X-Ray within the last two weeks)***. If you have had a CT of the chest within the last three years, please bring the films with you. Please expect the initial visit to last at least an hour. Some visits may take longer depending on the number of breathing tests performed. After the initial visit, your appointments will generally be much shorter.

Due to a high increase of patients not showing up for their scheduled appointments and in order for us to have available times for patients in need of appointments, we will implement the following policy effective April 1, 2010. We must be called twenty-four hours in advance if you are unable to keep your appointment or **we will not be able to reschedule your appointment for a later date**. There will also be a fee of $35.00 billed directly to you and not to your insurance company.

If you have any questions, please call the office where you are scheduled. We look forward to your first visit with our caring staff.

Sincerely,

James P. Loftin, MD
Melissa L. Tompkins, MD

PULMONARY CARE SPECIALISTS

4333 N. Josey Ln., Plaza 2, Suite 207, Carrollton
972-394-2971 FAX 972-492-1261

NAME _____ **AGE** _____

HOME PHONE _____ **WORK PHONE** _____

APPOINTMENT WITH _____**M.D.** **APPOINTMENT DATE** _____

PLEASE ANSWER ALL QUESTIONS AS COMPLETELY AS POSSIBLE.
IF YOU NEED MORE SPACE FOR ANY SECTION, PLEASE USE AN EXTRA PAGE.
IF YOU HAVE ANY PROBLEM WITH THIS FORM PLEASE CALL THE OFFICE.

Name of Address of Referring Physician

_____

_____

_____

Name and Address of Family Physician

_____

_____

_____

****

Please describe all of the problems that you are currently experiencing which caused you to seek treatment here today.

_____

_____

_____

_____

_____

_____

_____

Do you have any other medical problems? NO _____ **YES** _____ **if YES, list below.**

_____

_____

RESPIRATORY

Have you noticed any shortness of breath? NO _____ YES _____

If YES,

How long have you noticed this? _____

_____ when sitting or resting?
_____ when walking slowly?
_____ when walking fast?
_____ only when doing heavy work or physical activity?
_____ when climbing stairs? How many flights? _____

When you breathe, do your notice a wheeze or whistling
In your chest? NO _____ YES _____

How long have you noticed this wheezing?

_____ all my life
_____ over 10 years
_____ over 1 year
_____ just recently

How often does the wheezing occur?

_____ all the time
_____ nearly every day
_____ some every week
_____ some every month
_____ only on rare occasions

When does the wheezing occur?

_____ any time of the year
_____ seasonal (check which) _____Spring _____Summer _____ Fall _____ Winter
_____ any time day or night
_____ nighttime only
_____ only when physically active

Do you cough up any sputum or phlegm? NO _____ YES _____

If YES,

When do you cough it up?

_____ any time
_____ yellow or green
_____ brownish
_____ red-streaked (or blood streaked)

How much do you cough up?

_____ small amount- 1 tablespoon/day
_____ moderate amount- 1 tablespoon/day to ½ cup day
_____ more than ½ cup/day

Do you have a constant or bothersome cough? NO _____ YES _____
If YES, how long have you had it? _____

Do you have frequent chest colds? NO _____ YES _____
If YES, how many times per year on average? _____
And for how many years? _____

Do you cough blood? NO _____ YES _____
If YES, when was the last time you coughed up blood? _____
Have you ever had this happen before? NO _____ YES _____

Have you ever had difficulty breathing after taking aspirin? NO _____ YES _____

Have you ever had difficulty breathing after drinking wine? NO _____ YES _____

Do you cough or experience difficulty breathing after exposure
To strong smells (fumes, smoke, dust, perfumes, Etc.?) NO _____ YES _____

Do you use a feather pillow or a down filled pillow? NO _____ YES _____

Have you been exposed to anyone with tuberculosis? NO _____ YES _____

Have you had a skin test for tuberculosis? NO _____ YES _____
If YES, when _____ What was the result? NEG _____ POS _____

Do you cough, produce phlegm and/or wheeze when you exercise? NO _____ YES _____

How far can you walk at a normal pace on the level?
_____ room to room only
_____ 1 block or less
_____ 2 to 6 blocks
_____ unlimited

PAST MEDICAL HISTORY

LIST ALL CONDISTIONS FOR WHICH YOU HAVE RECEIVED MEDICAL TREATMENT.
LIST ALL HOSPITAL ADMISSIONS AND SURGICAL PROCEDURES.

	CONDITION/SURGERY	DATE	TREATMENT
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

List below **all** medications, eye drops, vitamins, laxatives, etc., that you take regularly or have taken during the **past month**. If name of medication is not known, please find out from your druggist the name or bring the medication with you. Include both prescription and non-prescription agents.

	NAME (IF KNOWN)	PURPOSE FOR WHICH TAKEN	HOW OFTEN? IF DAILY HOW MANY A DAY?
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Do you have any drug allergies? NO _____ YES _____ If YES, list below with type of reaction

	MEDICATION OR DRUG	REACTION
1.		
2.		
3.		
4.		

Estimate that last date that you had the following items:

Complete medical examination .....20 ___
Eye examination.....20 ___
Blood pressure check.....20 ___
Blood count.....20 ___
Flu vaccine.....20 ___
Pneumonia vaccine.....20 ___

Blood sugar check for diabetes.....20__
Electrocardiogram (EKG).....20__
X-Rays Chest.....20__
Mammogram.....20__
Prostate Test.....20__
Pap Smear.....20__

SOCIAL HISTORY

Are you: Single _____ Married _____ Separated _____
Divorced_____ Widowed _____ Widower _____

Have you ever used tobacco? NO _____ YES _____

If YES,

_____ Presently using:
_____ cigarettes _____ packs a day for _____ years
_____ other form of tobacco (describe_____) for _____ years

_____ None for _____ years
Smoked _____ packs a day for _____ years

Have you ever drunk alcoholic beverages? NO _____ YES _____
If YES,

_____ Socially: Amount _____ Frequency _____
_____ Daily: Amount _____ Frequency _____

Have you ever used illegal or recreational drugs NO _____ YES _____
If YES, describe _____
_____

Have you ever used IV or mainlined drugs? NO _____ YES _____
If YES, describe _____
_____

OCCUPATION

Check one or more:

_____ Self Employed
_____ Employed (by others)
_____ Retired
_____ Homemaker
_____ Student
_____ Unemployed

List ALL jobs you have ever performed (start with your present or most recent)

1. _____ FROM _____ TO _____
2. _____ FROM _____ TO _____
3. _____ FROM _____ TO _____
4. _____ FROM _____ TO _____
5. _____ FROM _____ TO _____
6. _____ FROM _____ TO _____

Have you been exposed to any toxic agent at work (dust, fumes, radiation, asbestos, etc.)? NO _____ YES _____
If YES, describe _____
_____

FAMILY HISTORY

Mother: Alive _____ Age _____ Deceased _____ Age at death _____
General health _____ Cause of death _____

Father: Alive _____ Age _____ Deceased _____ Age at death _____
General health _____ Cause of death _____

Brothers & Sisters	LIVING	DECEASED
	Age: _____ M/F _____ Health _____	Age _____ M/F _____ Cause _____
	Age: _____ M/F _____ Health _____	Age _____ M/F _____ Cause _____
	Age: _____ M/F _____ Health _____	Age _____ M/F _____ Cause _____
	Age: _____ M/F _____ Health _____	Age _____ M/F _____ Cause _____

How many children do you have? _____

Have you any children with medical problems? NO _____ YES _____ if YES, list below:

_____

_____

Have any of your Grandparents, Uncles, or Aunts died under the age of 65 years? NO____ YES ____
If YES, list with age and cause of death:

_____ _____

_____ _____

_____ _____

If any of your **BLOOD** relatives have had the following conditions, check and indicate their relationship to you:

_____ Asthma _____

_____ Chronic Bronchitis _____

_____ Emphysema _____

_____ Allergies _____

_____ Diabetes _____

_____ Tuberculosis _____

_____ Heart Disease _____

_____ High Blood Pressure _____

_____ Stroke _____

_____ Cancer _____

_____ Condition like yours _____

_____ Blood clots in legs or lungs _____

_____ Bleeding problems _____

REVIEW OF SYSTEMS

SKIN

Do you have any skin lesions: NO _____ YES _____

If YES, describe (or give its name if possible) _____

EYES

Do you wear glasses? NO _____ YES _____

When your eyes were last examined? 20_____

Have you noticed any difficulty with your vision? NO _____ YES _____

If YES, describe _____

EARS

Do you have difficulty hearing? NO _____ YES _____

Do you wear a hearing aid? NO _____ YES _____

Do you have frequent earaches? NO _____ YES _____

Do you have any discharge from your ears? NO _____ YES _____

Do you usually hear annoying buzzing or ringing in your ears? NO _____ YES _____

NOSE AND THROAT

Do you sneeze frequently? NO _____ YES _____
Is your nose continually stuffed or runny? NO _____ YES _____
Do you constantly feel drainage down the back of your throat? NO _____ YES _____
Do you have severe nosebleeds? NO _____ YES _____
Do you have intermittent hoarseness? NO _____ YES _____
Do you have persistent hoarseness? NO _____ YES _____
Has the sound of your voice changed? NO _____ YES _____
Do you often feel a choking sensation or lump in your throat? NO _____ YES _____

CARDIAC

Do you have a heart condition? NO _____ YES _____
If YES, describe _____

Do you have a chest pain with exertion? NO _____ YES _____
If YES, describe _____

Are you aware of an irregular heartbeat? NO _____ YES _____
If YES, describe _____

Do you sleep with 2 or more pillows or with a "wedge"? NO _____ YES _____
If YES, describe _____

Do you wake up at night with a "smothering" feeling? NO _____ YES _____
If YES, describe _____

Do you have swelling of your ankles? NO _____ YES _____
If YES, describe _____

Do you have pain or cramping in your legs when you walk? NO _____ YES _____
If YES, describe _____

Do you bleed easily? NO _____ YES _____
If YES, describe _____

GASTRO-INTESTINAL

Have you noticed any difficulty in swallowing food or water? NO _____ YES _____
If YES, describe _____

Do you have trouble with indigestion or heartburn? NO _____ YES _____
If YES, describe _____

Are you bothered with nausea or vomiting? NO _____ YES _____
If YES, describe _____

Has there been a recent change in your bowel habits? NO _____ YES _____
If YES, describe _____

Do you take OTC antacids? NO _____ YES _____
If YES, describe _____

Do you have a sense of reflux of stomach acid or stomach contents into your esophagus? Or into your throat? NO _____ YES _____

Have you had any bleeding from your rectum or with bowel movements? NO _____ YES _____
If YES, is it bright red blood? _____ How often does it occur? _____

Have you noticed any black or tarry stools? NO _____ YES _____
If YES, how often does it occur? _____

URINARY TRACT

Do you have burning or pain when you urinate? NO _____ YES _____
Do you get up more than once a night to urinate? NO _____ YES _____
Do you have any problem starting to urinate? NO _____ YES _____
Have you ever noticed blood in your urine? NO _____ YES _____

Women: Are you past menopause? NO _____ YES _____
Have you noticed any lumps in your breast? NO _____ YES _____

MUSCULO-SKELETAL

Do you suffer from joint pain or swelling? NO _____ YES _____
Do your muscles/joints frequently feel stiff or sore? NO _____ YES _____
Do you have osteoporosis? NO _____ YES _____

NEUROLOGIC

Do you have frequent or severe headaches? NO _____ YES _____
If YES, describe _____

In the past year have you fainted or lost consciousness? NO _____ YES _____
If YES, describe _____

Have you had any slurring or difficulty with your speech? NO _____ YES _____
If YES, describe _____

Do you have numbness or tingling of your head, arms or legs? NO _____ YES _____
If YES, describe _____

Have you had any weakness of your hands, arms, or legs? NO _____ YES _____
If YES, describe _____

Do you have trouble sleeping? NO _____ YES _____
If YES, describe _____

Do you snore?	NO _____	YES _____
Do you have pauses in your breathing while asleep?	NO _____	YES _____
Do you have leg cramps or restless legs at night?	NO _____	YES _____
Do you get sleepy in the daytime?	NO _____	YES _____
Do you have difficulty getting up in the morning?	NO _____	YES _____
Do you still feel tired when you get up?	NO _____	YES _____
Do you suffer from insomnia?	NO _____	YES _____
Do you have "sleep paralysis"?	NO _____	YES _____
Do you have vivid dreams as you start to fall asleep?	NO _____	YES _____

WEIGHT

What is your present weight? _____lbs. What is your usual weight? _____lbs.
Has your weight changed in the past year? _____ No _____ Gained _____ Lost
If you have gained or lost more than 10lbs, what do you believe is the reason?

_____

_____

HOBBIES

Please list your hobbies:

_____ _____ _____
_____ _____ _____

TRAVEL

Please list destinations and dates for travel outside the U.S. in the past 3 years:

_____ _____ _____
_____ _____ _____

PETS

Please list all pets (including fish) and indicate if indoor or outdoor:

_____ _____ _____
_____ _____ _____

DIET

Are you on any special diet? NO _____ YES _____
If YES, describe _____

_____

EXERCISE

Do you exercise? NO _____ YES _____

If YES, describe the type and duration _____ min and

Frequency _____ times per week.

Please bring all X-Rays, medical reports and medications with you to our office. Please list any other information, which you feel may be helpful:

Completed by: _____

All information provided is complete and accurate to the best of my knowledge.

Signed _____ Date _____

Reviewed by _____ Date _____

PULMONARY CARE SPECIALISTS

CONFIDENTIAL PATIENT DATA

Patient Name _____ **Birth Date** _____ Sex: M F

Address _____ SS# _____

City, State, Zip _____ Occupation _____

Preferred Pharmacy: Street, City, Zip Code _____

Please check the preferred method of contact:

- ☐ Home (___)_____
- ☐ Work (___)_____
- ☐ Cell (___)_____

Meaningful Use:

Race_____
Language_____
Marital Status_____

_____I give my consent to leave a detailed message with medical information

_____I DO NOT give my consent to leave a detailed message with medical information

Email address: _____

Employer Name_____Phone_____

Employer's Address_____

Primary Care Doctor_____ Phone_____

Referring Doctor (If different) _____ Phone_____

Emergency Contact

Name_____

Relationship_____

Phone_____

Other_____

Responsible Party (if other than the patient)

Name_____

Address_____

City, State, Zip_____

Phone_____

Relationship to patient_____

Signature_____

Printed Name_____

PULMONARY CARE SPECIALISTS

PRIMARY INSURANCE COVERAGE

Name of Insurance Company_____ HMO_____PPO_____

Subscriber/Card Holder Information: Name_____ Birth Date_____

Policy #_____Group#_____

Insurance Company Address_____Phone number_____

SS#_____Relationship to Card Holder: Self Spouse Child Other

SECONDARY INSURANCE INFORMATION

Please circle one: I have secondary insurance I do not have secondary insurance coverage

Name of Insurance Company_____-_____HMO_____PPO_____

Subscriber/Card Holder Information: Name_____Birth Date_____

Policy #_____Group#_____

Insurance Company Address_____Phone number_____

SS#_____Relationship to Card Holder: Self Spouse Child Other

BENEFIT ASSIGNMENT AND MEDICAL RECORD RELEASE

I authorize my insurance benefits to be made directly to the treating physician for services rendered and all future claims for services rendered. I attest that the above insurance information is accurate and that I am an eligible member. I also authorize the release of all information necessary for the purpose of payment for services rendered for current and future claims. I acknowledge that I have read the financial policy of the practice, I understand the policy, and agree to give consent for treatment.

SIGNATURE OF PATIENT OR GUARDIAN_____

PRINTED NAME_____**DATE**_____

TEXAS Health and Human Services | Texas Department of State Health Services

TEXAS IMMUNIZATION REGISTRY (ImmTrac2)
ADULT CONSENT FORM

(Please print clearly)

First Name _____ Middle Name _____ Last Name _____

Date of Birth (mm/dd/yyyy) _____ ( ) Telephone _____ Email address _____ Gender: ☐ Female ☐ Male

Address _____ Apartment # / Building # _____

City _____ State _____ Zip Code _____ County _____

Mother's First Name _____ Mother's Maiden Name _____

The Texas Immunization Registry is a free service of the Texas Department of State Health Services (DSHS). The immunization registry is a secure and confidential service that consolidates immunization records for public health purposes (e.g., giving all doctors treating a patient a central place to see that patient's immunization records). With your consent, your immunization information will be included in ImmTrac2. *For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation for that minor by completing the ImmTrac2 Minor Consent Form (# C-7) available for downloading at www.ImmTrac.com.*

Consent for Registration and Release of Immunization Records to Authorized Persons / Entities

I understand that, by granting the consent below, I am authorizing release of my immunization information to DSHS and I further understand that DSHS will include this information in the Texas Immunization Registry. Once in ImmTrac2, my immunization information may by law be accessed by: a Texas physician, or other health care provider legally authorized to administer vaccines, for treatment of the individual as a patient; a Texas school in which the individual is enrolled; a Texas public health district or local health department, for public health purposes within their areas of jurisdiction; a state agency having legal custody of the individual; a payor, currently authorized by the Texas Department of Insurance to operate in Texas for immunization records relating to the specific individual covered under the payor's policy. **I understand that I may withdraw this consent at any time.**

State law permits the inclusion of immunization records for First Responders and their immediate family members (older than 18 years of age) in the Registry. A "First Responder" is defined as a public safety employee or volunteer whose duties include responding rapidly to an emergency. An "immediate family member" is defined as a parent, spouse, child, or sibling who resides in the same household as the First Responder. For a family member younger than 18 years of age, a parent, legal guardian, or managing conservator may grant consent for participation as an "ImmTrac2 child" by completing the Immunization Registry (ImmTrac2) Consent Form (# C-7).

Please mark the appropriate box to indicate whether you are a First Responder or an Immediate Family Member.

☐ I am a **FIRST RESPONDER**. ☐ I am an **IMMEDIATE FAMILY MEMBER** (older than 18 years of age) of a First Responder.

By my signature below, I **GRANT** consent for registration. I wish to **INCLUDE** my information in the Texas immunization registry.

Individual (or individual's legally authorized representative): Printed Name _____

Date _____ Signature _____

Privacy Notification: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See *http://www.dshs.texas.gov* for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003, and 559.004)

Questions? (800) 252-9152 • (512) 776-7284 • Fax: (866) 624-0180 • www.ImmTrac.com
Texas Department of State Health Services • ImmTrac2 Group - MC 1946 • P. O. Box 149347 • Austin, TX 78714-9347

PROVIDERS REGISTERED WITH ImmTrac2: Please enter client information in ImmTrac2 and **affirm** that consent has been granted. **DO NOT fax to ImmTrac2. Retain this form in your client's record.**

Stock No. F11-13366

Revised 04/2019

FINANCIAL POLICY

Patient Name: _____ **Date of Birth:** _____

CASH POLICY Pay for service is due in full at the time service is provided in our office.
FOR PATIENTS WITH INSURANCE We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.
MEDICARE PATIENTS We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.
NONCOVERED SERVICES Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.
PERSONAL INJURY CASES This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.
MISSED APPOINTMENTS In fairness to other patients and the doctor, we required at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

Please check on: I have paid my insurance deductible for the calendar year _____ ☐ Yes ☐ No ☐ Don't know

MEDICARE PATIENTS: SIGNATURE ON FILE I request payment of authorized Medicare benefits be made on my behalf to the health care professional providing any services furnished me. I authorize any holder of medical information about me to release to the health care professional's billing staff any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

ASSIGNMENT OF INSURANCE BENEFITS
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to the health care professional providing health services to me. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I understand that my insurance is a contract between myself and my insurance company. The healthcare professionals' billing staff will file my claim and will work to resolve any problems obtaining payment from my insurance company, but ultimately it is my responsibility to contact my insurance company to resolve any problems.

The patient is ultimately responsible for all professional fees.

I have read, understood, and agreed to the above financial policy for payment of professional fees.

Signature: _____

Date: _____

PULMONARY CARE SPECIALISTS, PA

James P. Loftin, M.D. **Melissa L. Tompkins, M.D.**

RELEASE OF MEDICAL RECORDS

I, _____

Date of Birth_____authorize

leave blank

Doctor/practice name_____

Address: _____

_____

To release my medical records to:

James P. Loftin, MD
Melissa L. Tompkins, MD

4333 N. Josey Lane
Suite 207
Carrollton, TX 75010

Phone no: 972-394-2971
Fax number 972-492-1261

Please include the following:

_____ labs _____ radiology tests
_____ office notes _____ spiro/pft
_____ other _____

Patient's Signature _____
Printed Name: _____
Date: _____ Witness: _____

I understand that I have the right to revoke this authorization, in writing, at any time, by sending written notification to the practice. I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations. The practice will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

VII. ACKNOWLEDGEMENT AND REQUESTED RESTRICTIONS.

By signing below, you acknowledge that you have received this *Notice of Privacy Practices* prior to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as set forth herein except as expressly stated below.

I hereby request the following restrictions on the use and/or disclosure (specify as applicable) of my information:

_____

_____

_____

_____

I give my permission to speak with the following persons regarding my healthcare and any financial issues related to my care:

Name_____

Phone number_____Relationship _____

Name_____

Phone number_____Relationship _____

Name_____

Phone number_____Relationship _____

Patient Name: _____ Patient Date of Birth_____

(Please Print Name)

SIGNATURES:

Patient/Legal Representative: _____ *Date*: _____

If Legal Representative, relationship to Patient: _____

Witness (optional): _____Date: _____

PULMONARY CARE SPECIALISTS
NOTICE OF PRIVACY PRACTICES

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.

EFFECTIVE 1/1/2015

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Pulmonary Care Specialists, PA, including its providers and employees (the "*Practice*").

I. OUR OBLIGATIONS.

We are required by law to:

- Maintain the privacy of your medical information, to the extent required by state and federal law;
- Give you this Notice explaining our legal duties and privacy practices with respect to medical information about you;
- Notify affected individuals following a breach of unsecured medical information under federal law; and
- Follow the terms of the version of this Notice that is currently in effect.

II. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

I. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. **Individuals Involved in Your Care or Payment for Your Care.** We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. **As Required by Law.** We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. **To Avert an Imminent Threat of Injury to Health or Safety.** We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. **Organ and Tissue Donation.** If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. **Research.** We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

O. **Military and Veterans.** If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. **Workers' Compensation.** We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. **Public Health Risks.** We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services. The types of information generally include information used:

- To prevent or control disease, injury, or disability (including the reporting of a particular disease or injury).
- To report births and deaths.
- To report suspected child abuse or neglect.
- To report reactions to medications or problems with medical devices and supplies.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- To provide information about certain medical devices.
- To assist in public health investigations, surveillance, or interventions.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances, we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. **Inmates.** If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. **Marketing of Related Health Services.** We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. **Fundraising.** We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. **Electronic Disclosures of Medical Information.** Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

III. OTHER USES OF MEDICAL INFORMATION

A. **Authorizations.** There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. **Psychotherapy Notes, Marketing and Sale of Medical Information.** Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. **Right to Revoke Authorization.** If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

IV. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. **Right to Inspect and Copy.** Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" of your medical information. This is a list of the disclosures we have made for up to six years prior to the date of your request of your medical information, but does not include disclosures for Treatment, Payment, or Health Care Operations (as described in Sections II A, B, and C of this Notice) or disclosures made pursuant to your specific authorization (as described in Section III of this Notice), or certain other disclosures.

If we make disclosures through an electronic health records (EHR) system, you may have an additional right to an accounting of disclosures for Treatment, Payment, and Health Care Operations. Please contact the Practice's HIPAA Officer at the address set forth in Section VI below for more information regarding whether we have implemented an EHR and the effective date, if any, of any additional right to an accounting of disclosures made through an EHR for the purposes of Treatment, Payment, or Health Care Operations.

To request a list of accounting, you must submit your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

Your request must state a time period, which may not be longer than six years (or longer than three years for Treatment, Payment, and Health Care Operations disclosures made through an EHR, if applicable) and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a twelve-month period will be free. For additional lists, we may charge you a reasonable fee for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

D. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care

operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

E. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

F. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

G. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.