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
Kathy Johnson, PA-C
Ebonyck Simmons, NP-C

Melissa L. Tompkins, M.D., F.C.C.P.

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Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of our medical record.

Name: (Last, First, MI)	☐ **M** ☐ **F**	**DOB**
Pharmacy Name:	**Pharmacy number:**	
Marital Status: ___Single ___Married ___Separated ___Divorced ___Widowed ___Domestic partner		
Primary Care Doctor:	**Referring Doctor:**	

PERSONAL HEALTH HISTORY

Chief Complaint:

List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers:

Name of Drug	Strength	Frequency Taken

Past Medical History: ☐ **Hypertension** ☐ **Diabetes** ☐ **Hyperlipidemia**
☐ **Emphysema** ☐ **Asthma** ☐ **Other:**

Allergies/Intolerance to Medicines and Foods:

Name of Drug or Food	Reaction You Had

Surgeries/Hospitalizations:

Year	Type of Surgery/Reason for Hospitalization:

Flu Vaccine ☐ **No** ☐ **Yes Date:** _____ **Pneumonia Vaccine** ☐ **No** ☐ **Yes Date:** _____

FAMILY HEALTH HISTORY

	Age	Age at Death	Significant Health Problems or Cause of Death
Father			
Mother			

Siblings

Sex	Age	Age at Death	Significant Health Problems or Cause of Death

Children

Sex	Age	Age at Death	Significant Health Problems or Cause of Death

	Age	Age at Death	Significant Health Problems or Cause of Death
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			

Grandchildren

Sex	Age	Age at Death	Significant Health Problems or Cause of Death

PERSONAL AND SOCIAL HISTORY

Occupation _____

Who lives with you at home?_____

Do you have any pets at home? _____

Have you traveled outside Texas in the past year?_____

Exercise

☐ **Sedentary (No exercise)** ☐ **Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)**

☐ **Occasional Vigorous Exercise (i.e. work or recreation less than 4x/week for 30 min.)**

☐ **Regular Vigorous Exercise (i.e. work or recreation 4x/week for 30 minutes)**

Caffeine: None Coffee Tea Cola #of Cups/Cans Per Day? _____

Alcohol: ☐ **None** ☐ **Liquor/Day** ☐ **Beer/Day** ☐ **Wine/Day**

Tobacco: Do you use tobacco?..... ☐ **Yes** ☐ **No**

☐ **Cigarettes**___ **Pks/day** ☐ **Chew** ____ **#/day** ☐ **Pipe** ____**#/day**

☐ **Cigars**___ **#/day** ☐ **#of Years** ☐ **or Year Quit** _____

Problems

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ **Change in appetite**	☐ **Chills**	☐ **Fever**	☐ **Sinus congestion**
☐ **Sore throat**	☐ **Swollen glands**	☐ **Cold intolerance**	☐ **Heat intolerance**
☐ **Weight loss**	☐ **Cough**	☐ **Shortness of breath at rest/night**	☐ **Shortness of breath with exertion**
☐ **Wheezing**	☐ **Coughing up blood**	☐ **Chest pain at rest**	☐ **Chest pain with exertion**
☐ **Irregular heartbeat**	☐ **Daytime sleepiness**	☐ **Daytime fatigue**	☐ **Snoring**
☐ **Reflux/heart burn**	☐ **Abdominal pain**	☐ **Diarrhea**	☐ **Black Stools**
☐ **Nausea**	☐ **Vomiting**	☐ **Blood in urine**	☐ **Difficulty urinating**
☐ **Frequent urination**	☐ **Painful joints**	☐ **Weakness**	☐ **Dry skin**
☐ **Itching**	☐ **Rash**	☐ **Dizziness**	☐ **Fainting**
☐ **Headache**			

Other:_____

_____

_____

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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_____

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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**_____

FINANCIAL POLICY

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.

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.

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 agree to the above financial policy.

Patient or guarantor 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
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: _____

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