METROPLEX PULMONARY &SLEEP CENTER, P.A
1701 Eldorado Parkway Suite 250 McKinney, Texas 75069
Phone: 972-838-1892 Fax: 214-548-4205

PATIENT HISTORY FORM			
Name: (Please print)			
Date of birth		Age:	
Describe the current medical problem or reason for today's visit:			
Have you had any recent **CT Scans**, **x-rays** or **lab tests**, relating to this problem? Yes No			
If yes, when and where were those done?			
Who is your primary care physician?			
Who is your referring physician for today's visit?			
Have you ever been diagnosed with the following?			
asthma	heart attack	sleep apnea	thyroid disease
chronic bronchitis	stroke	kidney disease	high cholesterol
emphysema	hypertension	gastric ulcers	congestive heart
pneumonia	diabetes	hepatitis	tuberculosis
Past Surgical History (If you have a list we can make a copy):			
Other Hospitalizations:			
Are you allergic to any medications? Yes No			
If yes please write the name of the Medication(s			
Current Medications: Please list **all medications** you are currently taking. We can also make a copy of your medication list if you have it with you.			
Are you using: Oxygen		CPAP	Nebulizer
Do you smoke (current smoker)? Yes No		if yes- how many packs a day?	
Ex-smoker: Number of years smoked		how many packs per day?	
Do you consume alcohol on a regular basis?		Yes No	If yes-how much?
Do you have any history of family diseases?			
Have you ever had the flu vaccine? Yes No			
Have you ever had the pneumonia vaccine? Yes No			
Occupation:			
Are you married? Yes No	Do you have any children? Yes No		
Do you have pets at home? Yes No			
Have you been exposed to dust, fumes, or asbestos? Yes No			
Do you snore? Yes No			
Do you stop breathing at night? Yes No			
Do you have difficulty falling asleep? Yes No			
Do you have difficulty staying asleep? Yes No			
What time do you go to bed?	And wake up?		
Time you usually fall asleep?	Number of times you wake up at night?		
Signature of Patient:			Date:

METROPLEX PULMONARY &SLEEP CENTER, P.A
1701 Eldorado Parkway Suite 250 McKinney, Texas 75069
Phone: 972-838-1892 Fax: 214-548-4205

Do you sleepwalk? Yes No Do you talk while sleeping? Yes No
Do you sweat at night? Yes No Do you have nightmares/abnormal dreams?
Do you feel tired in the morning? Yes No
Do you have difficulty staying awake during the daytime? Yes No
Do you have restless leg symptoms? Yes No Do your legs ache at night? Yes No
Do you feel muscle weakness while laughing or crying? Yes No
Do you have: Fevers chills Do you sweat at night?
Do you get short of breath? Yes No with exertion (exercise) Yes No
When did you first notice shortness of breath? Days Weeks Months Years
Has the shortness of breath gotten worse over time? Yes No
If so, has it gotten worse: slowly suddenly
If so, how much exertion does it take: (circle all that apply?)
a) walking slowly b) walking quickly c) climbing up a slope/ hill d) climbing stairs
Does anything else make you short of breath?
Do you wake up at night short of breath? Yes No
Do your feet swell? Yes No
Do you feel shortness of breath when you first lie down at night? Yes No
When lying down do you prop your head up to breath comfortably? Yes No
Do you wake up wheezing at night? Yes No
Do you cough? Yes No How long have you been coughing for?
Does anything cause you to cough or worsen it?
Is cough worse at certain times of the day?
Is cough worse at night? Does it wake you up at night?
Do you bring up sputum? Yes No
What color is your sputum: Circle one: clear, white, gray, yellow, and green
On average how much sputum do you cough up during a day?
Have you ever noticed blood in your sputum? Yes No
Do you have pain/discomfort in your chest? Yes No If so, what area of chest?
What type of pain: a) sharp b) dull c) stabbing d) constant e) intermittent
Does pain shift to another part of your body? Yes No
Is pain worse with exercise? Yes No
Is pain worse with deep breathing? Yes No
Do you wheeze? Yes No What makes you wheeze?
Have you ever been exposed to Tuberculosis? Yes No
Do you suffer from: headaches seizures passing out spells dizziness?
Do you experience: nausea vomiting diarrhea reflux
Do you experience: arthritis muscle aches
Did you notice: weight loss weight Gain fatigue
Print Patient's Name:
Signature of Patient: Date:

METROPLEX PULMONARY &SLEEP CENTER, P.A
1701 Eldorado Parkway Suite 250 McKinney, Texas 75069
Phone: 972-838-1892 Fax: 214-548-4205

Patient Registration		
Name: (please print)		Date of birth:
Address:		State: Zip:
Email address:		
Cell phone #:	Home Phone #	Work Phone#
Marital status:	Spouse's name:	
SS#: Employer:		
Emergency contact name: (Please print)	Phone #	
Relation:		
Which is the best number to contact you?		
Can we leave a message on your voice mail? Yes	No	
You can request your medical records to be mailed to your house. We will send those to you by USPS Certified mail and with signature confirmation. However, you must send us a written and signed request if you wish to receive your medical records via email.		
Your Pharmacy's name:		Phone number
Your oxygen and/or CPAP machine supplier's name:		Phone number
INSURANCE INFORMATION		
Primary Insurance Company:		
Name of insured:		
Group #:	ID #:	
Secondary/Supplemental Insurance:		
Name of Insured:		
Group #:	ID #	
Tertiary/Supplemental Insurance:		
Name of Insured:		
Group#:	ID #:	
ASSIGNMENT OF INSURANCE BENEFITS		
I request that payment of authorized insurance benefits be made on my behalf to Metroplex Pulmonary and Sleep Center for any services furnished by the provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration, and its agents any information needed to determine these benefits or the benefits payable for 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.		
Signature of Patient:		
Or Authorized Representative:		
Date:		

METROPLEX PULMONARY &SLEEP CENTER, P.A
1701 Eldorado Parkway Suite 250 McKinney, Texas 75069
Phone: 972-838-1892 Fax: 214-548-4205

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I acknowledge that Metroplex Pulmonary and Sleep Center provided me with a written copy its Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

_____ _____

Patient Signature Date

_____ _____

Personal Representative Signature (if applicable) Relationship to Patient

METROPLEX PULMONARY &SLEEP CENTER, P.A
1701 Eldorado Parkway Suite 250 McKinney, Texas 75069
Phone: 972-838-1892 Fax: 214-548-4205

Patient is responsible for the services/provided charges if insurance does not cover.

It is necessary for our office to enact the following policies effective January of each year due to the increase in high deductibles, co-insurance portions, co-payments of insurance companies' pending claims and withholding payments. **I hereby give authorization to Dr. Shahrukh Kureishy/Dr. Ferzana Mir and their staff to provide medical treatment. I understand that no guarantees have been made with regards to treatment success, and that there may be complications associated with the condition or with its proposed treatment. Please initial _____.**

We ask for your insurance information when we schedule your first appointment as well as at each of your follow-up to revise any changes. We do our best to verify that our doctors are contracted, and in network with your insurance plan to cover your office visit, PFT Pulmonary Function (breathing) Test, sleep study take home device Test, Labs (orders sent out), CPAP, or CPAP Supplies and Spirometry might not be paid by your insurance. By signing below you are agreeing to pay for these services yourself if those services are denied by your insurance or determined by your insurance as not to be "medically necessary."

Based upon information provided to us by your insurance company we will expect payment according to the benefits quoted. Your copayment, co-insurance or deductible per your insurance company, and as indicated on most insurance cards will be collected before seeing the doctor. We will then file your office visit superbill with your insurance company. However, you will be responsible for your portion after your insurance pays, and as it indicates on your EOB. Any outstanding balance will be due and payable upon receipt of the statement. Also, we will not be held responsible if you or your accompanied person/s fall and injures in or outside our office. Furthermore, many insurance plans have a requirement that patients must provide additional information to them before they will pay your claim. When this is the case, your insurance company will inform us that they have "pended" your claim for additional information. Therefore, the full balance due on your visit becomes your responsibility. Once an insurance company "pends" a claim there is nothing that our office can do to get the claim paid. It is completely your responsibility to contact your insurance company to provide them the needed information so your insurance company pays the claim within thirty days. Additionally, you must notify us at the time of service if your insurance plan, group, or policy number changes so we can file your claim precisely.

Visits that have been filed by us in a timely manner but denied by your insurance after sixty days will become your responsibility. Please remember that our office files to your insurance as a courtesy to you. It is important to remember that your insurance policy is a contract between you and the insurance company.

I also understand that failure to appear on scheduled follow up or new patient visit appointment may result in a delay in the diagnosis, and treatment of a potentially serious condition. We call in advance to remind an upcoming appointment, and/or reschedule if the appointment cannot be kept. However, we will not be held responsible for complications arising from missed appointments due to the patient's noncompliance.

We reserve the right to charge $35 for missed appointment and no show not given (48 hours' notice by the patient.) Returned checks for insufficient funds will be subjected to $35 fees as well. Payment is expected at the time of service.

Signature of Patient: _____

Patient's Printed Name: _____

Responsible person's name if patient is unable to sign: (Please print) _____

Responsible Person's signature: _____

Relation with the patient: _____

Date: _____

6

Shahrukh A. Kureishy M.D
Metroplex Pulmonary &
Sleep Center
1701 Eldorado Parkway
Suite 250
McKinney, TX 75069

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE (____) _____ ALT. PHONE (____) _____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (____) _____ Fax (____) _____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ☐ All health information
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ Other _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)
_____ Drug, Alcohol, or Substance Abuse Records
_____ Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X _____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X _____ _____
Signature of Minor Individual DATE