



912 S. Fleishel | Tyler, TX 75701 | 903-592-6901

Thank you for choosing Pulmonary Specialists of Tyler for your pulmonary needs.

Your appointment is on

MON TUES WED THURS FRI

Date: _____ Arrival Time: _____

PFT Time: _____ CXR Time: _____

You will see _____

Your appointment is scheduled at the following location:

- Tyler Clinic** – 912 S. Fleishel, Tyler.
- Sulphur Springs Allergy Clinic** – 107 Medical Circle, Sulphur Springs.
- Sulphur Springs Clinic** – 107 Medical Circle, Sulphur Springs.
- Jacksonville Clinic** – 2026 Jackson St., Jacksonville.
- Carthage Clinic** – 704 North Davis Street, Carthage.
- Pittsburg Clinic** – 2701 Hwy 271 South (ETMC Pittsburg), Pittsburg
- Athens Clinic** – 117 Medical Circle, Athens

- Please complete all new patient paperwork before arriving for your appointment. Also, bring your New Patient Folder along with your insurance card and driver's license. This will reduce the amount of time spent registering.
- You may receive a phone call prior to your appointment to go over the pink sheet located in the patient packet. This discussion will also reduce the time spent registering.
- On this and every visit, please bring a list of your **MEDICATIONS**, including dosages.
- You will be reminded with a phone call the day before your appointment.
- Failure to cancel your appointment within 24 hours may result in a \$25.00 charge.

We look forward to seeing you. If you have any questions, please contact us at (903) 592-6901 or toll-free at (800) 722-5864.

Sincerely,

Pulmonary Specialists of Tyler, P.A.



Pulmonary Disease • Interventional Pulmonology
Critical Care • Sleep Medicine • Allergy

PATIENT REGISTRATION

PLEASE PRINT IN INK

Please put N/A in the blanks that do not apply to you

| | |
|---|--|
| Patient Information | Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed |
| Name _____ | Sex <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Home Phone (____) _____ | Student <input type="checkbox"/> N/A <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time |
| Work Phone (____) _____ | Best hours to contact _____ |
| Cell Phone (____) _____ | Email _____ |
| Address _____ | SSN _____-_____-_____ |
| City _____ State _____ Zip _____ | Date of Birth ____/____/_____ |
| Employer _____ <input type="checkbox"/> Retired | Driver's License # _____ |
| Address _____ | State where Driver's License was issued _____ |
| Referring Physician _____ | Phone (____) _____ |
| Primary Care Physician _____ | Phone (____) _____ |

| | |
|---|--|
| Spouse, Parent, Legal Guardian Information | <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Legal Guardian |
| Name _____ | Employer _____ |
| Address _____ | Work Phone (____) _____ |
| City _____ State _____ Zip _____ | Address _____ |
| SSN _____-_____-_____ | City _____ State _____ Zip _____ |
| Driver's License # _____ | |
| Emergency Contact | <i>Please be aware that by listing this person, you are giving Pulmonary Specialists of Tyler permission to release your medical information to them in the event of an emergency.</i> |
| Name _____ Relationship _____ | Phone (____) _____ |

| | |
|-------------------------------------|---|
| Insurance Information | <i>Please list policyholder if other than the patient. Please list primary company first.</i> |
| Primary Insurance (Company) _____ | Policy # _____ |
| Address _____ | Group # _____ |
| Name of Policyholder _____ | Relationship to Patient _____ |
| Date of Birth ____/____/_____ | SSN _____-_____-_____ |
| Employer _____ | Address _____ |
| Secondary Insurance (Company) _____ | Policy # _____ |
| Address _____ | Group # _____ |
| Name of Policyholder _____ | Relationship to Patient _____ |
| Date of Birth ____/____/_____ | SSN _____-_____-_____ |
| Employer _____ | Address _____ |

I certify that this information is true and correct.

Name _____ Date _____

**Authorization for Use of Disclosure of Information for
PULMONARY SPECIALISTS OF TYLER, PA (PSOT) AND
TYLER INPATIENT MANAGEMENT SPECIALISTS (TIMS)**

AUTHORIZATION FOR VERBAL RELEASE OF INFORMATION

I. I, _____, hereby authorize PSOT/TIMS to disclose the following protected information to the following (name of those to receive or disclose additional information pertaining to treatment, payment, and/or health care operations):

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

Name: _____

Relationship to Patient: _____

II. This protected health information may also be used or disclosed for the following purposes:

Information directly related to the financial records of your account. This information may include, but is not limited to, demographic and/or insurance information, date of service, type of service provided, and/or charges (reasons for denial or patient responsibility).

III. This authorization shall be in force until _____ unless PSOT/TIMS receives written notification from me.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the offices of Pulmonary Specialists of Tyler, PA or Tyler Inpatient Management Specialists at 912 South Fleishel, Tyler, TX 75701.

Patient Name (printed)

Patient Date of Birth

Patient Signature / Legal Signature

Date



912 S. Fleishel | Tyler, TX 75701 | 903-592-6901

Name _____ Date _____

Referring Doctor _____

What is your main problem that we may help with? _____

List all medications you are taking and how you take them (even over the counter): _____

Are you allergic to any medications? _____

Have you ever had: Asthma Emphysema Diabetes High blood pressure Heart disease Cystic fibrosis Cancer

List any other illnesses and all surgeries: _____

List age and cause of death of each immediate family member: _____

Circle diseases that run in your family: Asthma Emphysema Diabetes High blood pressure Heart disease Cystic fibrosis

What is/was your occupation? _____

Any fume/dust/asbestos exposure? _____

Do you or have you ever smoked? _____ For how long? _____ Packs per day _____ Date stopped _____

Do you or have you ever consumed alcohol? _____ If so, what type and how much per day? _____

List any pets or animals you have: _____

List any recent out of state travel: _____

FOR NURSE USE ONLY

PLEASE CIRCLE ANY OF THE FOLLOWING PROBLEMS IF THEY HAVE BEEN SIGNIFICANT:

- Fever (100 degrees or greater) Blurry/double vision Severe headache Ear pain/congestion
- Nose bleeding Sore throat Coughing up blood
- Chest pain on exertion Ankle/leg swelling Blood in stool Vomiting blood Swollen lymph nodes
- Muscle aches/pains New skin rash Tension Depression Anxiety
- Sleep problems Indigestion/heartburn

BP _____ HR _____ RR _____ Temp _____ O2 saturation _____

Age _____ Weight _____ Height _____ CXR _____

PULMONARY SPECIALISTS OF TYLER, PA TYLER INPATIENT MANAGEMENT SPECIALISTS

Please read the following and initial to the left of each statement that you have read and understand the statement.

_____ **Release Authorization**

I hereby authorize the release of all medical records and account data necessary to process any and all claims for payment of services rendered by Pulmonary Specialists of Tyler, PA, or Tyler Inpatient Management Specialists. This authorization remains valid and effective from the date signed until I revoke it in writing.

_____ **Assignment of Benefits**

I hereby authorize payment of government and private medical benefits directly to Pulmonary Specialists of Tyler, PA, or Tyler Inpatient Management Specialists for services rendered. This authorization remains valid and effective from the date signed until I revoke it in writing. I understand I am financially responsible to Pulmonary Specialists of Tyler, PA, or Tyler Inpatient Management Specialists for all charges.

_____ **Preauthorization and Payment with Managed Care Insurances**

Pulmonary Specialists of Tyler, PA, or Tyler Inpatient Management Specialists will do its best to ensure the medical expenses are billed to the insurance carrier properly and will assist the patient with reasonable efforts to collect from any managed care plans, PPO, HMO, and standard insurance carriers. IF INSURANCE INFORMATION IS NOT GIVEN CORRECTLY OR IS OMITTED, THE BALANCE OF THE ACCOUNT IS THE RESPONSIBILITY OF THE PATIENT.

_____ **Authorization for Treatment**

I authorize Pulmonary Specialists of Tyler, PA, or Tyler Inpatient Management Specialists to treat and provide any healthcare services my provider deems necessary for treatment and/or diagnosis including biopsies. I also understand that in the course of treatment, photographs may be taken for clinical, commercial, or educational purposes.

_____ **Acknowledgement of Review of Notice of Privacy Practices**

I have been offered a copy of this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand I am entitled to receive a copy of this document.

I have read and understand the above and I have initialed each section.

Patient Name (printed)

Patient Date of Birth

Patient Signature / Legal Signature

Date

**PULMONARY SPECIALISTS OF TYLER, PA (PSOT) AND
TYLER INPATIENT MANAGEMENT SPECIALISTS (TIMS)**

Financial Policies

Consent to Pay: In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time the services are rendered. Our providers accept Medicare and many commercial insurance plans. Medicare will forward claims to most secondary payers. If we are contracted providers to your insurance plan, you will be required to pay your co-payment(s)/co-insurance and any unmet deductible at the time of service, as mandated by your insurance company. If we are not a contracted provider, you will be required to pay for your services at the time of service. It is your responsibility to verify with your insurance plan if we are a contracted provider. We accept Visa, MasterCard American Express, and Discover for your convenience. If you have a legitimate hardship, please ask to speak with a patient account representative so we may work with you.
_____ (Initials)

I understand I will be responsible for any remaining balance not covered by my commercial insurance company, Medicare, and/or my supplemental policy. I authorize the transfer of credits from one entity to the other to satisfy any outstanding balances. I have read the financial policy and agree to meet my financial obligation in accordance with this policy. _____ (Initials)

Please be advised any outpatient procedures done where the doctor is involved in the actual test, will result in a statement being generated from the hospital as well as the physician's practice. _____ (Initials)

It is your responsibility to provide Pulmonary Specialists of Tyler, PA/Tyler Inpatient Management Specialists with current insurance information on each visit. Without insurance information, you will be responsible to pay for services at the time of the visit. _____ (Initials)

Please note that failure to cancel an appointment within 24 hours may result in a \$25.00 charge.

Patient/Guarantor Name (printed)

Patient/Guarantor Date of Birth

Patient/Guarantor Signature

Date

**PULMONARY SPECIALISTS OF TYLER, PA (PSOT) AND
TYLER INPATIENT MANAGEMENT SPECIALISTS (TIMS)
Notice to the Parents or Legal Guardians of a Minor**

If your child is a minor, you **must** be present at your child's **initial visit** to sign the parental consent form below and provide your child's social security number. The consent form you sign gives the physicians and staff of Pulmonary Specialists of Tyler, PA permission to treat your child. Without a signed consent form, we cannot legally treat a minor child.

If you are not the parent, but are the **legal guardian**, you will need to provide legal documentation that you are the legal guardian. This information will be kept in the child's file.

CONSENT TO TREAT MINOR

I authorize Pulmonary Specialists of Tyler, PA to treat and provide any healthcare services to my child that the provider deems necessary for treatment and/or diagnosis including biopsies. I also understand, in the course of treatment, photographs may be taken for clinical, commercial, or educational purposes.

Unaccompanied Minors

I grant permission to treat and provide any healthcare services to my child that the provider deems necessary for treatment if my child arrives at the office unaccompanied. Agreed to _____

Minor Accompanied by Others

If I am unable to accompany my child to the appointment, the below listed individuals have my permission to accompany my child. This agreement is required in order for the unaccompanied child to be seen and treated. Agreed to _____

I further acknowledge this consent will remain in effect until either I revoke, in writing and delivered to you, or the minor reaches the age of 18 years.

Patient Name

Date of Birth

Parent/Legal Guardian Signature

Date

Witness Signature

Date

Parent/Legal Guardian Information

Name _____

SSN _____

Date of Birth _____

Relationship _____

Work # _____

Cell # _____

Home # _____

Name _____

SSN _____

Date of Birth _____

Relationship _____

Work # _____

Cell # _____

Home # _____

Other Individuals Allowed to Accompany My Child

Name _____

Relationship to Patient _____

Name _____

Relationship to Patient _____

Name _____

Relationship to Patient _____



CONSENT FOR DIAGNOSTIC TESTING

Pulmonary Disease • Interventional Pulmonology
Critical Care • Sleep Medicine • Allergy

Name: _____

Date of Birth: _____

I authorize the performance upon _____ of diagnostic testing, which may include as indicated: Pulmonary function tests (PFT), allergy prick and intradermal (skin) testing, nasal endoscopy and CT scan. I have read and I understand the accompanying Patient Information Sheet printed on the back of this page, which explains the nature and purpose of these diagnostic tests, the risks involved, and the possibility of complications. I understand that no guarantees or assurances are given by anyone as to the results of these tests.

I also understand that if an uncommon reaction should occur (as explained in the Patient Information Sheet), such reaction may require immediate treatment with the injection of adrenalin or other emergency measures if necessary.

Print the Name of the Patient Here

Signature

Date

Witness



Pulmonary Disease • Interventional Pulmonology
Critical Care • Sleep Medicine • Allergy

Name: _____

Date of Birth: _____

TYPES OF DIAGNOSTIC TESTS:

- I. **PULMONARY FUNCTION TESTS:** This test measures your breathing ability by having you blow into a tube.
- II. **SKIN TESTING FOR ALLERGIES:** This testing is done to find what you are allergic to and how severe your allergy is. The purpose is to identify what things (dust, mold, grass) should be avoided and if allergy shots to decrease your reactions to these items should be given. This is done by taking a small needle and injecting an antigen (a liquid allergy substance) under your skin to see if you have a positive test. A positive test would be similar to a mosquito bite and would tell us that you are allergic to that substance.
- III. **NASAL ENDOSCOPY:** The purpose of this test is to examine the inside of your nose and sinuses, and look for signs of infection. The test involves spraying the nose with a numbing medication and decongestant, followed by the Doctor looking through a small, lighted scope into your nose.
- IV. **LARYNGOSCOPY:** The Doctor will look at your throat and voice box with a flexible telescope after your nose and throat are sprayed with numbing decongestant medication.
- V. **CT SCAN:** The purpose of this test is to see beyond what the nasal endoscopy shows in the sinuses, to find signs of infection, and to further see the structure of your nose and sinuses. Completing the test simply involves lying on the table and getting X-ray (pictures) taken.
- VI. **CHEST X-RAY:** The purpose of this test is to evaluate the condition of your lungs. The test involves standing in front of a board, holding still, and holding your breath when instructed. Generally, two pictures are taken for each exam.
- VII: **METHACHOLINE CHALLENGE:** You will first have measurements of lung function made (PFT). You will then breathe in very tiny amounts of medicine, Methacholine, and the measurements of lung function will be repeated after 15 minutes. Methacholine causes short-lived (less than 60 min.) symptoms of asthma in sensitive persons. If symptoms or a change in lung function occurs, the tests will be stopped. If not, a higher dose of Methacholine will be administered and the measurements repeated 5 minutes after each dose until the highest dose of Methacholine is reached, or airway measurements decrease. If severe symptoms of asthma are caused, it will be treated by giving you medicine to breathe (bronchodilator).

While severe reactions are uncommon, skin testing and the numbing medicine used for the nasal endoscopy carry some risk of reaction which might consist of itching, hives, nasal stuffiness, sneezing, wheezing, and shortness of breath, or rarely shock; such reactions require immediate treatment with injected adrenaline and rare severe cases, hospitalization for treatment with oxygen, fluids and drugs as needed.



ALLERGY HISTORY

Pulmonary Disease • Interventional Pulmonology
Critical Care • Sleep Medicine • Allergy

Please answer the following questions related to your allergy history.

SYMPTOMS

Check the symptoms that you are experiencing:

Hay Fever Runny Nose Itchy Eyes Itchy Throat Watery Eyes

Are your symptoms seasonal? Yes No

If so, which season? _____

Do you currently have eczema? Yes No

Have you ever had eczema in the past? Yes No

TRIGGERS

What trigger factors cause a worsening in your symptoms (such as exercise, pollens, weather changes, animals, etc.)? _____

PREVIOUS TESTING OR IMMUNOTHERAPY

If you have undergone allergy testing, when and where was it done?

Have you ever received allergy injections? Yes No

If yes, by whom? _____ For how long? _____

Did the shots relieve your symptoms? Yes No

FOOD OR STINGING INSECTS

Do you currently have allergy problems related to: (please check)

Stinging Insects Fire Ants Latex

Foods: _____

SINUS-RELATED

Have you been treated with antibiotics for sinusitis? Yes No

If yes, how often have you been treated in the past year? _____

Have you ever been told that you have nasal polyps? Yes No

Have you ever had sinus surgery? Yes No

CHILDHOOD

Did you suffer from asthma as a child? Yes No

Did you have frequent respiratory infections as a child? Yes No

Were you exposed to passive cigarette smoke as a child? Yes No