The Respire Institute
PULMONARY AND SLEEP MEDICINE

Financial Policy

At The Respire Institute, we believe clear communication about our financial policies is essential for quality care. Please review the following:

- **Insurance Responsibility**: It is your responsibility to provide accurate and updated insurance information. Charges for services are your responsibility, including copays, coinsurance, deductibles, and non-covered services. Copays are due at the time of service.
- **Insurance Benefits**: While we strive to provide accurate information based on your insurance company's details, this information may not always be correct or up to date. **It is the responsibility of the insured and dependents to verify coverage and benefits directly with the insurance company.** Please do not rely solely on the information we provide.
- **Payments**: Balances must be paid upon receiving your statement via debit/credit card as we are a *cashless facility*. Returned checks incur a $25 fee.
    - We accept the following payment types: Visa, Mastercard, and American Express
- **Delinquent Accounts**: Unpaid balances over 90 days will result in further action. Payment plans are available—please contact our account specialist at 281-949-7023.

Acknowledgment
By signing below, I acknowledge that I have read and understand the Financial Policy of The Respire Institute. I authorize The Respire Institute to release necessary medical records to my insurance company for payment purposes and assign benefits directly to The Respire Institute.

Signatures

Patient/Guardian: _____ Date: _____

Print Patient Name: _____ DOB: _____

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HIPAA Release Form

This form complies with the Health Insurance Portability and Accountability Act (HIPAA) and the Texas Medical Privacy Act. It authorizes the use and disclosure of your Protected Health Information (PHI). Please indicate your preferences below:

Communication Preferences

Do we have your permission to:

- Leave a detailed message on your primary voicemail? [ ] YES [ ] NO
- Leave a detailed message at your place of employment? [ ] YES [ ] NO
- Discuss your medical condition with a family member? [ ] YES [ ] NO
- Discuss your account with anyone answering your phone? [ ] YES [ ] NO

If we may discuss your health information with others, please list their details:

1. Name: _____ Phone: _____ Relation: _____
2. Name: _____ Phone: _____ Relation: _____

Authorization Details

Please indicate the type of health information you are authorizing The Respire Institute to release:

[ ] Complete Health Record: Includes all records such as mental health, communicable diseases (HIV/AIDS), and treatment for alcohol or drug abuse.

OR

[ ] Partial Health Record: Includes only the records you select below.

Please check all that apply:

- [ ] Mental health records
- [ ] Communicable diseases (HIV/AIDS)
- [ ] Alcohol or drug abuse treatment
- [ ] Other (please specify): _____

Acknowledgment

I have read this form and understand how my health information will be used or disclosed. This authorization is valid for one year from the signature date unless revoked. To withdraw permission, I must notify The Respire Institute in writing.

Signatures

Patient/Guardian: _____ Date: _____

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Printed Name: _____ DOB: _____

Relationship to Patient: _____

Authorization for Disclosure of Protected Health Information

Patient Information

Name: _____ Other Name(s) Used: _____

Date of Birth (DOB): _____ Phone: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Authorization Details

I authorize the transfer/receipt of the following healthcare information:

[ ] Complete Record [ ] Progress Notes [ ] Diagnostic Test Reports [ ] X-Ray Reports
[ ] Films and Images [ ] Consultation Reports [ ] Sleep Studies [ ] Laboratory Reports
[ ] Other: _____

Dates of Service: From _____ to _____

Reason for Disclosure (select one):

[ ] Treatment/ Continuing of Care [ ] Personal Use [ ] Billing or Claims [ ] Insurance [ ] Legal
[ ] Disability Determination [ ] School [ ] Employment [ ] Other: _____

Recipient Information

- **Release To**: _____ Phone: _____ Fax: _____
- **Obtain From**: _____ Phone: _____ Fax: _____

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Authorization Period
This authorization is valid for 365 days from the date of signing unless otherwise specified.

Right to Revoke
You may withdraw this authorization at any time by notifying The Respire Institute in writing. Revocation will not apply to information already disclosed.

Acknowledgment and Signature
I understand that the disclosed information may be re-disclosed by the recipient and may no longer be protected under federal or state privacy laws. I release The Respire Institute and its staff from all liability for lawful release of my Protected Health Information.

Patient/Guardian Signature: _____ Date: _____
Printed Name: _____ Relationship to Patient: _____
Witness: _____

Methods of records request/submission:
Fax: 469-290-6331
Email: Rsainz@mpsds.com

Patient Information Form

Patient Name: _____ Date of Birth: _____
Primary Phone: _____ Home Address: _____
Email _____
Referring Doctor: _____ Primary Care Physician: _____

Primary Insurance: _____
Name of Insured and Relation to Patient: _____ ID Number: _____Group Number: _____
Secondary Insurance: _____
Name of Insured & Relation to Patient: _____ ID Number: _____Group Number: _____
Preferred Pharmacy: _____ Pharmacy Phone Number: _____

LIST ALL MEDICINES & SUPPLEMENT(S) YOU ARE CURRENTLY TAKING: Including those taken as needed.

MEDICATION (Name and Dose)	**DIRECTIONS**

ALLERGIES (Medication, Environmental or Food)	**REACTION**

MEDICAL HISTORY: (Please check and give date of occurrence on space provided)

SURGICAL/ PROCEDURE HISTORY:

DATE	TYPE OF SURGERY/ PROCEDURE

FAMILY HISTORY: List any blood relative's health conditions.

(*Please check and give relationship on space provided. *If grandparents, please use maternal or paternal)*

[ ] Cancer _____ [ ] Other Cancer _____ [ ] Bronchitis _____ [ ] High Cholesterol _____
[ ] Stroke _____ [ ] Heart Disease _____ [ ] Bronchitis _____ [ ] High Blood Pressure _____
[ ] Asthma _____ [ ] Sleep Apnea _____ [ ] Lung Fibrosis _____ [ ] Autoimmune Disease _____
[ ] Diabetes _____ [ ] Emphysema _____ [ ] Cystic Fibrosis _____

SOCIAL HISTORY:

Do you smoke cigarettes, cigars, e-cigarettes, vapes, hookah etc.? [ ] YES [ ] NO
If so what kind: _____
If so, how many packs per day? _____ How many years have you smoked? _____
If no, How long ago did you quit? _____

Do you consume alcohol? [ ] YES [ ] NO
If so, how many drinks per week? _____

Do you consume any caffeinated or energy Drinks? [ ] YES [ ] NO
If so, how many drinks per day? _____

Have you ever used illicit drugs? [ ] YES [ ] NO
If so, what type and how often? _____

Respiratory / Allergy

Have you seen or had any previous pulmonologist? [ ] YES [ ] NO
If yes, please list the physician: _____

Respiratory Review of Symptoms

Have you experienced any:

[ ] Shortness of Breath [ ] Rapid Breathing [ ] Wheezing or Whistling in your chest [ ] Acid Reflux or Heart burn
[ ] Chest Pain/ Tightness [ ] Dry Coughing [ ] Productive Coughing (with Phlegm)

Allergy Review of Symptoms

Please mark Yes or No if you suffer from any of these symptoms

EYES: (itchy, watery or swelling)	YES	NO	**SNEEZING**:	YES	NO
EARS: (itchy, draining or congested)	YES	NO	**NASAL CONGESTION:**	YES	NO
NOSE: (runny or congested)	YES	NO	**COUGH**: (allergy related)	YES	NO
HEADACHES: (allergy related)	YES	NO			

Sleep Questionnaire

Patient Name: _____ Height: _____Weight: _____

Do you have any sleep concerns? [ ] Yes [ ] No

1. List your main sleep concern: _____
2. How long has this been present? _____
3. Have you had a previous sleep study or screenings? [ ] YES [ ] NO
   If yes, when and where? _____

Sleep Habits

1. How long does it take you to fall asleep? _____
2. How many hours of sleep do you normally get? _____
3. What time do you go to bed on **weekdays?** _____AM / PM **Weekends?** _____AM / PM
4. What time do you awaken on **weekdays?** _____ AM/ PM **Weekends?** _____AM / PM

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the situations described below, in contrast to feeling just tired? Even if you haven't done some of these things recently try to work out how they would have affected you. This refers to your usual way of life in recent times.

Use the following to choose the most appropriate number for each situation:

0 = would never doze	1 = slight chance of dozing
2 = moderate change of dozing	3 = high chance of dozing

Situation:	**Chance of dozing**
Sitting and reading	
Watching TV	
Sitting, inactive in a public place (e.g. a theatre or a meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon when circumstances permit	
Sitting and talking to someone	
Sitting quietly after a lunch without alcohol	
In a car, while stopped for a few minutes in the traffic	
Total:	