The Respire Institute

FINANCIAL POLICY

The Respire Institute believes that communicating our financial policy is good healthcare practice. **CHARGES INCURRED FOR SERVICES RENDERED ARE THE PATIENT'S RESPONSIBILITY REGARDLESS OF INSURANCE COVERAGE.**

It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.

YOU ARE RESPONSIBLE FOR ALL COPAYS, COINSURANCES, DEDUCTIBLES AND NON-COVERED SERVICES. We are obliged to collect your copay at the time of service per your insurance company. We require the balances due, to be paid when you receive your statement. There is a $25.00 Charge for a check that does **not** clear with your bank.

Further action will take place if balances are not paid within 90 days. Payment arrangements can be made with our account specialist representative by calling **281-949-7023.**

Form Requests:

I have had the opportunity to read/receive a copy of the Financial and Privacy Policies of The Respire Institute and authorize The Respire Institute, its physician's and providers to release medical records to the insurance company responsible for my health coverage should it become necessary for payment of services provided.

I hereby assign benefits and authorize payment to go directly to The Respire Institute for any medical services provided but not to exceed the reasonable and customary charges for these services.

THIS OFFICE IS NOT RESPONSIBLE FOR INCORRECT BENEFIT INFORMATION GIVEN TO US BY YOUR HEALTHCARE INSURANCE CARRIER OR FOR CHANGES IN COVERAGE. A DESCRIPTION OF BENEFITS IS NOT A GUARANTEE OF COVERAGE AND CANNOT BE RELIED UPON AS SUCH. IN THE EVENT OF NON –PAYMENT BY YOUR INSURANCE COMPANY THE CHARGES ON YOUR ACCOUNT WILL BE YOUR RESPONSIBILITY.

I understand that I am financially responsible to the physician for all charges not covered by this agreement. **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.**

KNOWING YOUR INSURANCE BENEFITS ARE THE RESPONSIBILITY OF THE INSURED AND DEPENDENTS. WE ARE ONLY PROVIDING INFORMATION GIVEN TO US BY YOUR INSURANCE COMPANY. THIS INFORMATION MAY NOT BE CORRECT AND SHOULD NOT BE RELIED UPON. PLEASE CONTACT YOUR INSURANCE COMPANY TO INSURE COVERAGE AND BENEFITS.

We accept cash, debit card, Master Card, Visa and American Express.

_____ _____

Patient/ Guardian-Responsible Party **Date**

_____ _____

Print Patient Name **D.O.B**

HIPAA Release Form

This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Covered entities, must obtain a signed authorization from an individual or the individual's legally authorized representative to disclose that individuals Protected Health Information (PHI). The Authorization provided by use of the form means the organization, entity or person authorized can disclose, communicate, or send named individuals PHI to the organization, entity or person identified on the form, including through use of any electronic means.

Due to HIPAA regulations, do we have permission to?

YES NO Leave a detailed message on your answering machine or voice mail at home?
YES NO Leave a detailed message at you place of employment?
YES NO Discuss your medical condition with family member?
YES NO Discuss your account with any person answering your home phone?

Due to HIPAA, we are required to have permission to discuss your health information with anyone beside yourself. If we can discuss your health information with anyone else, please list their information below.

1._____

Name **Phone #** **Relations**

2._____

Name **Phone #** **Relations**

Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records ☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment ☐ Other (please specify): _____

I hereby declare that I have read and understand this office's Procedure Policy and HIPAA regulations. I authorize The Respire Institute to implement the above regulation of the office and honor my noted request. This form is valid for one year after signature date.

SIGNATURE AND AUTHORIZATION:

I have read this form in its entirety and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of PHI that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities. **Date signed is the effective date of this authorization**

_____ _____

Printed Name of Parent/Guardian **Signature of Patient/Guardian**

_____ _____

Relationship to Patient **Date**

Authorization for Disclosure of Protected Health Information

Patient Name _____ Other name(s) used: _____
D.O.B _____ Phone #: _____ Email: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____

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

Release to: _____ Obtain From: _____
_____ _____
Phone: _____ Phone: _____
Fax: _____ Fax: _____

Dates of Service: _____ through _____

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

Reason for Disclosure:

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

This authorization is valid until the 180 days after the date it is signed, unless otherwise stated, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of The Respire Institute to disclose such information as herein contained. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject re-disclose by the recipient and may no longer be protected. I hereby release and hold harmless the above-named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by sending The Respire Institute a letter via mail, email or fax. If I revoke this authorization, the revocation will not apply to information that has already been released in good faith before the revocation was received.

Signature of Patient: _____ Date: _____

Printed Name of Patient Representative: _____ Date: _____

Witness: _____ Relationship to Patient: _____

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

Katy/ West Campus
18300 Katy Freeway Suite 615
Houston, TX 77094
Phone: 713-464-8099
Fax: 713-465-1921

Memorial Location
10837 Katy Freeway Suite 250
Houston, TX 77079
Phone: 713-464-8099
Fax: 713-465-1921

Katy
701 S. Fry Rd Suite 225
Houston, TX 77450
Phone: 713-464-8099
Fax: 713-465-1921

The Respire Institute

PATIENT INFORMATION FORM

Legal Last Name: _____ Legal First Name _____ M.I._____

Date of Birth: _____ Home Address: _____

Home Phone: _____ Cell Phone: _____

Email _____

Referring Doctor: _____ Primary Care Physician: _____

Primary Insurance: _____ Name of Insured and Relation to Patient: _____

ID Number: _____ Group Number: _____

Secondary Insurance: _____ Name of Insured and Relation to Patient: _____

ID Number: _____ Group Number: _____

PHARMACY NAME: _____PHARMACY PHONE NUMBER: _____

CROSS STREETS: _____

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING: Prescription medication, including those taken as needed.

MEDICATION NAME & DOSE	DIRECTIONS

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

[ ] Pneumonia _____ [ ] Heart Failure _____ [ ] Seizures_____ [ ] Depression _____
[ ] Diabetes _____ [ ] High Cholesterol _____ [ ] Bronchitis_____ [ ] Anxiety _____
[ ] Asthma _____ [ ] Tuberculosis _____ [ ] Cancer _____ [ ] Stroke_____
[ ] Heart Attack _____ [ ] Blood Clots _____ [ ]Thyroid Issues _____
[ ] Autoimmune Disease _____ [ ] High Blood Pressure_____ [ ]Other health condition_____

ALLERGIES TO MEDICATION OR FOOD	REACTION

SURGICAL/ PROCEDURE HISTORY:

DATE	TYPE OF SURGERY/ PROCEDURE

FAMILY HISTORY: Mainly 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 noticed 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			

The Respire Institute

SLEEP INTERVIEW QUESTIONNAIRE

Section I: Patient Information

Patient Name: _____ Height: _____Weight: _____

Section II: Main Complaint

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

Section III: Sleep Habits

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

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:	