SLEEP CONSULTANTS, INC.

2941 OAK PARK CIRCLE, SUITE 200 • FORT WORTH, TEXAS 76109
(817) 332-7433 • FAX (817) 394-6282

1201 FAIRMOUNT AVENUE • FORT WORTH, TEXAS 76104
(817) 335-5288 • FAX (817) 338-0927

6100 HARRIS PKWY, STE. 285 • FORT WORTH, TEXAS 76132
(817) 263-5864 • FAX (817) 263-3791

Comprehensive Care for People with Sleep Disorders
Diagnosis, Treatment, Follow-up, Education, Research

Sleep Laboratory – 2941 Oak Park Circle, Ste. 200, Fort Worth, TX 76109
Email: Information@SleepConsultants.com
Internet: http://www.SleepConsultants.com

_____ has an appointment with _____ on _____ at _____ with a check-in time of _____. This is your initial appointment only, which takes about an hour. If testing is needed, it will be scheduled for a later date.

We want to take this opportunity to welcome you to the practice and thank you for choosing us to provide your health care. We appreciate your trust in us and look forward to keeping you healthy.

Please complete the enclosed information BEFORE your scheduled appointment and bring the completed forms with requested information including current insurance card(s), all your medications (including inhalers, over-the-counter medications, herbs) and your CPAP or BiPAP machine if you are using one.

The Sleep and Health questionnaires are used to conduct this appointment so it is very important that this is completely filled out ahead of time. **If this is not filled out before you arrive, you may be asked to reschedule.** It would be helpful to bring someone with you who is familiar with your sleep habits.

Many patients seen in our offices have sensitive respiratory conditions. Please avoid use of scented body spray, perfume, cologne, aftershave, or anything with a heavy scent.

If a referral is required, you will need to bring your referral and/or referral information to the office at the time of your visit. If we do not have this referral, you will not be seen by the doctor. The referral needs to be made out to the doctor named above. Any sleep testing is done in one of our sleep laboratories and is billed by Texas Pulmonary & Critical Care Consultants. If you have any questions concerning your benefits, please call your insurance company.

If you need to reschedule your appointment, please call us at 817-263-5864 as early as possible. Please help us serve you better by keeping scheduled appointments.

Sincerely,

Sleep Consultants, Inc.

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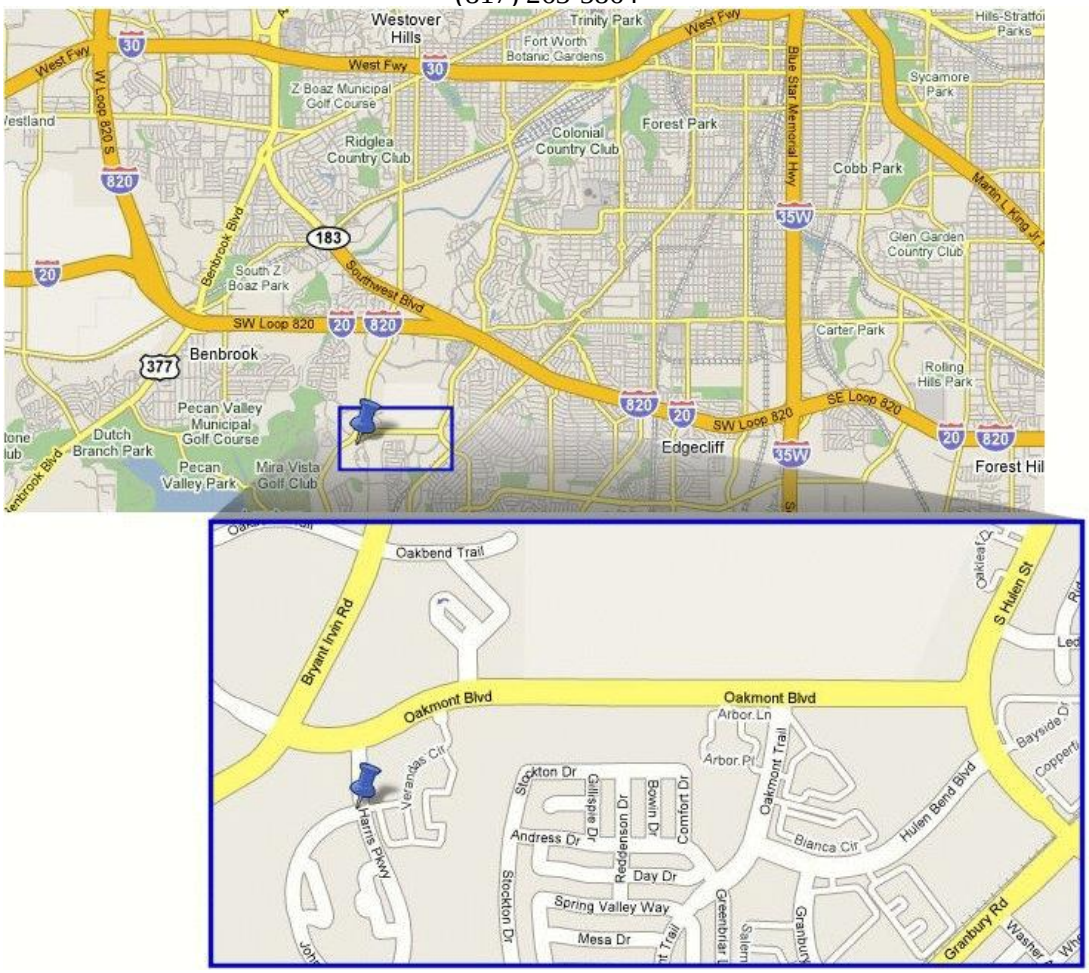

From Burleson or Waco :
Proceed to I-35W north driving toward Fort Worth. Take exit (45A) to merge into I-20/820W toward Abilene. Take the Bryant Irvin Road exit. Turn left onto Bryant Irvin Rd. Go south on Bryant Irvin Rd. Turn left onto Oakmont Blvd. Turn right onto Harris Parkway. Go one block and the hospital will be on your right. Pull into the main parking lot. Follow signs to the Plaza section of the hospital. (This will be the north side of the hospital.) When you enter the plaza, the bank of elevators will be to your left. Take the elevator to the second floor. From the elevator, go right to suite 285. We are located on the left side at the end of the hall.

From Abilene:
Proceed to I-20E/ US80-E driving east toward Fort Worth. Continue to follow I-20 E. Take the Bryant Irvin Road exit. Turn left onto Bryant Irvin Rd. Go south on Bryant Irvin Rd. Turn left onto Oakmont Blvd. Turn right onto Harris Parkway. Go one block and the hospital will be on your right. Pull into the main parking lot. Follow signs to the Plaza section of the hospital. (This will be the north side of the hospital). When you enter the plaza, the bank of elevators will be to your left. Take the elevator to the second floor. From the elevator, go right to suite 285. We are located on the left side at the end of the hall.

SLEEP CONSULTANTS PATIENT QUESTIONNAIRE

Thank you for completing this questionnaire. Your answers enable us to provide a thorough evaluation.
If you have any of the following symptoms or medical problems, or if you take medications or therapy for the symptom/problem, please circle items or fill in blanks as appropriate:

Feeling poorly, ill | Double vision | Blurred vision | Wear glasses
Wear contact lenses | Sleep with contacts in? yes no | Glaucoma | Headaches
Migraine | Insomnia | Dizziness | Fainting
Epilepsy / seizures | Neuropathy | Restless legs syndrome | Memory problems
Dementia | Stroke / TIA | Depression | Anxiety
ADD / ADHD | Autism | Short temper | Claustrophobia
PTSD | Other mood disorder / mental illness: _____ | Runny nose
Stuffy nose | Post-nasal drainage | Sinus trouble | Nosebleeds
Sore throat | Hoarseness | Dental problems: _____
Wear dentures: upper lower both | Sleep with dentures in? yes no | Rapid weight gain or loss
Change in appetite | Indigestion/Heartburn | Reflux | Abdominal pain
Difficulty swallowing | Nausea | Vomiting | Constipation
Diarrhea | Bloody stools | High blood pressure | Ankle swelling
Racing heart | Irregular heartbeat / palpitations | Atrial fibrillation
Chest pain | Coronary artery disease | Congestive heart failure | Cough
Wheezing | Shortness of breath at rest | Shortness of breath with activity | Asthma
COPD | Emphysema | Coughing up blood | Sleep apnea
Previous sleep studies (when/where): _____ | Inactive / sedentary | Obese
Diabetes: type 1 or 2 | Hypoglycemia | Cold / heat intolerance | Thyroid disease
Other hormone abnormalities: _____ | General weakness
Localized muscle weakness | Chronic fatigue syndrome | Osteoporosis | Renal failure
On dialysis | Difficulty urinating | Prostate enlargement
Frequent urinary tract infections | Incontinence | Disinterest in sex
Erectile dysfunction | Other sexual dysfunction _____
Cancer: type / location? _____ | In remission? yes no | Muscle aches
Low back pain | Fibromyalgia | Other chronic pain: _____
Rash | Fever | Hepatitis
Tuberculosis or positive PPD test | HIV-positive | AIDS
Other infectious disease(s): _____ | Mental disability | Physical disability

Surgical History – Please list all surgeries and the year they were performed:

_____

_____

_____

Hospitalizations and Emergency room visits – Please include reason and year:

_____

_____

Dental/orthodontic history – Please include procedure and year:

_____

Please list all prescription medications you take. Continue on the back if needed, or bring a list with you.

Medication	Dose	Time of day taken	Reason	Length of time used	Prescribing physician

List all non-prescription drugs, vitamins, and supplements you take:

Medication	Dose	Time of day taken	Reason	Length of time used	Prescribing physician

Please list all allergies or intolerance / adverse reactions:

Medications: _____

Foods: _____

Environment, etc.: _____

Date of last flu shot: _____ Date of last pneumonia vaccination: _____

Review of systems:

If you have had any of the following symptoms recently, please circle all that apply:

General: fevers chills night sweats (enough to soak your shirt or sheets)
weight loss/gain (how much? _____ In what amount of time? _____)

Head, eyes, ears, nose, throat:

	itchy/watery eyes	hay fever			
	post nasal drainage	bleeding nose or gums			
	sore throat	hoarseness			
	sinus congestion or drainage (color? _____)				
Cardiovascular:	shoulder or arm pain	swelling in your legs			
	shortness of breath when lying flat				
	awakening at night short of breath				
Pulmonary:	snoring	insomnia	daytime sleepiness		
	legs twitches/discomfort				
Gastrointestinal:	nausea	vomiting	diarrhea	constipation	heartburn
	reflux	indigestion	abdominal/stomach pain		
Genitourinary:	bloody urine	painful urination	trouble starting/stopping		
Musculoskeletal:	joint pain or swelling	muscle pain			
Hematologic:	easy bleeding or bruising				
Lymphatic:	swelling of lymph nodes under jaw, on neck, under arms or in groin				
Skin:	new rashes or spots				
Back:	pain or swelling				
Neurological:	headaches	seizures	passing out	numbness/tingling in hands or feet	

Tobacco / nicotine history:

Do you smoke? **Yes** **No** If yes, how many packs per day? ____ For how many years? ____
If you smoked in the past, how many packs per day? ____ For how many years? ____ Quit in? ____
Do you chew tobacco? **Yes** **No** If yes, how many cans per week? ____ For how many years? ____
Quit chewing tobacco in (year)? _____ Do you currently use an electronic cigarette? **Yes** **No**
Exposure to second-hand tobacco smoke (circle): Never/rarely Occasionally Often Regularly

How many caffeinated beverages do you consume per day, on average? _____
Of those, how many do you consume after 4 PM? _____

Alcohol consumption - drinks per week:

Beer _____ Wine _____ Mixed Drinks _____ Hard Liquor _____
Do you drink every day? **Yes** **No**
Do you drink before bedtime specifically to help you sleep? **Yes** **No**
Are you ever hungover from drinking? **Yes** **No**
Have you or others ever felt that you should decrease your drinking? **Yes** **No**

Substance abuse now or in the past (circle):
Prescription drugs Marijuana Cocaine Narcotics Recreational drugs IV drugs

Do you have regular physical activity or exercise? **Yes** **No** If yes, please describe type of activity, frequency, etc.: _____

List hobbies and social activities you enjoy:

_____

Age	Weight	Age	Weight
20	_____	50	_____
30	_____	60	_____
40	_____	70	_____

Have you ever considered or attempted suicide? **Yes** **No**
Do you feel you are living with unusual stress at this time? **Yes** **No**
If yes, please explain: _____

WOMEN: Do you have complaints that vary with the stage of your menstrual cycle? **Yes** **No**
Are your menstrual periods in any way abnormal or irregular? **Yes** **No**
Are you pregnant? **Yes** **No**
Are you past menopause, or are you having menopausal symptoms now? **Yes** **No**

Use space below for any additional comments about your health or medical history:

_____
_____
_____

Family Medical History (please list all known medical problems, including sleep and psychiatric problems):

Mother _____
Father _____
Siblings _____
(*Note if sister or brother)* _____
Children _____
(*Note if daughter or son)* _____
Other _____

SLEEP QUESTIONNAIRE: Date:_____

Please complete this questionnaire as it will help the doctor help you. As some questions are personal, you may choose to leave the answers blank and discuss them with your doctor if you wish.

Patient Name _____ Occupation _____ Age_____

Please briefly describe your sleep complaints, including when they started.

_____

_____

1. **Yes** **No** Did you have a problem with your sleep as a child? If yes, please describe: _____
2. **Yes** **No** Are you unable to fall asleep at night?
3. **Yes** **No** Are you unable to remain asleep at night, or do you often wake up earlier than you would like?
4. **Yes** **No** Do you take, or have you ever taken, any medications or other substances to help you sleep? If yes, please list, and describe how well they work: _____

_____

_____

5. **Yes** **No** Do you toss and turn a lot, or have difficulty getting comfortable in bed?
6. **Yes** **No** Do you sleep with a TV or radio on?
7. **Yes** **No** Do you use a computer, cell phone, or other electronic device before bed or during the night?
8. **Yes** **No** Do you lie awake at night with thoughts racing through your mind?
9. **Yes** **No** Are you afraid of the dark or of going to sleep?
10. **Yes** **No** Do you get an uncomfortable, hard-to-describe feeling in your legs or elsewhere accompanied by a strong urge to move?
11. **Yes** **No** Do these symptoms begin or worsen when sitting or lying down?
12. **Yes** **No** Does movement (stretching, bending, walking) temporarily relieve the symptoms?
13. When do the symptoms occur (circle which)? morning afternoon evening night
14. **Yes** **No** Do you itch at night?
15. **Yes** **No** Do you ever wake up with chest pain or palpitations?
16. **Yes** **No** Does other pain disturb your sleep? If yes, please describe:
17. **Yes** **No** Do you grind or clench your teeth during sleep?
18. **Yes** **No** Do you wake up with jaw pain?
19. **Yes** **No** Do you feel you get too much or not enough sleep? (If yes, please circle which.)
20. **Yes** **No** Do you feel your sleep quality is poor? (That is, no matter how much sleep you get, you do not wake up feeling rested).
21. **Yes** **No** Do you commonly breathe through your mouth, especially at night?
22. **Yes** **No** Have you ever been told you snore?
23. **Yes** **No** Does your snoring disturb others?
24. **Yes** **No** Has anyone ever told you that you stop breathing during sleep?
25. **Yes** **No** Do you sometimes wake up choking, breathing hard, coughing, or gasping for breath?
26. **Yes** **No** Have you dreamed of drowning or being suffocated?
27. **Yes** **No** Do you wake up at night with heartburn?
28. **Yes** **No** Do you sweat excessively during sleep?
29. **Yes** **No** Do you commonly wake up in the morning with a sore throat or hoarseness?
30. **Yes** **No** Do you wake up in the morning with a headache?
31. **Yes** **No** Have you wet the bed during sleep as an adult?
32. **Yes** **No** Do you often have frightening dreams or nightmares?

33. **Yes** **No** Do you ever wake up screaming?
34. **Yes** **No** Have you ever been told that you make rolling/rocking movements in sleep?
35. **Yes** **No** Have you ever been told that you act out dreams?
36. **Yes** **No** Do you awaken during the night or in the morning with feelings of sadness, fear, anxiety, worry, irritability, anger, disorientation, or confusion? (Please circle all that apply.)
37. **Yes** **No** Do you sleep walk or engage in other activity while asleep?
38. **Yes** **No** Do you talk in your sleep?
39. **Yes** **No** Do you fall out of bed?
40. **Yes** **No** Do you eat a meal within two hours of going to bed?
41. **Yes** **No** Do you eat or drink anything, or take any medications *during* the night (*after* going to bed)? If so, what? _____
42. **Yes** **No** Do you usually sleep with someone?
43. **Yes** **No** Are you awake at night because of your bed partner's noise or movement?
44. **Yes** **No** Do you think your bed partner may have a sleep disorder?
45. **Yes** **No** Are you awake at night to assist a person or animal?
46. **Yes** **No** Are you awake at night because of noise, heat, cold, or light? (Circle which)
47. **Yes** **No** Do you have hallucinations or dream-like states as you fall asleep or wake up? If yes, circle which.
48. **Yes** **No** Do you ever feel paralyzed when falling asleep or waking up? If yes, circle which.
49. **Yes** **No** Do you use an alarm clock to wake up?
50. **Yes** **No** MEN: Do you wake up with penile erections?
51. **Yes** **No** Is it easy for you to get out of bed in the morning?
52. **Yes** **No** Do you rely on caffeine (coffee, tea, etc. the) to stay awake during the day?
53. **Yes** **No** Do you have sudden attacks of physical weakness or paralysis during the day?
54. **Yes** **No** If so, do laughing, anger, or other emotional factors trigger the attacks?
55. **Yes** **No** Do you feel tired or physically fatigued during the day even when you are not sleepy?
56. **Yes** **No** Is your daytime performance in work or recreation less efficient than you would like?
57. **Yes** **No** Do you yawn frequently during the day?
58. **Yes** **No** Do your eyes burn or tear during the day?
59. **Yes** **No** Do you feel distracted and unable to concentrate?
60. **Yes** **No** Do you frequently feel depressed, fearful, anxious, worried, irritable, angry, disoriented or confused during the day? (Please circle all that apply.)
61. **Yes** **No** Have you ever "come to" and discovered that you have performed a complex activity (i. e. driving a car) without remembering it (blackouts)?

62. Rate your chance of dozing in the following situations, with 0 = never, 1 = slight, 2 = moderate, and 3 = high:

_____ Sitting and reading
_____ Watching TV
_____ Sitting inactive in a public place (e.g. a theater or 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 traffic

63. **Yes** **No** Do you have uncontrollable urges to sleep during the day or fall asleep unintentionally?
64. **Yes** **No** Have you had accidents or close calls while driving because you were sleepy or "foggy"?
65. **Yes** **No** Does your occupation involve shift-work, night-work or travel across time zones? If yes,

please describe, including whether or not you keep the same schedule on days off from work: _____

66. **Yes No** Do your sleep problems occur in cycles or only at certain times? (Examples: every 10 days, only when away from home, women: during your period, etc.) If yes, please explain: _____

67. **Yes No** Do you commonly sleep in locations other than a bed in a bedroom? If yes, please indicate where: couch recliner floor elsewhere _____

68. Do you function most poorly in the morning, afternoon, or evening? (Please circle which.)

69. List things that make daytime or nighttime symptoms and complaints worse.

_____

70. List things that make daytime or nighttime symptoms and complaints better.

_____

71. In what position(s) do you prefer to sleep? Circle:
supine (on back) right side left side prone (on stomach) in recliner

72. Usual bedtime: _____ AM / PM If different on days off: _____ AM / PM

73. How long does it take you to go to sleep? _____

74. Usual wake time: _____ AM / PM If different on days off: _____ AM / PM

75. How much sleep do you feel you get each night? _____ hours

76. Number of awakenings per night: _____ How long do you stay awake? _____

77. Number of bathroom trips per night: _____

78. How long does it take you to become fully alert and functional in the morning? _____

79. If you take naps, how long are they (include even brief dozing while watching TV, reading, etc.)? _____
What time of day? _____ How many naps per week? _____

80. Describe anything about your sleep/wake schedule that you dislike? _____

_____

81. Is there a sleep/wake schedule you would prefer to your present schedule, but have difficulty achieving?

_____

82. Do you have any other daytime symptoms or complaints which you feel may be related to sleep? If yes, please explain: _____

_____

I certify that all information is correct and complete. If any information changes, I will notify Sleep Consultants, Inc.

Signature _____ Date _____

If not filled out by patient, please print name and relationship to patient:

_____

TWO-WEEK SLEEP DIARY

1. Answer the questions in the shaded areas.
2. Draw a line through the times you were asleep.
3. Put downward-pointing arrows (↓) at the times you went to bed and upward-pointing arrows (↑) at the times you got up.

				1 = Poor 2 = Fair 3 = Good				
		I took a sleeping pill		(Each tick mark represents 1 hour)	Rate your quality of sleep	Rate your level of daytime alertness	I took a nap *(If yes, indicate time of nap and length. If no, leave blank.)*		Rate your mood today
Date		YES	NO	9:00 PM · 10 PM · 11 PM · midnight · 1 AM · 2 AM · 3 AM · 4 AM · 5 AM · 6 AM · 7 AM · 8 AM · 9:00 AM	(1-3)	(1-3)	Time	Length	(1-3)
EXAMPLE			***N***		***1***	***2***	***4 PM***	***45 min***	***2***
	Night 1								
	Night 2								
	Night 3								
	Night 4								
	Night 5								
	Night 6								
	Night 7								
	Night 8								
	Night 9								
	Night 10								
	Night 11								
	Night 12								
	Night 13								
	Night 14								

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ASSESSMENT OF PATIENT'S BEHAVIOR BY BED PARTNER

Please answer the following questions about your bed partner's behavior over the past *six months* by circling the word that reflects your opinion.

1.	Snores loudly.....	never	rarely	sometimes	often	always
2.	Keeps you awake by loudly snoring.....	never	rarely	sometimes	often	always
3.	Snores loudly in all positions	never	rarely	sometimes	often	always
4.	Snoring results in you sleeping separately	never	rarely	sometimes	often	always
5.	Breathing pauses and/or snorts are heard	never	rarely	sometimes	often	always
6.	Body movements (e.g. legs, arms, body jerks, etc.).....	never	rarely	sometimes	often	always
7.	Grinding teeth.....	never	rarely	sometimes	often	always
8.	Acting out dreams	never	rarely	sometimes	often	always
9.	Sleep onset within 5 minutes or less	never	rarely	sometimes	often	always
10.	Poor concentration and/or short term memory.....	never	rarely	sometimes	often	always
11.	Increased irritability and quick temper.....	never	rarely	sometimes	often	always

Please estimate the likelihood of your bed partner falling asleep in the following common situations.

0 = never 1 = slight 2 = moderate 3 = high N/A = no chance to observe or form an opinion

12. _____ Sitting and reading.
13. _____ Watching television.
14. _____ Sitting inactive in a public place (e.g. a theater or meeting).
15. _____ As a passenger in a car for an hour without a break.
16. _____ Lying down to rest in the afternoon when circumstances permit.
17. _____ Sitting and talking to someone.
18. _____ Sitting quietly after a lunch without alcohol.
19. _____ In a car while stopped for a few minutes in traffic.

_____ Total of 12-19

Patient's Name: _____

Date: _____

Name of Person Completing Questionnaire: _____

Relationship: _____

PATIENT REGISTRATION FORM

Date:_____

Patient Name _____ Birth Date _____ Sex _____ SSN _____
Last First Middle

Are you currently residing in a skilled nursing facility? Yes No If yes, name of facility _____

Home Address _____
Street City State Zip+4

Home Phone _____ Cell Phone _____ Work Phone _____

Preferred contact method for reminders (select one or more):
☐Voice message (circle preferred number above) ☐Text (cell phone above) ☐Email (below) ☐Do Not Remind Me

Email address _____ ☐ I decline access to the portal

Patient Employer _____ Employer Phone _____

Employer Address _____
Street City State Zip+4

Marital Status _____ Patient Language _____

Race ❑American Indian or Alaskan Native ❑Asian ❑Asian Pacific American ❑Black/African American ❑Caucasian (White) ❑Hispanic ❑More Than One Race ❑Native American ❑Native Hawaiian ❑Other Race ❑Pacific Islander ❑Subcontinent Asian American ❑Unknown ❑Decline to Answer

Ethnicity ❑Latino/Hispanic ❑Other ❑Decline to Answer

Spouse's Name _____ Spouse's Employer _____

Spouse's Work Phone _____ Address _____

Referred By _____ Phone _____ Fax _____

Address _____
Street City State Zip+4

Primary Care Physician _____ Phone _____ Fax _____

Address _____
Street City State Zip+4

List other physicians you are currently seeing _____

Notify in case of emergency *(Do not list anyone who lives with you)*

Name _____ Phone _____ Relationship _____

Address _____
Street City State Zip+4

Have you signed a: Living Will: Yes No DNR (Do Not Resuscitate): Yes No (Please provide a copy)
Durable Power of Attorney: Yes No Date signed:_____ (Please provide a copy)

Pharmacy _____ Phone _____

Are you currently using a DME (Durable Medical Equipment) company? Yes No

If yes, which one? _____

If no, who does your insurance company require you to use? _____

Who does your insurance company require you to use for: Lab _____ X-ray _____

Is this a work-related illness/injury? Yes No Date of illness/injury _____ Date last worked _____

Cause of accident, if any _____

I hereby authorize release of my medical records from_____to Texas Pulmonary & Critical Care Consultants, PA. This authorization expires upon written notice from patient/patient representative.

_____ _____
Signature of Patient or Responsible Party Date

Updated 11/25/20

FINANCIAL POLICY

PRIMARY INSURANCE POLICY:

Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Insured's DOB _____ Ins Start Date _____
Relationship to Patient _____ SSN _____ Sex _____

SECONDARY INSURANCE POLICY:

Insurance Co. _____ ID No. _____ Group No. _____
Name of Insured _____ Insured's DOB _____ Ins Start Date _____
Relationship to Patient _____ SSN _____ Sex _____

Responsible Party Name _____ Phone _____ Relationship _____
Address _____
Street City State Zip+4

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment. Full payment or copayment (if applicable) is due at the time of service. We accept cash, check, Visa, MasterCard, Discover or American Express. We are not responsible for misinformation given by your insurance company. You will be refunded any over-payments or billed for any balance after the claim processes.

Regarding Insurance – We cannot bill your insurance company unless you give us your insurance information. If we are nonparticipating with your insurance, and they have not paid the balance within 90 days, the balance will be transferred to you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and/or not considered reasonable and necessary under the Medicare Program and/or other medical insurance. These charges will be your responsibility. Our office makes every effort to obtain referral authorizations from the Primary Care offices for patients on HMOs. Should we not be able to obtain a referral, charges will be your responsibility.

Appeals – You appoint Texas Pulmonary & Critical Care Consultants, P.A. and/or Sleep Consultants, Inc. to act as your authorized representative in requesting an appeal from your insurance plan in the event of denial of services/denial of payment. You agree that if the payment denial is overturned on appeal, the plan's payment should be paid directly to Texas Pulmonary/Sleep Consultants, and you direct the plan to do so in that event.

Out of Network Billing – The physicians may not be participating providers with your insurance plan and, if not, benefits may be reduced and/or your portion may be applied to your out-of-network deductible.

_____ _____
Signature of Patient or Responsible Party Date

Acknowledgment of Review of Notice of Privacy Practices

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

_____ _____
Signature of Patient or Personal Representative Date

A copy of our Notice of Privacy Practices will be provided at your request.

Texas Pulmonary & Critical Care Consultants, PA

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Texas Pulmonary & Critical Care Consultants, PA, must have my consent, therefore I authorize Texas Pulmonary & Critical Care Consultants, PA to disclose my PHI as described in the provided forms to the recipients listed below:

Description of the information to be disclosed (check all that apply):

☐All Procedures ☐Test Results ☐Appointments ☐Other ☐Surgeries ☐Billing/Account information

Name(s) of the person(s) authorized to obtain the above-mentioned information. (e.g. physician other than your referring doctor, family members and other specified person/persons)

Name:_____Relationship:_____

Name:_____Relationship:_____

Patient's Contact Information:

I authorize Texas Pulmonary & Critical Care Consultants, PA to contact me at the following number with results or questions:

Home_____ Cell_____ Work_____

May we leave a detailed message on your answering machine or voicemail?

Yes☐ No☐ Failure to check one of these boxes may delay results

By Patient: (printed name) _____ DOB: _____

Patient Signature: _____ Date:_____

Or Patient's Representative (print name, sign and describe authority)

_____ Date:_____

By signing this HIPAA Patient Acknowledgement form, you acknowledge and authorize that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. You understand that your records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that you have the right to revoke this authorization at any time, provided you do so in writing; that you have been given the opportunity to ask questions; that you have received a copy of the signed authorization; that you may inspect a copy of your PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to you or your treatment upon receipt of this signed authorization; and that you may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

SLEEP CONSULTANTS, INC.

2941 OAK PARK CIRCLE, SUITE 200 • FORT WORTH, TEXAS 76109
(817) 332-7433 • FAX (817) 394-6282

1201 FAIRMOUNT AVENUE • FORT WORTH, TEXAS 76104
(817) 335-5288 • FAX (817) 338-0927

6100 HARRIS PKWY, STE. 285 • FORT WORTH, TEXAS 76132
(817) 263-5864 • FAX (817) 263-3791

Comprehensive Care for People with Sleep Disorders
Diagnosis, Treatment, Follow-up, Education, Research

Sleep Laboratory – 2941 Oak Park Circle, Ste. 200, Fort Worth, TX 76109
Email: Information@SleepConsultants.com
Internet: http://www.SleepConsultants.com

Advanced Practice Provider Consent

This facility has on staff advanced practice providers to assist in the delivery of pulmonary care.

These advanced practice providers are not physicians. They have received advanced education and training in the provision of health care. Each can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care.

I have read the above and hereby consent to the services of an advanced practice provider for my health care needs.

I understand that at any time I can refuse to see the advanced practice provider and request to see a physician.

_____ _____

Name Date

_____

Signature