TEXAS INSTITUTE OF CHEST & SLEEP DISORDERS, PA

Today's Date: _____

Name _____ Sex_____
Last First Middle

Address _____
City State Zip

Date of Birth _____/_____/_____ SS#_____ Marital Status _____

Home Phone_____ Cell_____ Work Phone_____

Employer_____ Primary Care Physician _____

RESPONSIBLE PARTY (If different from patient)

Name _____ Date of Birth _____/_____/_____
Last First

Address _____
City State Zip

Home Phone _____Cell Phone _____ SS#_____

Employer_____Work Phone_____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD AT TIME OF CHECK IN)

Primary Insurance Name _____

Ins Address _____

Name of Insured _____

Insured's ID # _____

Group # _____

Home Add (If Different) _____

Relationship to patient _____

Secondary Insurance Name _____

Ins Address _____

Name of Insured _____

Insured's ID # _____

Group # _____

Home Add (If Different) _____

Relationship to patient _____

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1. In case of Emergency who should be notified? _____ Phone # _____
2. Who referred you to us: _____
3. **May we contact you via EMAIL? YES or NO EMAIL ADDRESS: _____**
4. Patient of TEXAS INSTITUTE OF CHEST & SLEEP DISORDERS have the right of patient confidentiality on all medical information and test results. All information shall be held in confidence and shall not be disclosed to any person, except upon the expressed consent of the patient or by the guidelines of his/her medical insurance. All reports will only be given to patient unless otherwise noted below. If the patient is a minor, all information will be explained to the patient or legal guardian.

   Name of Person whom we may speak with about your care: _____

5. I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient/Guardian Signature _____ DATE: _____

TEXAS INSTITUTE OF CHEST & SLEEP DISORDERS, PA

Dr. Alex E. Lechin Dr. Dean Nasser

14262 Gulf Freeway

Houston, Texas 77034

Ph (281) 481-0091 Fax (281) 481-0093

ACKNOWLEDGEMENT AND AUTHORITY FOR TREATMENT AND PAYMENT: I consent to treatment as necessary or desirable to the care of the patient named above, including but not restricted to whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor, his/her nurse of qualified designate. I acknowledge and understand that I am ultimately responsible for all of my charges and services rendered to me. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate.

AUTHORIZATION TO OBTAIN INFORMATION: I, Authorized any physician, medical practitioner, hospital, other medical or medically related facility, insurance or related facility, insurance or reinsuring company, the Medical information Bureau, Inc., consumer reporting agency, or employer having information available as diagnosis, treatment and prognosis with respect to any physical or mental condition and =/or treatment of me and any other nonmedical information to give to the group policy holder, my employer, or its legal representative, any and all such information. I, Understand the information obtained by use of the authorization will be used to determine eligibility for insurance, and eligibility for benefits under any exiting policy. Any information obtained will not be released by/to any person or organization except to the group policy holder, my organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization. I AGREE that a photographic copy of this Authorization shall be valid as the original. I AGREE this Authorization shall be valid for one year from the date shown above.

RETURN CHECK POLICY: Texas Institute of Chest & Sleep Disorders imposes a service charge for checks that are returned. The returned check fee is $25.00. We do not redeposit returned checks. When we receive a returned check, the check writer is notified by certified mail and given 10 calendar days to settle the debt by cash, money order or credit card. If the debt is not paid in 15 days from the date of the letter, the check will be turned over for collections.

CANCELLATION POLICY: Effective May 23, 2005, Texas Institute of Chest & Sleep Disorders will implement a "MISSED APPOINTMENT" fee of $50.00 for New Patients, $25.00 for established patients, $50 for PFT/Stress Test and $150 for Sleep studies. Due to the large number of patients who fail to keep scheduled appointments Texas Institute of Chest & Sleep disorders must implement a cancellation policy. We will make every attempt to contact you with a reminder of your appointment. If you are unable to keep your appointment, You will need to contact our office within 24 hours to reschedule. Our ability to accommodate urgent patients or work-in patients relies on our ability to predict our schedule. If your appointment is confirmed and you do not keep the appointment them, the cancellation fee will be charged in order to schedule your next appointment.

POLICY FOR INSURANCE PARTICIPANTS: If we are filing your insurance through a contracted plan, it is YOUR RESPONSIBILITY to notify the receptionist that you are on a certain plan and give your insurance card and/or referral, to the receptionist BEFORE SERVICES ARE RENDERED. Should you NOT have your insurance card and/or referral with you at the time of service, you will be asked to reschedule your appointment for a time when you can bring the insurance card and/or referral. DEDUCTIBLES AND CO-PAYMENTS will be collected at the time of visit, and we will bill your insurance for the balance under these plan provisions. We honor all our insurance contracts and take adjustments as we are instructed by our payers. After your insurance pays and the insurance company states that you are still have a balance, you will be responsible for the balance.

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRATICES: I have reviewed the office 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 _____ Date _____

Print Name_____