

Patient Registration Form

(Please Print)

PATIENT INFORMATION

Dr. Mr. Mrs. Ms. Jr. Sr. Other _____

Patient's Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Marital Status Married Single Divorced Widowed Legally Separated Other

Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Home _____ Day Evening Work _____ Day Evening
Cellular _____ Pager _____ May we contact you at work? Yes No

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Occupation _____

Emergency Contact Name _____ Phone Number _____

Relationship to Patient _____

RESPONSIBLE PARTY INFORMATION

Responsible Party Name (Last) _____ (First) _____ (Middle) _____

Also Known As Name (Last) _____ (First) _____

Social Security Number _____ - _____ - _____ Female Male Date of Birth ____/____/____

E-Mail Address _____

Phone Numbers Home _____ Day Evening Work _____ Day Evening

Address _____

City, State, ZIP (+4) _____

Employment Status Employed Full-Time Student Part-Time Student Retired Self-Employed Unemployed

Employer _____ Employer Phone Number _____

Patient Relationship to Responsible Party _____

PRIMARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insurance Company/Phone Number _____ (____)

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth ____/____/____ Insurance Company Address _____

SECONDARY INSURANCE INFORMATION

(provide your insurance card to the front desk at check-in)

Name of Insured _____ Patient Relationship to Insured _____

Insurance Company/Phone Number _____ (____)

Subscriber ID (Policy Number) _____ Group ID _____ Copay Amount _____

Effective Date _____ Termination Date _____ Female Male

Insured Date of Birth ____/____/____ Insurance Company Address _____

I agree that the information supplied on this form is accurate and up-to-date to the best of my knowledge.

Patient (or Responsible Party) Signature _____ **Date** _____

HOUSTON PEDIATRIC PULMONARY AND SLEEP ASSOCIATES
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the Authorization for Research Form. If no, proceed to Section B.

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name: _____ Birth Date: _____ Social Security No. (optional): _____

Patient's Address: _____ Requestor's Name/Phone Number (if patient is not the requestor): _____

PHI Recipient Name: Houston Pediatric Pulmonary and Sleep Associates
 Address/City/State/Zip: 7400 Fannin, Suite 1130 Houston, TX 77054
 Phone Number: (713)794-0200
 Fax Number: (713)794-0203

PHI Sender Name: _____ Address/City/State/Zip: _____
 Phone Number: () _____
 Fax Number: () _____

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)

Date: _____ Event: _____

Purpose of Disclosure: _____

Is this request for psychotherapy notes?

Yes, then this is the only item you may request on this authorization.

No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
<input type="checkbox"/> All PHI in record		<input type="checkbox"/> Physician Orders		<input type="checkbox"/> Demographics	
<input type="checkbox"/> History and Physical		<input type="checkbox"/> Laboratory		<input type="checkbox"/> Rehabilitation Services	
<input type="checkbox"/> Consult Report		<input type="checkbox"/> Imaging/Radiology		<input type="checkbox"/> Special Test/Therapy	
<input type="checkbox"/> Operative Report		<input type="checkbox"/> Nursing Notes		<input type="checkbox"/> Itemized Bill/Claims	
<input type="checkbox"/> Progress Notes		<input type="checkbox"/> Medication Record		<input type="checkbox"/> Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not, applicable, check here

I understand that:

- I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
- I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
- I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
- I will receive a copy of this form after I sign it.

Continued on next page

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative: _____ Date: _____

Print Name of Patient's Representative: _____ Relationship to Patient: _____

HCA PHYSICIAN SERVICES
HOUSTON PEDIATRIC PULMONARY AND SLEEP ASSOCIATES

Notice of Privacy Practices

Effective Date: April 1, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Facility Privacy Official by dialing the main medical office number.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment and billing-related information. This notice applies to all of the records of your care generated by the medical office, whether made by medical office personnel, agents of the medical office, or your provider.

Your health insurance, hospitals and other treatment providers may have different policies or notices regarding the use and disclosure of your health information.

Our Responsibilities:

We are required by law to maintain the privacy of your health information and provide you a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures:

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other medical office personnel who are involved in taking care of you at the medical office. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the medical office also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the

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treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may also combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and students for educational purposes. And we may combine health information we have with that of other medical offices to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

We may also use and disclose health information:

- To business associates we have contracted with to perform the agreed upon service and billing for it;
- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health-related benefits or services;
- To contact you as part of fundraising efforts;
- To inform Funeral Directors consistent with applicable law;
- For population based activities relating to improving health or reducing healthcare costs;
- For conducting training programs or reviewing competence of health care professionals; and
- When disclosing information, primary appointment reminders and billing/collections efforts we may leave messages on your answering machine or voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include billing services, transcriptionists, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Individuals Involved in Your Care or Payment for Your Care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

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Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, or other community based initiatives or activities in which our facility is participating.

As required by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors, Coroners and Medical Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others

Law Enforcement/Legal Proceedings: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

State Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing healthcare costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to:**

Inspect and Copy: You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed healthcare professional chosen by the medical office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

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Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the medical office. We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or healthcare operations where an authorization was not required.

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of your home. The facility will grant requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services.

Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of This Notice: You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

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To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the medical office and include the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the medical office by contacting the main number and asking for the Facility Privacy Official or with the Secretary of the Department of Health and Human Services. To file a complaint with the medical office, contact the Privacy Official. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time.

If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in the doctor's office or clinic.

Houston Pediatric Pulmonary and Sleep Associates
7400 Fannin Street, Ste. 1130
Houston, TX 77054

**Patient Consent and
Acknowledgement of Receipt of "Notice of Privacy Practices"**

*(Please Read and Sign below)*_____

I, the undersigned, hereby consent to the following Treatment:

- Administration and performance of all treatments
- Administration of any needed anesthetics
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient
- Use of prescribed medication
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of the attending physician or their assigned designees

I fully understand that this is given in advance of any specific diagnosis or treatment.

I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that **Sarat C. Susarla, MD / John M. Robertson, MD** may include consent at satellite offices under common ownership.

I, the undersigned, authorize **Sarat C. Susarla, MD / John M. Robertson, MD** to use and disclose my information for the purposes of treatments, payment, and healthcare operations as described in the Notice of Privacy Practices.

A photocopy of this consent shall be considered as valid as the original.

MEDICARE PATIENTS: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to **Sarat C. Susarla, MD / John M. Robertson, MD**.

I acknowledge that I have been given the Houston pediatric Pulmonary Assoc. dba Sarat C. Susarla, MD / John M. Robertson, MD Notice of privacy Practices. I understand that if I have any questions or complaints that I should contact the Privacy Official. (Patient or Guardian Initial) _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Name: _____ Date of Birth: _____

Patient (or Responsible Party) Signature

Relationship

Date