Alexander N. Stadnyk, M.D.
6624 Fannin St, Suite 1450 * Houston, TX 77030
Tel 713-799-9916 * Fax 713-799-9917

Registration Form

Date: _____ Referred By: _____

Patient Name: _____ Marital Status: [ ]S [ ]M [ ]D [ ]W

Date of Birth: _____ Age: _____ Sex: [ ]M [ ]F

Driver's License Number: _____ State: _____ Social Security Number: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address, City, State, Zip: _____

E-mail Address: _____ Occupation: _____

Employer: _____ Employer Phone: _____

Emergency Contact (name, relationship, phone#)

Race: (please circle one or more) *1.American Indian/Alaskan Native 2.Asian 3.Native Hawaiian 4.Black/African American 5.White 6.Hispanic 7.Other Pacific Islander 8.Other Race 9.Decline to Answer*

Ethnicity: (please circle one) *1.Hispanic or Latino 2.Not Hispanic or Latino 3.Decline to Answer*

Primary Insurance: _____

Member ID# _____ Group# _____

Policyholder's name and relationship to Patient: _____

Policyholder's date of birth: _____

Secondary Insurance: _____

Member ID# _____ Group# _____

Policyholder's name and relationship to Patient: _____

Policyholder's date of birth: _____

Do you have a living will, health proxy or a person designated for health decisions in the event of a major illness:

[ ]No [ ]Yes, name/relationship to patient _____

Assignment of Benefits and Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Alexander N. Stadnyk, M.D. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I authorize Alexander N. Stadnyk, M.D. release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. A photocopy of this agreement shall be as valid as the original.

Signature: _____ Date: _____

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Date: _____

Patient Name and Date of Birth: _____

MY CONTACT PHONE NUMBERS AND E-MAIL INFO

Home: _____ Cell: _____ Work: _____

E-Mail: _____

PHARMACY INFORMATION

Local Pharmacy Name and Phone Number: _____

Mail Order Pharmacy/Phone Number/Member ID# (optional):

_____

I authorize contact from this office to **confirm appointments, treatments and billing information** in the following sequence (check one):

Primary [ ]home [ ]cell [ ]work [ ]e-mail
Second [ ]home [ ]cell [ ]work [ ]e-mail
Third [ ]home [ ]cell [ ]work [ ]e-mail

I authorize information **about my health be conveyed via** (check one):

Primary [ ]home [ ]cell [ ]work [ ]e-mail
Second [ ]home [ ]cell [ ]work [ ]e-mail
Third [ ]home [ ]cell [ ]work [ ]e-mail

Please list any other **parties who can have access to your health information** (this **includes relatives, friends and any care takers** who can have access to this patient's records and receive test results by phone):

Name and Phone#: Relationship to patient:

_____

_____

_____

_____

_____

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FINANCIAL POLICY

ANY CHANGES IN INSURANCE COVERAGE, ADDRESS, AND TELEPHONE OR OTHER DEMOGRAPHICS MUST BE GIVEN TO THE FRONT DESK WHEN YOU SIGN IN FOR YOUR APPOINTMENT.

To assist us in establishing your account please provide the following:

1) Current insurance information on your registration form
2) Please present your insurance card so that a copy can be made for your chart.
3) A separately ***signed consent disclosure*** for authorization for the release of information necessary for filing your insurance claim(s), faxing orders, releasing medical information to other physicians and/or for insurance pre-certifications.
4) All ***co-pays and deductibles*** designated by your PPO or HMO will be **PAID UPON CHECK IN**.

INSURANCE

Insurance is a contract between you and your insurance company. We are not a party to your contract though we may have a contractual fee schedule agreement with the insurance company. We will not become involved in disputes with your insurance company regarding deductibles, non-covered/covered expenses, co-insurance or "reasonable and customary" charges other than to supply factual information as necessary. Payment plans are available but arrangements must be made in advance with our Practice Manager or Patient Account Manager. We accept checks, cash and credit cards (Visa, MasterCard and American Express).

Medicare: We are a participating provider with Medicare. We will also file with your secondary or supplementary policy. Please make sure that you provide our front desk with your Medicare and supplementary cards. You will be asked to sign a Waiver of Liability Form in the event that a service is provided, which we know is not covered by Medicare.

Indemnity/Fee for Service: As a courtesy to our patients we will file with your insurance provided you have met your annual deductible and pay your coinsurance at the time of service. *If you have not met your yearly deductible you must pay at the time of service and a claim will be filed with your insurance upon request.*

Contracted Managed Health Care: (HMO's, PPO's, EPO's) **It is your responsibility to make sure that OUR physician is currently enrolled with your plan. All necessary referrals must have been obtained prior to each visit.** If your referral has not been completed prior to your arrival in the office it may mean a delay in being seen by the physician and the possible rescheduling of your appointment. You are obligated by your insurance company to pay the copay at the time of your visit.

PROCEDURES

Insurance will be verified including deductible and co-insurance prior to your pre-operative visit. Payment in full is required in advance if insurance benefits are not assigned or in the event there is no insurance. Any overpayment by the insurance will be promptly refunded to the patient (or responsible party). Other financial arrangements may be discussed with our Patient Account Manager

MINORS/UNACCOMPANIED MINORS

The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for that date of service regardless of insurance or divorce decree status. Unaccompanied minors must have authorization for medical treatment signed by his i.e. parent or legal guardian and is responsible for providing current insurance information and any necessary payment at the time of service.

PRIVATE PAY

If you have no health insurance, payment is expected in full at the time of service.

Returned Check Fee: **There will be a $25.00 charge on all returned checks.**

I understand and agree that (REGARDLESS OF MY INSURANCE STATUS) I am ultimately responsible for the balance of my account for any professional services rendered. I authorize payment of insurance benefits to be paid directly to the physician. I authorize the release of any medical information necessary to process my claims. I have read and certify that all the above information is true, complete and correct to the best of my knowledge. I will notify the office staff of any changes in my health status or the above information.

Printed Name and Date of Birth: _____

Signature and Date: _____

Alexander N. Stadnyk, M.D.
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Consent to Disclose Private Healthcare Information for Treatment and Healthcare Operations

I authorize and consent for Dr. Alexander N. Stadnyk and staff to release any and all medical, including, but not limited to, medical notes, physician narratives, office notes, operative notes, discharge summaries, doctor's orders, nurse's notes, lab reports, test results, physical therapy progress notes, patient progress notes, diagnosis, post operative reports, post operative diagnosis, pathology reports, x-rays, CT scans, any diagnostic studies, laboratory studies, clinical abstract, historical charts, any records reflecting treatment for substance abuse, mental illness, AIDS, HIV virus, alcohol abuse and other information contained therein, any documents and opinions relevant to past, present or future physical and mental condition, care or hospitalizations, and any other personal health information regarding my medical care as necessary to carry out treatment, obtain payment and conduct other healthcare operations.

This includes released by fax, telephone requests, mail and e-mail to self, other physicians, healthcare providers and insurance provider.

The release of the matters listed above is being authorized for purposes of obtaining medical treatment, payment for such services and other healthcare operations.

A copy of this authorization is agreed by me to have the same effect and force as an original.

Any person, firm or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I understand that I may request restrictions and I may revoke this consent in the future if I should so desire.

Printed Name and Date of Birth: _____

Signature and Date: _____

Special Restrictions:

Notice of Privacy Practices

I have received and reviewed a copy of the currently effective notice of privacy practices for this healthcare facility which explains how my medical information will be used and disclosed. A copy of this signed and dated document shall be as effective as the original.

Printed Name: _____

Signature: _____

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Date: _____

Patient Name and Date of Birth: _____

Primary Care Physician and Phone No. _____

History of PRESENT Illness (check one or more)

Short of breath	Wheezing	Chest pain
Lung Infection	Abnormal X-ray/CT scan	Cough (dry, w/phlegm, w blood)

OTHER:

PAST Medical History (check one or more)

Asthma	Diabetes	CHF	COPD	GERD
TB	High blood pressure	Irritable bowel	Cancer	Cystic fibrosis
Emphysema	Liver disease	Wegeners granulomatosis	Coronary artery disease	Sleep disorder
Clotting disorder	HIV	Pancreatitis	Renal failure	Sarcoidosis
Scleroderma	Sjogren syndrome	SLE	Stroke	Sleep apnea
Bronchiectasis	Rheumatoid arthritis	Chemotherapy	Pulmonary embolism	DVT

OTHER:

SOCIAL History (check one)

Do you smoke? [ ]current smoker, [ ]former smoker, [ ]never smoker

Alcohol? [ ]yes [ ]no

Pets? [ ]yes [ ]no

Work with toxic chemicals or gases? [ ]yes [ ]no

Been exposed to asbestos or sandblasting or dusts? [ ]yes [ ]no

Travel outside US? [ ]yes [ ]no

Exercise? [ ]yes [ ]no

Caffeine? [ ]yes [ ]no

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Date: _____

Patient Name and Date of Birth: _____

Family History

Mother: [ ]alive/age____ [ ]deceased/age_____

[ ]asthma [ ]COPD [ ]tuberculosis [ ]cancer [ ]diabetes [ ]hypertension

[ ]heart disease [ ]stroke [ ]mental illness

Father: [ ]alive/age_____ [ ]deceased/age_____

[ ]asthma [ ]COPD [ ]tuberculosis [ ]cancer [ ]diabetes [ ]hypertension

[ ]heart disease [ ]stroke [ ]mental illness

Siblings: #brothers_____[ ]alive [ ]deceased; #sisters_____[ ]alive [ ]deceased

[ ]asthma [ ]COPD [ ]tuberculosis [ ]cancer [ ]diabetes [ ]hypertension

[ ]heart disease [ ]stroke [ ]mental illness

Children: #sons_____[ ]alive [ ]deceased; #daughters_____[ ]alive [ ]deceased

[ ]asthma [ ]COPD [ ]tuberculosis [ ]cancer [ ]diabetes [ ]hypertension

[ ]heart disease [ ]stroke [ ]mental illness

Paternal Grandfather: [ ]alive [ ]deceased;; [ ]asthma [ ]COPD [ ]tuberculosis [ ]cancer [ ]diabetes

[ ]hypertension [ ]heart disease [ ]stroke [ ]mental illness

Paternal Grandmother: [ ]alive [ ]deceased;; [ ]asthma [ ]COPD [ ]tuberculosis [ ]cancer [ ]diabetes

[ ]hypertension [ ]heart disease [ ]stroke [ ]mental illness

Maternal Grandfather: [ ]alive [ ]deceased;; [ ]asthma [ ]COPD [ ]tuberculosis [ ]cancer [ ]diabetes

[ ]hypertension [ ]heart disease [ ]stroke [ ]mental illness

Maternal Grandmother: [ ]alive [ ]deceased;; [ ]asthma [ ]COPD [ ]tuberculosis [ ]cancer [ ]diabetes

[ ]hypertension [ ]heart disease [ ]stroke [ ]mental illness

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Date: _____

Patient Name and Date of Birth: _____

Surgical History

Surgery	Date

Hospitalization – past illness requiring hospital stay

Hospitalization	Date

Allergies to Medication, Drugs

Medication,Drug	Reaction

Current Medication, Dosage, Frequency

Alexander N. Stadnyk, M.D.
Pulmonary Diseases
6624 Fannin, Suite 1450
Houston, TX 77030

PATIENT'S COPY

WELCOME TO OUR OFFICE

Dr. Alexander N. Stadnyk is certified in Internal Medicine and in Pulmonary Diseases by the American Board of Internal Medicine. He holds Fellowships in the American College of Physicians, American College of Chest Physicians and the Royal College of Physicians and Surgeons of Canada. Dr. Stadnyk is specially trained to diagnose and treat disorders of the lungs and breathing and has additional training in pulmonary oncology. He is particularly interested in asthma, lung injury and smoking-related lung disease, including lung cancer. Detection of disease at its earliest and most treatable stages is emphasized.

University and Hospital Affiliations

Dr. Stadnyk is Clinical Associate Professor at the Baylor College of Medicine. For this reason, you may be seen at times by an intern or resident as well as by Dr. Stadnyk, and your case thoroughly reviewed for teaching purposes. Although most patients appreciate this opportunity, you may inform us if you do not wish to participate in this process. Dr. Stadnyk is on the Medical Staff of several Medical Center Hospitals.

Office hours and appointments

Dr. Stadnyk's scheduled clinic hours are from 9:00AM - 5:00PM Monday thru Thursday and 9:00AM - 3:00PM on Fridays. Appointments may be made by calling 713-799-9916 on weekdays between 9:00 a.m. and 5:00 p.m. Please let us know what problems you are having so that enough time is set-aside for you. If you are unable to keep your scheduled appointment, please inform us as soon as possible, so that this time may be given to another patient.

Medical Records

Your medical records are confidential and information will not be released to anyone unless we have written authorization from you in the office. If you have changes to your address or telephone, or any other corrections to update your records, please call or write.

Insurances, Fees and Payments

Most insurance plans are accepted as well as some HMO/PPO plans (please call your insurance plan and check if Dr. Stadnyk is a provider). If you have an HMO plan, patients must have an authorization/referral from their PCP for each office visit. It is important that you bring your insurance card for each visit. Dr. Stadnyk is a Medicare Part B participating physician. Charges for services are determined by the time spent and the severity or complexity of the problems. Our fees are comparable to those of other lung specialists with similar training and expertise in the Medical Center area. Most plans require the patient to pay a co-pay or a percentage of each office

visit along with a yearly deductible. Payment is appreciated at time of service to reduce costs that are associated with billing. For your convenience, we accept American Express, MasterCard and Visa credit cards. We are concerned with the costs of medical care and appreciate your suggestions. Please do not hesitate to discuss your fees with us. If you have any questions - we are always ready to work with you.

Telephone and Answering service

The office telephone is 713-799-9916 and the office facsimile is 713-799-9917. In general, we feel that it is not possible to practice the best medicine over the telephone, but recognize that minor problems can sometimes be dealt with in this way. If you need to speak to Dr. Stadnyk, your call will be returned as soon as conditions permit. When the office is closed, the answering service will take all calls and will page Dr. Stadnyk or the doctor taking his calls to return your call. If your call has not been returned within 30 minutes, please check back with the answering service. In an emergency, have someone call the office and come to the St. Luke's Episcopal Hospital Emergency Room. If that is not possible, go to the nearest hospital Emergency Room, and have them notify us.

Pulmonary Call Group

Dr. Stadnyk shares evening, weekend and holiday patient care responsibilities with other qualified pulmonary specialists.

Test results and Prescriptions

Dr. Stadnyk prefers to go over your x-ray and laboratory tests with you. If you do not hear from us within several days after your test, please call the office. Prescription refills can be requested during office hours or you may call your pharmacy directly. Please refill your prescription at least 2 days before your medicine runs out. Dr. Stadnyk may not authorize refills of regular medication if the patient has not been seen within 6-12 months.

Parking

To self-park or valet park, drive into the parking garage on Fannin Street entrance. Take the garage elevator to the lobby and the lobby elevator to the 14th floor. We do not validate parking.

About this brochure

We hope that you will find this brochure helpful and suggest that you keep it handy with your medical information. Please call us if you would like an extra copy for your friends, relatives or if you have specific questions that we may answer.

Welcome to our office!

Alexander N. Stadnyk, M.D. - Pulmonary Diseases

NOTICE OF PRIVACY PRACTICES
(*PATIENT'S COPY*)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW CAREFULLY
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by the applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we make the changes. Before we make significant changes in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional
copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner or provider performance, conducting training programs, accreditation, and certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure performed by your authorization while it was in effect. Unless you give us written authorization, we cannot use or discuss your health information for any reason except those described in this Notice.

To Your Family and Friends: With your authorization we can disclose your health information to a family member,
friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying and locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of

your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable
inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies or other similar forms of health information.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose you health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voicemail message, postcards, or letters.

PATIENT RIGHTS

Access: You have the right to inspect and obtain a copy of your health information, with limited exceptions. You must
make a request in writing to obtain access to your healthcare information. You may obtain a form to request access by
using the contact information listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities,
for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period,
we may charge you a reasonable, cost-based fee for responding to these additional requests. Our practice will notify you of the costs involved with additional requests, and you may withdraw you request before you incur any costs.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in emergency situations. You may obtain a form to request restricted disclosure by using the contact information listed at the end of this Notice.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to an alternative location. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendments: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written format.

QUESTIONS AND COMPLAINTS

If you want more information about or privacy practices or have questions or concerns please contact us.
If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary
of the Department of Heath and Human Services. To file a complaint with our practice please contact Lisa Libranda, Practice Representative, 713.799.9916. All complaints must be submitted in writing.