Alexander N. Stadnyk, MD - Pulmonary Diseases
6624 Fannin Street, Suite 1450 * Houston, Texas 77030-2326
May 25, 2006

PATIENT INFORMATION FORM

Patient's Name:			Patient's Sex: [ ] Male [ ] Female Marital Status: [ ] Single [ ] Married [ ] Divorced/Separated [ ] Widowed
Date of Birth:	Age:	Social Security Number:	Driver's License Number:
Street Address and Apt #, if any:		City and State	Zip Code
Home Tel No.:	Work Tel No.:	Cell or Pager No:	

*Do you authorize Dr. Alexander N. Stadnyk and his staff to contact you at home, work or cell? [ ] yes [ ] no

*In the event we are unable to contact you, do you authorize Dr. Alexander N. Stadnyk and his staff to leave a message on your voice mail? [ ] yes [ ] no

Email Address:

Emergency Contact Name, relationship to Patient, and Phone Number:

Your Pharmacy Name and Phone Number:

Patient's Employer Name:	Employer Address:	Work Number:
Spouse's Name:	Spouse's Employer Address:	Work Number:

PRIMARY INSURANCE: _____

Policyholder's Name and Relationship to Patient: _____

Date of Birth and Social Security Number: _____

Member ID#: _____ Group #: _____

SECONDARY INSURANCE: _____

Policyholder's Name and Relationship to Patient: _____

Date of Birth and Social Security Number: _____

Member ID#: _____ Group #: _____

LIVING WILL

Do you have a Living Will, health proxy or a person designated for health decisions in the event of a major illness?
[ ]NO [ ]YES, that person is _____

The information that I provide on this form is accurate and complete to the best of my knowledge.

SIGNATURE : _____ **DATE:** _____

Patient is [ ] a minor or [ ] Unable to sign because _____
My relationship to the patient is _____ *and I have signed this consent on his/her behalf.*

_____ _____

Print Name *Date*

Patient Name: _____
Date of Birth: _____

1) Who is the referring doctor?

2) Are you **ALLERGIC** to any medications; if yes, please list:

3) Please list your **MEDICATIONS**:

4) **PERSONAL HISTORY** – have you ever had, or been told you had:

Tuberculosis	[ ] Yes	[ ] No
Emphysema	[ ] Yes	[ ] No
Chronic Bronchitis	[ ] Yes	[ ] No
Asthma	[ ] Yes	[ ] No
Recent Infections	[ ] Yes	[ ] No
Colds	[ ] Yes	[ ] No
Pneumonia	[ ] Yes	[ ] No
Allergies	[ ] Yes	[ ] No
Chest Surgery	[ ] Yes	[ ] No

5) **OCCUPATION** – Have you every worked:

On a farm	[ ] Yes	[ ] No
Near gasses or fumes	[ ] Yes	[ ] No
In a dusty place	[ ] Yes	[ ] No

6) **SMOKING HABITS** – Have you ever smoked:

[ ] N/A

[ ] Cigarettes [ ] Cigars [ ] Pipe

Number of years: _____
Still Smoke: [ ] Yes [ ] No

7) **COUGH** – Do you cough:

In the morning	[ ] Yes	[ ] No
At Night	[ ] Yes	[ ] No
Blood	[ ] Yes	[ ] No
Phlegm	[ ] Yes	[ ] No

8) **DYSPNEA** – Do you get short of breath:

At rest	[ ] Yes	[ ] No
On exertion	[ ] Yes	[ ] No

CONSENT TO DISCLOSE
PRIVATE HEALTHCARE INFORMATION
FOR TREATMENT, AND/OR HEALTHCARE OPERATIONS

I,_____, Social Security Number _____, date of birth _____, **hereby authorize and consent for Dr. Alexander N. Stadnyk to release any** and all medical, and/or psychological reports or records, 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, MRIs, any records reflecting treatment for substance abuse, mental illness, AIDS, HIV virus, alcohol abuse, including any x-rays, diagnostic studies, laboratory slides, clinical abstract, histories charts, and other information contained therein, any documents and opinions relevant to past, present, or future physical and mental condition, treatment, care or hospitalizations, and any other personal health information regarding my medical care as necessary to carry out treatment, obtain payment, and/or conduct other healthcare operations.

This includes released by fax, telephone requests, mail and/or email to self, other physicians and/or health care providers.

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

A copy of this authorization is agreed by the undersigned 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 further understand that I have the right to review Dr. Alexander N. Stadnyk's privacy notice and to request restrictions. I further understand that I revoke this consent in the future if I should so desire.

Signed this _____day of _____, 20_____.

_____
Signature

_____
Printed Name

Special Restrictions:

_____

Effective as of April 14, 2003

Alexander N. Stadnyk, M.D.
Pulmonary Diseases
6624 Fannin, Suite 1450
Houston, TX 77030-2326
Tel. 713-799-9916 / Fax 713-799-9917

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship.

ANY CHANGES IN INSURANCE COVERAGE, ADDRESS, AND TELEPHONE OR OTHER DEMOGRAPHICS MUST BE GIVEN TO THE FRONT DESK REPRESENTATIVE 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 receptionist 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/her 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.**

For your convenience we accept cash, check, MasterCard, Visa, American Express and Traveler's Cheques.

Our staff is very knowledgeable in referral authorization, pre certifications and pre authorization procedures for all insurance plans. At times, you may be required to obtain additional information from your insurance plan. Being knowledgeable about your insurance policy and referrals is to your benefit and proper claim(s) payment.

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.

By my signature, I certify that I have read the above information or that the information has been read or translated to me, and that I understand the above terms and conditions and will verify so by giving my signature.

_____ _____

Patient Signature **Date**

Patient is [ ] a minor or [ ] Unable to sign because _____
My relationship to the patient is _____ *and I have signed this consent on his/her behalf.*

_____ _____

Print Name *Date*