Breathing Center of Houston

Patient Intake

First Name**:** _____ Last Name**:** _____ Initial: _____

Home Address: _____City: _____ State: _____ Zip:_____

Home Phone: _____Work Phone: _____

Cell Phone: _____ Email: _____

Preferred Method of Contact (for appointment reminders): ☐ Text ☐ Email

*Social Security #: _____ (Needed in order to process any insurance claims)

Birth Date: _____ Age: _____ Sex: ☐ Male ☐ Female

Primary Care Physician: _____ Pulmonary Physician: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

***A copy of your insurance card(s) and photo ID will be required at your first visit.**

Primary Insurance: _____ I am the policy holder: ☐ Yes ☐ No

Secondary Insurance: _____ I am the policy holder: ☐ Yes ☐ No

If yes, skip the Policy Holder Information Section and provide a copy of the current insurance card to Breathing Center of Houston. If no, please complete Policy Holder Information Section below and provide current insurance card to Breathing Center of Houston.

POLICY HOLDER INFORMATION - If other than self

First Name**:** _____ Last Name**:** _____ Initial:_____

Home Address: _____City: _____ State: _____ Zip:_____

Home Phone: _____Work Phone: _____

Cell Phone: _____ Social Security #: _____Birth Date: _____

Patient Agreement

Thank you for choosing the Breathing Center of Houston to meet your cardiopulmonary needs. We are committed to providing you with quality and affordable health care. Please read through the following policy and ask us any questions you may have. Copies of these agreements will be kept on file and are available to you upon request.

Patient Understanding and Acceptance of Risks Associated with Treatment

As your doctor it is our responsibility to inform you of the potential risks and benefits of your treatment, but we also want to assure you that we strive to minimize these risks by providing thorough clinical examination and by performing diagnostics as clinically indicated. Furthermore, we continually review medical literature pertaining to current trends within our profession as well as throughout the entire medical community to ensure the safest and most effective care.

Some responses to therapeutic interventions are muscle soreness, muscle fatigue, increased discomfort, overall tiredness and/or joint stiffness and/or pain. It is important that you inform your treating staff member of any of these responses following your treatment and more importantly it is crucial that you continue to attend your appointments as scheduled so your condition can be documented and your symptoms effectively managed.

I also understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls, and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego rehabilitation all together.

Therapeutic interventions consist of the following types of treatments: stretching, flexibility exercises, strengthening exercises, joint mobilizations and myofascial release.

Therapeutic interventions are generally quite safe though there are risks associated with each of these procedures. The primary risk is potential aggravation of your current condition and/or underlying condition. As with any physical activity and/or exercise there is also the risk of injury. Though this risk is minimal as you are under the direct supervision of experienced clinical staff, it may still exist.

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Breathing Center of Texas uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health Information is contained in a electronic medical record that is the physical property of Breathing Center of Houston. How we may use or disclose your health information;

For Treatment: We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider such as a physician, therapist, nurse or other person providing health services to you will record information in your record related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond.

For Payment: We may use and disclose health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations: We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- Evaluate the performance of our staff;
- Assess the quality of care and outcomes in your case and similar cases;

- Learn how to improve our facilities and services;
- Determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments: We may use your information to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Required by Law: We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- For judicial and administrative proceedings pursuant to legal authority;
- To report information related to victims of abuse, neglect or domestic violence;
- To assist law enforcement officials in their law enforcement duties.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities. Health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Government Functions: Your health information may be disclosed for specialized government functions such as protection of public official or reporting to various branches of the armed services.

Workers' Compensation: Your health information may be used or disclosed in order to comply with laws and regulation related to Workers' Compensation. Other uses: Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent our facility has taken in reliance on such.

Your Health Information Rights: You have the right to:

- Obtain a paper copy of the notice of information practices upon request;
- Inspect and obtain a copy of your health record as provided for in 45 C.F.R. § 164.524;
- Request that your health record be amended as provided in 45 C.F.R. § 164.526;
- Request communications of your health information by alternative means or at alternative locations;
- Receive an accounting of disclosures made of your health information as provided by 45 C.F.R. § 164.528.
- Request a restriction on certain uses and disclosures on your information proved by 45 C.F.R. § 164.522; however, our facility is not required to agree to a requested restriction.

Concerns / Complaints: You may complain to our facility and / or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a concern. To register a concern with our facility, please contact the Administrator to complete and return a Patient Concern Form to our facility.

Our Obligations: Our facility is required by law to:

- Maintain the privacy of protected health information;
- Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- Abide by the terms of this notice;
- Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- Accommodate reasonable request you may make to communicate health information by alternative means or at alternative locations.

This office reserves the right to change information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made publicly available and posted at the facility.

Financial Agreement/ Assignment of Benefits

(Effective May 24,2011)

As a courtesy Breathing Center of Houston verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we were quoted, the insurance company will side with the plan and will not honor the benefit quote we received. It is the policy of Breathing Center of Houston that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. This arrangement is part of your contract with your insurance company. At the conclusion of your visits with us you may be billed for any outstanding balances.

If there is a credit, you will be provided a refund promptly. We are contracted with many insurance companies, but ultimately all financial responsibility is yours, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred. If your insurance changes, please notify us before your next visit so we can make the appropriate changes.

Cancellation Policy: If you need to cancel your appointment, please give 24 hours' notice, so we can offer your appointment to another patient. If less than 24 hours' notice is given you will be charged a $25 cancellation fee.

No Show Policy: If you do not show up for a scheduled appointment, you will be charged a $25 no show fee. After your first no show, you will be given a courtesy call to remind you of your next appointment. A total of 3 no shows may result in discharge from the program. Your referring physician will be notified, and you may need to obtain a new referral before restarting the program.

For Medicare Beneficiaries: You hereby authorize payment of Medicare benefits to be made on your behalf to the Breathing Centers of Texas, PLLC. You further authorize Breathing Centers of Texas, PLLC, if it chooses, to pursue on your behalf any appeals of the denial of your insurance benefits, and to release your medical records as required to determine benefits payable. You certify that you have disclosed any and all health insurance coverage information with the Breathing Center of Houston.

Patient Acknowledgement of Billing Practice: A patient may be treating with the professionals and clinicians in one or more facets of the Breathing Center of Houston. The treating doctors, physical therapists, and clinicians include, but are not limited to:

- Dr. Jason Jorgensen D.O.
- Andrea Pallais PT, DPT
- Ashley Spiegel PT, DPT
- Bryce Jeffrey PT, DPT
- Christopher Brown PT,PHD(c),DPT,CSCS
- Michele Dyogi PT,MPT

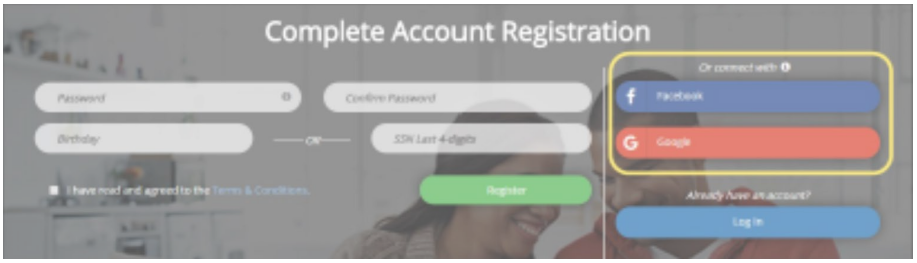
Due to the multiple disciplines utilized for patient care, Breathing Center of Houston is under the direction of Medical Director, Dr. Jason Jorgensen D.O. All claims for patient care are submitted to insurance companies under the direction of our Medical Director, Dr. Jason Jorgensen D.O. The Breathing Centers of Texas are in- network on most major medical insurance plans and it will be the above-mentioned specialist which will be seen on all explanation of benefits and correspondence from the insurance company. During patient care, the benefit levels that will be utilized on insurance plans are the specialist and physical therapy benefits. By signing this acknowledgement, the patient understands the billing practices for Breathing Center of Houston.

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the medical facility. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. You further authorize Breathing Center of Texas, LLC, if it chooses, to pursue on your behalf any appeals of the denial of your insurance benefits, and to release your medical records as required to determine benefits payable. I have reviewed the information provided regarding the benefits and risks of treatment provided at The Breathing Center of Houston. I acknowledge that I understand and accept the risks associated with my treatment. You certify that you have disclosed any and all health insurance coverage information with the Breathing Center of Houston.

_____ _____

Signature of Patient or Responsible Party **Date**

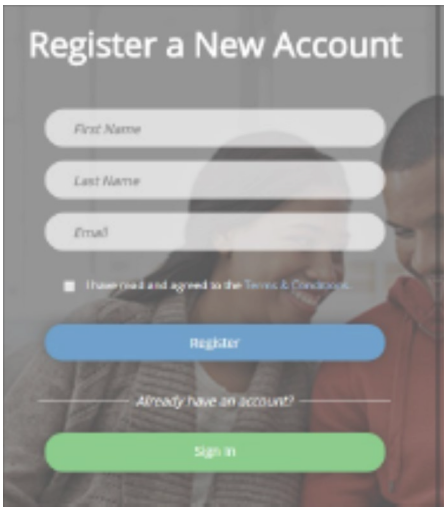
Register for the Patient Portal



The Patient portal offers several benefits to providers and users. Increasingly, portals offer benefits like patient-provider messaging, online bill pay, scheduling capabilities, and more. It will also give us a chance to share information with you as patients—such as education, upcoming appointment reminders, and the ability to view and pay bills online.

How do I register for the Patient Portal?

Fill out the form at: https://patientportal.advancedmd.com/account/logon?lk=131781 or request an email be sent to you by your administrative assistant. *Note: Use the name and email our office has on file.



If you need help creating or accessing your patient portal, please contact the administrative assistant at your respective clinic.

New Patient History

Has your doctor given you a medical diagnosis related to your lungs/breathing difficulty? ☐ YES ☐ NO

If YES, please list your medical diagnosis here: _____

To the best of your memory, when did you receive this diagnosis? _____

When did you first begin having symptoms/problems related to your diagnosis? _____

Have you had a test/procedure related to your lungs or breathing in the past year? ☐ YES ☐ NO
(Examples: Pulmonary Function Test (PFT), Bronchoscopy, Lung Biopsy, Thoracentesis/Drain fluid off lungs, MRI, CT scan, X-ray, or other imaging of the lungs)

If YES, please list:_____

Are you currently in any type of clinical research study related to your lungs? ☐ YES ☐ NO

If YES, please list: _____

Are you currently being evaluated for, or are on a lung transplant list? ☐ YES ☐ NO

If YES, which hospital system is your transplant team affiliated with? _____

Have you been placed on the transplant list? ☐ YES ☐ NO

PLEASE LIST ANY PRIOR SURGICAL PROCEDURES BELOW (WITH DATES) TO THE BEST OF YOUR MEMORY

Surgery	Date
_____	_____
_____	_____
_____	_____

Home Health Episode/ Previous Treatment

Are you currently seeking any type of treatment from a home health agency? ☐ YES ☐ NO

If yes what is the agency's name: _____ Phone _____ Contact _____

Are you being visited by a nurse at your home at this time? ☐ YES ☐ NO

Does anyone come to your home to provide any type of assistance to you? ☐ YES ☐ NO

Have you had any type of home assistance within the last 6 months? ☐ YES ☐ NO

Previous Treatment/ History

History of smoking? ☐ YES ☐ NO

If YES, what age or year at did you start smoking? _____

Age or year at which you quit smoking? _____

Average/typical number of packs per day you smoked during that time? _____

Do you have a history of environmental/occupational exposure to the lungs? ☐ YES ☐ NO

If YES, what type of exposure? (Include dates):_____

Medication list
(We simply ask it to be brought in so that it may be scanned into the system) Prescription, Over-The-Counter, Herbals, and Supplements

Within the last 12 Months;

1. Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? ☐ YES ☐ NO
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with? ☐ YES ☐ NO
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened? ☐ YES ☐ NO
4. Has anyone tried to force you to sign papers or to use your money against your will? ☐ YES ☐ NO
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? ☐ YES ☐ NO

Do you use supplemental oxygen at any point in the day or night? ☐ YES ☐ NO

If YES, which oxygen delivery systems do you own or rent?

☐ Home concentrator ☐ Portable Concentrator ☐ Large Tanks ☐ Mini-Tanks ☐ CPAP
☐ Continuous regulator ☐ Pulsed/On demand system

Please estimate what percent of the day you use oxygen: _____

What oxygen flow rates do you use: (1) At rest: _____ (2) With exertion: _____

Occupational History

I am currently: ☐ Employed ☐ Unemployed ☐ Retired ☐ On Disability

What is your current (or former) occupation? _____

Are you currently (or previously) being treated by any of the following healthcare professionals?

☐ Physical Therapist ☐ Chiropractor ☐ Dietitian/Nutritionist ☐ Smoking Cessation Program
☐ Psychologist/Psychiatrist/Mental Health Professional

Exercise/Physical Activity/Sport History

Have you ever participated in a formal exercise program? ☐ YES ☐ NO

If yes, when was the last time? _____

CIRCLE THE ONE BEST RESPONSE TO DESCRIBE YOUR SHORTNESS OF BREATH.

	Grade	Description of Breathlessness
○	0	I only get breathless with strenuous exercise
○	1	I get short of breath when hurrying on level ground or walking up a slight hill
○	2	On level ground, I walk slower than people of the same age because of breathlessness or have to stop for breath when walking at my own pace.
○	3	I stop for breath after walking about 100 yards or after a few minutes on level ground
○	4	I am too breathless to leave the house, or I am breathless when dressing

MOST IMPORTANTLY, WHAT ARE YOUR PERSONAL GOALS IN RELATION TO YOUR HEALTH AND WHAT OUR PROGRAM CAN HELP YOU ACHIEVE:

_____

_____

_____

_____

Patient Health Questionnaire (PHQ-9)

1. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
a. Little interest or pleasure in doing things.	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much.	☐	☐	☐	☐
d. Feeling tired or having little energy.	☐	☐	☐	☐
e. Poor appetite or overeating.	☐	☐	☐	☐
f. Feeling bad about yourself, or that you are a failure, or have let yourself or your family down.	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching TV.	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual.	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Dyspnea Functional Limitations

Please respond to each question or statement by marking one box per row.

Considering your shortness of breath over the past 7 days, rate the amount of difficulty you had when doing the following activities…

	No Difficulty (0)	A Little Difficulty (1)	Some Difficulty (2)	Much Difficulty (3)	I did not do this in the past 7 days
Dressing yourself without help	☐	☐	☐	☐	☐
Walking 50 steps/paces on flat ground at a normal speed without stopping	☐	☐	☐	☐	☐
Walking up 20 stairs (2 flights) without stopping	☐	☐	☐	☐	☐
Preparing meals	☐	☐	☐	☐	☐
Washing dishes	☐	☐	☐	☐	☐
Sweeping or mopping	☐	☐	☐	☐	☐
Making a bed	☐	☐	☐	☐	☐
Lifting something weighing 10-20 lbs (about 4.5-9kg, like a large bag of groceries)	☐	☐	☐	☐	☐
Carrying something weighing 10-20 lbs (about 4.5-9kg, like a large bag of groceries) from one room to another	☐	☐	☐	☐	☐
Walking (faster than your usual speed) for ½ mile (almost 1 km) without stopping ..	☐	☐	☐	☐	☐

Last Updated: 2 September 2016

My Medication List

Name: _____

List all known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements.

Medication Name	Dose (mg,units,drops)	Frequency	Route of Administration