AYASS LUNG CLINIC & SLEEP CENTER

REGISTRATION FORM

(Please Print)

Today's date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Social Security no.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. ____________ ❑ Insurance Plan ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance]

❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize ayass lung clinic & sleep center or insurance company to release any information required to process my claims.

______________________________ ______________________________

Name			DOB	HT	WT(lb)
BP	RR	SpO2	HR	Temp	
Peak Flow	CO	ppm	Collar Size	BMI	
Reason for Visit				Date	

SMOKER? Y N

Chart checked by

Chart reviewed by

MOST RECENT

PFT	
DLCO	
6MW	
ICG/EKG	
PSG	
CPAP	
NCV	
Echo	
Ultrasound	
Rhino Scope	
Occular	
Labs	
B Density	
Holter	
Cold Air	
NIOX	
Spirometry	

Vitals Time:
Visit Start:
Visit End:

Medications

☐ Medications reviewed See Chart

Allergies
☐ Allergy List reviewed See Chart
☐ No drug allergies
☐ No food allergies

Social History

☐ Never Smoker
☐ Tobacco ____#Packs X ____#Years
☐ Quit
☐ Alcohol use Yes or No

Family Medical History

☐ Asthma
☐ Congestive Heart Failure
☐ COPD
☐ Coronary Artery Disease
☐ Premature Onset
☐ Malignancy
☐ Pancreatitis
☐ Peripheral Artery Disease
☐ Renal Dysfunction
☐ Thrombotic disorder
☐ Thyroid Disease

Chief complaint/Reason for consult

History of Present Illness ☐ Patient is nonverbal. History obtained from ☐ Family ☐ Medical records

Review of Symptoms

See HPI	WNL		
☐	☐	Constitutional	Fatigue, malaise, fever/chills, weight loss, change in appetite
☐	☐	Eyes	Vision changes, new pain, scotomas
☐	☐	ENT/mouth	Nose bleeds, dental caries, dental abscesses, jaw pain
☐	☐	Resp	Dyspnea, cough, phlegm, hemoptysis, wheeze, witnessed apnea
☐	☐	CV	Chest pain, diaphoresis, ankle edema, PND, syncope
☐	☐	GI	Emesis, dysphagia, GERD, abdominal pain, diarrhea, melena
☐	☐	GU	Change in urinary habits, hematuria dysuria
☐	☐	Musc	Myalgas, recent trauma, bony fractures, arthralgias, joint swelling
☐	☐	Skin/breasts	Rashes, new masses or skin lesions, increased sensitivity to sun
☐	☐	Neuro	Seizure, episode or chronic muscle weakness
☐	☐	Endo	Hair loss, polydipsia
☐	☐	Hemelymph	Bleeding gums, unusual brusing, swollen lymph nodes
☐	☐	Allergy/Immun	Sinus probs, recurrent infections
☐	☐	Psych	Mood changes, agitation, psychosis, delirium, dementia

Past Medical and Surgical History

☐ Asthma
☐ Bronchiactisis
☐ COPD
☐ COP (BOOP)
☐ Cystic Fibrosis
☐ Histiocytosis
☐ Tuberculosis
☐ PAH
☐ Sarcoidosis
☐ Wegener's
☐ OSA
☐ Cerebral Artery Disease
☐ Congestive Heart Failure
☐ Coronary Artery Disease
☐ Diabetes
☐ GERD
☐ Obesity
☐ Morbid Obesity
☐ Hypertension
☐ Inflam bowel disease
☐ Malignancy
☐ Pleural Effusion
☐ Neuromuscular weakness
☐ Coocupational exposures
☐ Pancreatis
☐ Peripheral Artery Disease
☐ Scleroderma
☐ Seizure disorder
☐ Sogren
☐ Renal Dysfunction
☐ Rheumatoid arthritis
☐ Thrombotic disease
☐ Thyroid disease

☐ ILD
☐ Pulmonary Fibrosis
☐ Emphysema
☐ Vasculitis
☐ Allergic Rhinitis
☐ Non Allergic Rhinitis
☐ Atelectasis
☐ Prior Intubations
☐ Radiation Exposure
☐ Sleep Study
☐ Steroid Use
☐ CPAP
☐ BPAP

Vaccines:
☐ Flu ☐ BCG
☐ Pneumo ☐ Tetanus
☐ Pertussis ☐ Varicela

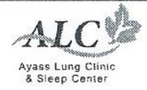
Occupational and Exposure History

☐ Inorganic dusts i.e. quarries, sandblasting, cement, stone carving, welding, plumbing, shipyard work, firefighter
☐ Organic dusts i.e., farming, building inspection, woodworking, remodeling, hardling vegetable matter or animals
☐ Noxious fumes i.e, spray painting, autobody work, working with dyes or glues, manufacturing plastic
☐ Hot tub or Jacuzzi
☐ High pressure washing
☐ Pets or feathers
☐ Chemicals or fires

MMRC Dyspnea Scale

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.

3021 Green Meadow Drive San Angelo, TX 76904 • 325-223-1800 (office) • 325-223-1810 (fax)



BRIEF HISTORY

In an effort to server you better, we request that you provide us with the following information.
This information will be used to provide you the best care and treatment possible.

PATIENT INFORMATION	Doctors Notes
Last Name: First: Age: Sex:	
Presenting Problem or Proposed Surgery:	

ILLNESS/INJURY: Please check if you have ever had:

Yes	No		Yes	No	
		High Blood Pressure			Kidney Stones
		Diabetes			Abdominal Bleeding
		Peptic Ulcers			Diverticulitis
		Heart Attack			Thyroid Problem
		Chest Pain/Tightness			Lung Problems/Asthma
		History of Heart Murmur			Shortness of Breath
		Stroke			Accidents/Broken Bones (list)
		Cancer			
		Hepatitis			
		Yellow Jaundice			
		Gallstones			

OPERATIONS: List names and dates of all operations you have had **None**

Year	Name of Operation	Type of Anesthetic, if known, and complications

Have you ever had a blood transfusion? No Yes Date:
List any hospital admissions or medical conditions not listed above:

FEMALES ONLY: Are you pregnant now or could you be? No Yes

ALLERGIES: Please list type and reaction **None**

Drug Name	Reaction	Drug Name	Reaction

Do you now use tobacco? No Yes Day# Yrs /

Have you ever used tobacco? No Yes Yrs Quit

Do you drink alcohol? No Yes Day# Yrs /

Have you ever used alcohol? No Yes Yrs Quit

Type:

The above information is true and accurate.
Patient Signature (parent if patient is a minor):

Request for Medical Records

Please completely fill out and fax back to 325-223-1810

Authorization for use and disclosure of protected health information

Patient Information:

Printed Name:______________________________ DOB:______________

Address:____

Social Security #:______________________ Telephone:__________________

Information is to be released: ___Mail ___ Fax ___ PickUp

From: ______________________________ To: ______________________________

______________________________ ______________________________

______________________________ ______________________________

City State Zip City State Zip

Please check type of information to be released:

___ Complete Health Record ___ Diagnosis & Treatment ___ Discharge Summary

___ History & Physical Exam ___ Consultation Reports ___ Other (Specify)

___ Laboratory Test Results ___ X-ray Reports ______________

___ Photographs ___ Complete Billing Record ______________

Purpose of request- If needed for appointment please specify date and time:

___ Treatment or consultation ___ Request of patient ___ Billing or claims payment

Date of Appointment:______________________________

Drug and/or Alcohol, and/or Psychiatric, and/or HIV/AIDS Records Release

I understand that the requested information may contain reference to or results of HIV/AIDS testing and/or treatment, drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information. I authorize the release of such confidential information to the indicated party, unless prohibited in my instructions above.

Re-disclosure

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act of 1996. The faciility, it's employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Time Limit & Right to Revoke Authorization

Except to the extent that action has already been taken in reliance on this authorization, at any time I can revoke this authorization by submitting a notice in writing to the Management Coordinator at Ayass Lung Clinic, 3021 Green Meadow Dr., San Angelo, TX 76904. Unless revoked, this authorization will expire 180 days from day of signature.

Signature of Patient or Personal Representative Whom May Request Disclosure

I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless specified above under Purpose of Request. I can view or receive a copy of the protected health information to be used or disclosed. I authorize Ayass Lung Clinic to use and disclose the protected health information specified above.

Signature:______________________________ Date:____________

Authority to Sign if not Patient:______________________________

Witness:____

*****PROCESSING TIME 7-10 WORKING DAYS*****

MEDICATION LIST

Please list all medications you
take and their dosages

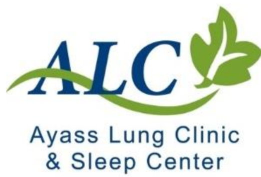
Patient Name: _______________________________ DOB: ________________

Drug Allergies: ____

Medication	Dosage	Started	Stopped	Prescribed by	Reviewed

Frisco Clinic & Laboratory
8501 Wade Blvd, Suite 750
Frisco, Texas 75034
Tel: (972) 668-6005
Fax: (972) 668-6720

San Angelo Clinic
3021 Green Meadow Dr.
San Angelo, Texas 79604
Tel: (325) 223-1800
Fax: (325) 223-1810



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San Angelo, Texas 79604
Tel: (325) 223-1800
Fax: (325) 223-1810

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired?

This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

0 = no chance of dozing
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION CHANCE OF DOZING

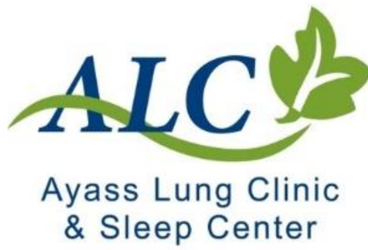
1. Sitting and reading __________
2. Watching TV __________
3. Sitting inactive in a public place (e.g. a theater or a meeting) __________
4. As a passenger in a car for an hour without a break __________
5. Lying down to rest in the afternoon when circumstances permit __________
6. Sitting and talking to someone __________
7. Sitting quietly after a lunch without alcohol __________
8. In a car, while stopped for a few minutes in traffic __________

To check your sleepiness score, total the points.
Check your total score to see how sleepy you are.
1 – 6 Congratulations, you are getting enough sleep!
7 – 8 Your score is average
9 + Seek the advice of a sleep specialist without delay

If your score is greater than 6 points then you are sleepy.
If your score is more than 10 points you are very sleepy.
If you score is more than 16 points you are dangerously sleepy.
If your score doesn’t improve after 2 weeks of 8 hours of sleep a night, it is recommended that you consult your doctor.

Patient Name:

Date:



PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: ____ DOB: ______________________

Signature: ____ Date: _____________________

Ayass Lung Clinic
& Sleep Center

CONSENT FOR TREATMENT

This CONSENT FOR TREATMENT is made and entered into this _________ day of _________, __________

by and between Mohamad Ammar Ayass, M.D. (“Physician”) and _________________________ (“Patient”).

I hereby state that I have honestly and without exaggeration or omission, completed a health questionnaire and I also state that I have or will before undergoing treatment, disclosed any and all information that might reasonably be considered relevant to decisions made by Physician regarding my care. I have disclosed all past illnesses, particularly those involving any form of illness. I also state that I have disclosed the past or present use of any substances including prescribed and not prescribed drugs, alcohol, steroids, vitamins, and dietary supplements.

I hereby hold harmless and waive any claim or defense against Physician for any harm or injury I sustain as a result of my failure to fully disclose all relevant facts about my physical and medical condition to physician. I waive any claim or defense against Physician for any harm or injury I sustain as a result of my failure to comply with the method of treatment and dosage schedule prescribed by Physician. I agree to immediately cease any medical treatment prescribed by Physician in the event of any adverse response or side effect arising from prescribed treatment and to avoid immediate written notice of such adverse response or side effect to Physician via fax to 325-223-1810. I agree to comply with prescribing instructions for use of all medications prescribed by Physician.

I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury, including but not limited to permanent injury and death. I acknowledge that no guarantees have been made to me as to the result of diagnostic testing, analysis of test results, examination of medical history, or treatment by Physician.

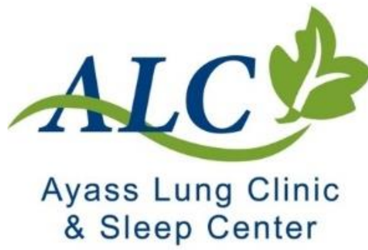
I acknowledge that if neither Medicare nor Medicaid covers the services which I contemplate will be provided by Physician, and I will not make a claim or payment or reimbursement for those services with these entities. I agree to have Ayass Lung Clinic, PLLC act as my independent agent, and I also acknowledge that payment is due to Physician at time of service for all services rendered and that this is an obligation independent of attempts by me to obtain insurance reimbursement.

I have read and understand the foregoing consent for treatment and have signed the same as my voluntary act and deed.

Patient Name (Please Print) ____

Patient Signature ____

Date ________________________



CONSENT TO PHOTOGRAPH

I hereby authorize my photograph to be taken for medical purposes.
I agree to the use of negatives and prints for monitoring my medical condition and identification purposes.

Patient Name (Please Print): ____

Patient Signature: ____

Date: _______________________________

If the patient is a minor or is unable to sign, please complete the following:

Patient Name (Please Print): ____

Legal Guardian or other Authorized Name (Please Print): _______________________________________

Legal Guardian or other Authorized Signature: ____

Date: _______________________________

Ayass Lung Clinic
& Sleep Center

FINANCIAL POLICY

Patient Name:____ Date of Birth:____________________

BASIC POLICY: Pay for service is due in full at the time service is provided in our office.
FOR PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.
MEDICARE PATIENTS: We will bill Medicare for you. We will also bill secondary insurance carriers for you. All copayments or deductibles are due and payable at the time service is provided.
NONCOVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.
PERSONAL INJURY CASES: This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.
WORKER'S COMPENSATION: If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.
YEARLY HEALTH CHECKS: Periodic preventative health checks may or may not be covered under your health insurance policy; however, they may be required by your physician.
MISSED APPOINTMENT: In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

Please circle one: I have paid my insurance deductible for the calendar year of __________ Yes No Don't Know

MEDICARE PATIENTS: SIGNATURE ON FILE I request payment of authorized Medicare benefits be made either to me or on my behalf to Ayass Lung Clinic PLLC for any services furnished to me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Name (Please Print):________________________________ Patient's Signature:________________________________ Patient's Medicare No:____________________ Date:______________	**PROVIDER** Mohamad Ammar Ayass, M.D.

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurances please read and sign below.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Ayass Lung Clinic PLLC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.
Signature:________________________________ Date:____________________

I have read, understood, and agreed to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees.

Signature:________________________________ **Date:**____________________