



LONE STAR PULMONARY AND SLEEP SPECIALISTS

Faisal Saeed, MD (Pulmonologist) & Sidra Saeed, MD (Sleep Medicine Specialist)

Policies & Consents

Please read and review carefully, then sign and date

Thank you for selecting Lone Star Pulmonary and Sleep Specialists for your healthcare needs. We understand that you have a choice when it comes to healthcare providers, and we are glad you chose us. This office policy was developed to help us make your experience in our office as pleasant as possible.

FINANCIAL POLICY: As a courtesy to you, Lone Star Pulmonary and Sleep Specialists will file all insurance claims for you. **It is your responsibility to present us with your most current insurance card and information.** Failure to do so may cause you to be responsible for the entire bill, if your failure to inform us of these changes causes your insurance company to deny payment. If your insurance requires a referral, you must obtain one from your primary care provider (PCP) prior to making an appointment. Referrals can be faxed to (940) 387-2563.

FORM FEE: There is a \$15.00 fee for processing forms which require more than a physician signature. Some forms may have a higher fee. This is billable directly to you (not your insurance company) and should be paid prior to the completion of the forms.

LABS: All tests and procedures are ordered for your benefit, and we are not liable for any costs your insurance may not cover. There will be no refunds after services are performed. If you have blood drawn or any other type of tests done in our office that needs to be sent to a lab for processing, please allow at least 48-hours before contacting our office for results. If we receive any **abnormal** results, the nurse will contact you after they have been reviewed by the physician. Copies of labs will be released by request only.

APPOINTMENTS: Please arrive on time. If for some reason you are going to be more than 15 minutes late, please call ahead to see if we can still accommodate you. There will be a **\$25.00 charge** to existing patients for same day cancellations and a **\$50.00 fee** for all new patients who fail to attend their scheduled appointment.

INSURANCE AND ADDRESS CHANGES: It is your responsibility to notify our office immediately if your insurance or personal information has changed. You will be held financially liable for charges incurred while you are not covered.

NEW PATIENTS: We request that you provide us with your completed new patient paperwork before your scheduled appointment. This will give us enough time to enter your information into the computer system to create your chart. If you are unable to provide your paperwork prior to your appointment, we will have to reschedule you.

PRESCRIPTION REFILLS: Please call your pharmacy and ask them to fax us a refill request. If you contact the office for a prescription refill, we will advise you to contact the pharmacy. Our fax number is (940) 387-2563.

PRIVACY POLICY: You acknowledge you have had an opportunity to review our Notice of Privacy Practices prior to signing this consent. We encourage you to review our Notice of Privacy Practices carefully. It provides more details on how Lone Star Pulmonary and Sleep Specialists may use and disclose your information. The Notice of Privacy Practices may change. A current copy may be requested from our office.

If you would like to request a restriction, please do so in writing. However, Lone Star Pulmonary and Sleep Specialists reserves the right to deny your request. If granted a request, we are bound by the terms of this agreement. You may also revoke this consent in writing. However, information on any treatment or service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the Notice of Privacy Practices for further information.

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Confidential Communication Compliance

In effort to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including Protected Health Information (PHI), Lone Star Pulmonary and Sleep Specialists would like to ensure the privacy of your medical information when using alternative types of communication.

These types of communications may include the following:

- Voice: messages left with spouse/significant other, family members, friends, and/or coworkers
- Voicemails: recorded messages left on home, work, or cell phones
- Electronic communication: email or online patient portal

Please answer the following questions:

May we leave a message on a home, cell, or work voicemail or send you an email regarding an appointment, referral, or test results? Yes No N/A

May we discuss your appointments and/or treatment with your spouse or with the person who may answer your phone? Yes No N/A

May we leave messages concerning your appointments with a coworker, receptionist, or secretary, who regularly answers your calls? Yes No N/A

If you are over the age of 18, still living at home, may we discuss your appointments and/or treatment with your parent(s) or guardian? Yes No N/A

If you are over the age of 18, may be discuss your appointment and/or treatment with your children? Yes No N/A

If we may discuss your care with someone other than yourself, please indicate below:

_____ I do not wish for my medical care to be discussed with anyone other than myself

_____ You have my permission to discuss my medical care with the following individual(s):

Name: _____

Relation: _____

Name: _____

Relation: _____

Name: _____

Relation: _____

You must inform us, in writing, of any changes to your directives. This will be kept in your file, along with your acknowledgement of receipt of your Notice of Privacy Practices.

Printed patient name

Patient signature/responsible party

Date

Staff printed name

Staff signature

Date

LONE STAR PULMONARY AND SLEEP SPECIALISTS
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New Patient Information

Name: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Home phone: _____ Cell phone: _____ Alternate phone: _____
Email address: _____ SS#: _____
Preferred name: _____ Height: ___ft___inch Weight: _____lbs Neck: _____inch
Gender at birth: Male Female Gender you identify as: Male Female

Marital status: Single Married Divorced Widowed Other
Preferred Language: English Spanish Other: _____
Ethnicity: Hispanic/Latino Not Hispanic/Latino Prefer not to answer
Race: White Black/African American American Indian Other: _____ Prefer not to answer

Emergency contact: _____ Relation: _____
Phone: _____

Employer: _____ Occupation: _____ Retired
Address: _____ City: _____ State: _____ Zip: _____

Name of insured: _____ SS#: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Relationship to patient: _____ Employer: _____ Phone: _____
Primary Insurance: _____ Phone: _____
ID #: _____ Group #: _____
Secondary Insurance: _____ Phone: _____
ID #: _____ Group #: _____

Referred by: _____ Reason for visit: _____
Primary care physician: _____

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Patient name: _____ DOB: _____

Please explain the reason for your visit today: _____

Patient Health Questionnaire
Please answer the following questions

Little interest or pleasure in doing things?

Not at all Several days More than half of days Nearly everyday

Feeling down, depressed, or hopeless?

Not at all Several days More than half of days Nearly everyday

Trouble falling asleep, staying asleep, or sleeping too much

Not at all Several days More than half of days Nearly everyday

Feeling tired, or having little energy?

Not at all Several days More than half of days Nearly everyday

Poor appetite or overeating?

Not at all Several days More than half of days Nearly everyday

Feeling bad about yourself, or that you are a failure, or have let yourself or your family down?

Not at all Several days More than half of days Nearly everyday

Trouble concentrating on things, such as reading the newspaper, or watching television?

Not at all Several days More than half of days Nearly everyday

Moving or speaking so slowly that other people could have noticed or the opposite – being so fidgety or restless that you have not been moving?

Not at all Several days More than half of days Nearly everyday

Thoughts that you would be better off dead or hurting yourself in some way?

Not at all Several days More than half of days Nearly everyday

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Patient name: _____

DOB: _____

Generalized Anxiety Disorder
Please answer the following questions

Feeling nervous, anxious, or on edge?

Not at all Several days More than half of days Nearly everyday

Not being able to stop or control worrying?

Not at all Several days More than half of days Nearly everyday

Worrying too much about different things?

Not at all Several days More than half of days Nearly everyday

Trouble relaxing?

Not at all Several days More than half of days Nearly everyday

Being so restless that it's hard to sit still?

Not at all Several days More than half of days Nearly everyday

Becoming easily annoyed or irritated?

Not at all Several days More than half of days Nearly everyday

Feeling afraid, as if something awful might happen?

Not at all Several days More than half of days Nearly everyday

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Patient name: _____

DOB: _____

Other symptoms we need to know about Please mark all that apply

General

- | | | |
|--|--|--|
| <input type="checkbox"/> General fatigue | <input type="checkbox"/> Loss of or excessive appetite | <input type="checkbox"/> Weight loss or gain |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Fevers or chills | <input type="checkbox"/> Trouble speaking |

Sleep history

- | | | |
|---|---|--|
| <input type="checkbox"/> Currently on PAP therapy | <input type="checkbox"/> Stop breathing while asleep | <input type="checkbox"/> Previously diagnosed with sleep apnea |
| <input type="checkbox"/> Excessive daytime sleepiness | <input type="checkbox"/> Restless leg/limb movements | <input type="checkbox"/> Waking up repeatedly throughout the night |
| <input type="checkbox"/> Morning headaches | <input type="checkbox"/> Frequent bathroom trips at night | <input type="checkbox"/> Narcolepsy / cataplexy / sleep paralysis |
| <input type="checkbox"/> Working nights/swing shift | <input type="checkbox"/> Sleep walking | <input type="checkbox"/> Talking while asleep |
| <input type="checkbox"/> Acting out dreams | <input type="checkbox"/> Night terrors | |

Environmental exposure

- | | | |
|--|--|---|
| <input type="checkbox"/> Animal contact | <input type="checkbox"/> Contact with anyone with TB | <input type="checkbox"/> Exposure to asbestos |
| <input type="checkbox"/> Exposure to fiberglass | <input type="checkbox"/> Exposure to chemicals | <input type="checkbox"/> Exposure to military service chemicals |
| <input type="checkbox"/> Exposure to secondhand smoke | <input type="checkbox"/> Recent travel | <input type="checkbox"/> Exposure to mold |
| <input type="checkbox"/> Exposure to anyone with COVID | <input type="checkbox"/> Positive for COVID | <input type="checkbox"/> Prior diagnosis of COVID |

Skin

- | | | |
|----------------------------------|--|--|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Lumps | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Dryness | <input type="checkbox"/> Color changes | <input type="checkbox"/> Hair and/or nail changes (dry/weak, etc.) |

Headache

- | | | |
|-----------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Migraines | <input type="checkbox"/> Head injury |
|-----------------------------------|------------------------------------|--------------------------------------|

EENT

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> Nasal or sinus congestion | <input type="checkbox"/> Post-nasal drainage |
| <input type="checkbox"/> Deviated septum | <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Frequent sneezing | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Ear pain or drainage |
| <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Ringing in the ears (tinnitus) | <input type="checkbox"/> Change in vision |
| <input type="checkbox"/> Blurry or double vision | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Watery, itchy, or red eyes | <input type="checkbox"/> Flashing lights, specks, floaters | <input type="checkbox"/> Sore mouth or tongue |
| <input type="checkbox"/> Mouth dryness | <input type="checkbox"/> Thrush | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Neck pain or stiffness | <input type="checkbox"/> Neck lymph node swelling/lumps | |

Lungs

- | | | |
|---|--|--|
| <input type="checkbox"/> Cough (dry or wet, productive) | <input type="checkbox"/> Coughing up blood (hemoptysis) | <input type="checkbox"/> Phlegm: color _____ |
| <input type="checkbox"/> Shortness of breath, resting | <input type="checkbox"/> Shortness of breath, movement | <input type="checkbox"/> Wheezing |
| <input type="checkbox"/> Using inhalers or nebulizer | <input type="checkbox"/> On supplemental oxygen at night | <input type="checkbox"/> On supplemental oxygen 24/7 |

Heart

- | | | |
|--|---|--|
| <input type="checkbox"/> Chest tightness and/or pressure | <input type="checkbox"/> Palpitations | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Trouble breathing lying flat | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diagnosis of congestive heart failure |
| <input type="checkbox"/> Stents | <input type="checkbox"/> Bypass surgery | <input type="checkbox"/> Atrial fibrillation |

Blood

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Spontaneous bruising | <input type="checkbox"/> High blood sugar |
| <input type="checkbox"/> History of blood clots/DVT | | |

Gastrointestinal

- | | | |
|--|---|--|
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Dark, tarry stools with or without food |
| <input type="checkbox"/> Fresh blood in the stools | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Loose stools or diarrhea |
| <input type="checkbox"/> Abdominal pain or cramps | <input type="checkbox"/> Reflux/heartburn | <input type="checkbox"/> Choking on food/drink, trouble swallowing |

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Patient name: _____ **DOB:** _____

Urinary

- | | | |
|---|---|---|
| <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Urinary dribbling |
| <input type="checkbox"/> Frequent nighttime urination | <input type="checkbox"/> Burning on urination | <input type="checkbox"/> Blood in the urine |

Musculoskeletal

- | | | |
|--|--|-------------------------------------|
| <input type="checkbox"/> Muscle aches or pains | <input type="checkbox"/> Muscle spasms | <input type="checkbox"/> Joint pain |
|--|--|-------------------------------------|

Neurological

- | | | |
|--|---|---|
| <input type="checkbox"/> History of stroke | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Numbness in the limbs | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Gait disturbance |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Using a cane or walker | <input type="checkbox"/> Using a wheelchair |

Any other information we need to know regarding this visit? No If yes, please explain: _____

If you are seeing any specialists, please list their information below and the reason:

Cardiologist: _____

Neurologist: _____

Endocrinologist: _____

Infectious disease: _____

Oncologist: _____

Nephrologist: _____

Other: _____

Have you had any of the following immunizations/boosters?

Flu shot? No Yes Date: _____ Location: _____

Pneumococcal 23 shot? No Yes Date: _____ Location: _____

Prevnar 12 shot? No Yes Date: _____ Location: _____

Shingles shot? No Yes Date: _____ Location: _____

DTP shot? No Yes Date: _____ Location: _____

COVID 19 – 1st shot? No Yes Date: _____ Location: _____

COVID 19 – 2nd shot? No Yes Date: _____ Location: _____

COVID 19 – boosters? No Yes Date: _____ Location: _____

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Patient name: _____ DOB: _____

Medical History Please mark all that apply

- | | | |
|--|--|---|
| <input type="checkbox"/> COPD | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Pulmonary embolism or DVT | <input type="checkbox"/> Sleep apnea | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Pulmonary hypertension | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Testosterone replacement (males) |
| <input type="checkbox"/> Pulmonary fibrosis | <input type="checkbox"/> Restless legs | <input type="checkbox"/> Hormone replacement (females) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Narcolepsy | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Polycythemia/high blood count | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Anemia | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Diabetes, type 1 | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diabetes, type 2 | <input type="checkbox"/> Sexual dysfunction |

Other medical history: _____

Medical Tests

If you have had any of the following tests performed, please list the date and location performed

- | | |
|--|--|
| <input type="checkbox"/> Pulmonary function: _____ | <input type="checkbox"/> Mammogram: _____ |
| <input type="checkbox"/> Sleep study: _____ | <input type="checkbox"/> Bone density: _____ |
| <input type="checkbox"/> Chest x-ray: _____ | <input type="checkbox"/> Colonoscopy: _____ |
| <input type="checkbox"/> CT chest: _____ | <input type="checkbox"/> Other: _____ |

Have you been hospitalized recently? If yes, please list the location, dates, and reason for hospitalization:

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Patient name: _____ DOB: _____

Surgical History

Please mark all that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> Lung surgery | <input type="checkbox"/> Nasal surgery (deviated septum/polyps/sinus) | <input type="checkbox"/> Prostate surgery |
| <input type="checkbox"/> Bronchoscopy | <input type="checkbox"/> Gastric surgery (lap band/bypass/sleeve) | <input type="checkbox"/> Colon surgery |
| <input type="checkbox"/> Thoracentesis | <input type="checkbox"/> Heart bypass | <input type="checkbox"/> Thyroid surgery |
| <input type="checkbox"/> Lung biopsy | <input type="checkbox"/> Gallbladder surgery | <input type="checkbox"/> Cataract removal |
| <input type="checkbox"/> UPPP / palate surgery | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Fracture repair |
| <input type="checkbox"/> Inspire surgery | <input type="checkbox"/> Ovaries removed | <input type="checkbox"/> Hip replacement |
| <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> C-section | <input type="checkbox"/> Knee replacement |

Other surgical history: _____

Social History

- Never smoked Former smoker Smoker Dates of smoking (years or ages): _____
- Cigarettes – packs per day: _____ Tobacco pipe – times per day: _____
- Vaping/e-cigs – times per day: _____ Chewing tobacco – cans per day: _____
- Marijuana – times per day: _____ Illicit drug use: _____
- Cigars – times per day: _____ Other: _____

Are you interested in quitting smoking? Yes No

Do you drink alcohol? Yes No If yes, what do you drink & how often do you drink: _____

Do you have pets? Yes No If yes, what kind of pets: _____

Occupational History

Please check all that apply

Have you ever worked in or with any of the following or have you been exposed to any of the following:

- | | | | |
|-----------------------------------|--|--|----------------------------------|
| <input type="checkbox"/> Asbestos | <input type="checkbox"/> Chemicals/chemical smells | <input type="checkbox"/> Foundry | <input type="checkbox"/> Welding |
| <input type="checkbox"/> Mold | <input type="checkbox"/> Paint/paint fumes | <input type="checkbox"/> Sand blasting | <input type="checkbox"/> Quarry |

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Patient name: _____ **DOB:** _____

Family History

Biological father: Alive Deceased Age: _____

Medical conditions: _____

Biological mother: Alive Deceased Age: _____

Medical conditions: _____

Siblings:

Brothers (how many) _____ Sisters (how many) _____

Any medical conditions of brothers: _____

Any medical conditions of sisters: _____

Sleep History

Have you ever been diagnosed with sleep apnea? Yes No

If yes, what treatment are you using? Untreated PAP therapy Oral appliance Inspire or other surgery

Have you been told that you stop breathing in your sleep? Yes No

Have you woken up gasping or choking for air? Yes No

Do you snore? Yes No

Do you wake up tired? Yes No

Do you wake up repeatedly throughout the night? Yes No If yes, number of awakenings: _____

Do you remember your dreams in the morning? Yes No

Do you fall asleep quickly? Yes No

Are you sleepy during the daytime? Yes No

What time to you go to bed: _____ What time do you wake up in the morning: _____

Do you take naps during the day? Yes No If yes, how many: _____

Do you have a history of increased limb movements at bedtime? Yes No

Do you have a history of 'creepy crawly' sensations in your legs at bedtime? Yes No

Do you have a history of restless leg syndrome or periodic limb movements? Yes No

Do you have a history of narcolepsy? Yes No

Do you have a history of sleep walking? Yes No

Are you on any sleep medications? Yes No If yes, what are you taking: _____

Are you on any pain medications? Yes No If yes, what are you taking: _____

