

MCT Medical Colleagues of Texas, L.L.P.

Dr. Paul Bing

Dr. Jack Zhu

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Katy, Texas 77450

Please bring the following with you to your scheduled appointment:

1. Enclosed documents signed and completed
2. Health Insurance cards and photo ID
3. Recent films/CDs of chest x-rays and CT scans
4. Complete list of medications (inhalers and supplements included) with dosage and directions.

We look forward to treating you soon!

If you are unable to keep your appointment please call our office at 281-398-7954, option 1 to reschedule. Please allow at least a 24 hour notice.

Medical Colleagues of Texas, LLP

Patient Information

SS#: _____ First: _____ Middle Initial: _____ Last: _____
Sex: _____ DOB: _____ Marital Status: Minor Single Married Divorced Widow Separated
Race / Ethnicity _____ Language _____
Employment Status: Unemployed Retired Student Employed Employer: _____
Patient Address: _____ City: _____ State: _____ Zip: _____
Email: _____ Home Phone: _____ Work Phone: _____ Cell: _____
Referring Provider: _____ How did you hear about us: _____
Preferred Pharmacy: _____ Phone: _____ Location: _____
Emergency Contact: _____ Relationship: _____ Cell: _____ Home: _____ Work: _____

Responsible Party

Name of Person Responsible for this Account: _____ Relationship to Patient _____
Address (if different from patient's): _____
Cell: _____ Home Phone: _____ DOB: _____ SSN: _____
Employer: _____ Work Phone: _____
Have we seen other members in your family? No Yes Name: _____ DOB: _____

Insurance Information

Insured/Care Holder's Name: _____ Relationship to Patient: _____
DOB: _____ SSN: _____ Employer: _____
Insurance Company: _____ Group#: _____ Policy/ID #: _____
Address: _____ Provider Ins. Verification Phone #: _____

DO YOU HAVE ADDITIONAL INSURANCE? YES NO (If YES, Please Complete the Following)

Name of Insured _____ Relationship to Patient: _____
DOB: _____ SSN: _____ Employer: _____
Insurance Company: _____ Group#: _____ Policy/ID #: _____
Address: _____ Provider Ins. Verification Phone #: _____

PLEASE HAVE YOUR INSURANCE CARD AND DRIVER'S LICENSE AVAILABLE

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I authorize my insurance company to pay and hereby assign to Medical Colleagues of Texas, LLP all benefits payable for services rendered. I understand I am financially responsible to pay non-covered services.

Signature (Patient or Parent if Minor)

Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information required in the course of my treatment necessary to process insurance claims.

Signature

Date

Financial Policy of Medical Colleagues of Texas, LLP

Thank you for choosing Medical Colleagues of Texas to provide your health care. Our main concern is that you receive the proper treatment needed. In order to prevent any misunderstandings and to serve you better, we ask that all patients read and sign our financial policy. If you have any questions or concerns about our policies, please do not hesitate to ask.

1. As a courtesy we will file your insurance if you are a member of an insurance plan with which we are contracted. If you are not able to provide us with a valid insurance card, you will be required to pay cash for your visit. If your insurance has changed since your last visit, please inform us **BEFORE** your visit, and present us with your new card so that we may verify your coverage and benefits. If you do not inform us of any changes and we have not been able to collect from your previous insurance, you will be responsible for any unpaid balance. Most insurance plans require that a claim be filled within 90 days from date of service. Please remember that all charges are your responsibility whether or not your insurance pays.

**PAYMENT IS DUE AT THE TIME SERVICE IS RENDERED.
WE ACCEPT CASH, VISA, MASTERCARD, AND PERSONAL CHECKS.**

2. **FIXED CO-PAYS WILL BE COLLECTED AT THE TIME OF YOUR VISIT.** Inability to make payment at that time may require us to reschedule your visit. Deductibles, co-pays, co-insurance and non-covered services must be paid at the time the service is provided.
3. Charges incurred that are subject to a yearly deductible are due at the time of service. Deductibles and co-insurance amounts are determined and due prior to any procedure. Any overpayment will be promptly refunded.
4. **MEDICARE PATIENTS:** It can be considered Medicare fraud to waive deductibles and co-payments. Therefore, deductibles and co-payments will be collected at the time of service. We accept and file claims for "Medigap" secondary insurance plans; however, if we do not receive payment or an explanation of benefits within 30 days, the balance will be billed to you. It will be your responsibility to call your insurance company to determine the status.
5. **SHOT RECORDS:** Shot records will be furnished at no charge the first time. Duplicate records will be assessed a \$10.00 fee.
6. **MISSED APPOINTMENTS:** If you are unable to make your appointment, notice needs to be given to us 24 hours in advance. If you miss your appointment without proper notification, you may be charged a "missed appointment fee" in the amount of \$25.00.
7. **RETURNED CHECKS** will incur a \$30.00 fee. The amount of the check, plus the fee must be paid within 10 days of notification by money order, cash or credit card to prevent further action. If a second check is returned on your account, we will no longer be able to accept personal checks as payment.
8. There will be a \$25.00 pre-payment fee for completion of forms for "FMLA," disability, etc.

Patient Name _____ DOB _____
(Print Please)

Signature

Date

**Medical Colleagues of Texas, LLP
Acknowledgment and Consent of
Notice of Privacy Practices**

I understand that **Medical Colleagues of Texas**' Notice of Privacy Practices, which explains how my medical information will be used and disclosed, is posted in the waiting room. I understand that I am entitled to receive a copy of this document if requested.

Patient Record of Disclosures

In general, The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that communication of PHI be made by alternative means, such as leaving a message on answering machines, discussing your health information with someone other than yourself, and by communicating with you through electronic communication.

Personal Contact Information

Home phone#: _____ Cell Phone #: _____

Work Phone #: _____ May we leave a message? ___ Yes ___ No

Other than yourself, whom may we talk to about or leave medical information with?

Name: _____ Relationship: _____

Home #: _____ Cell #: _____ Work #: _____

Email Communication Consent

This office has established a **practice portal** for secure messaging. This allows you to communicate with us for reasons such as requesting appointments, requesting refills, billing questions, changing personal information, or paying your balance. This method of communication is not appropriate in an emergency, nor is it intended to provide medical care via email. Medical questions that require decision making should be addressed during an office visit. To begin using these services, you will need to create a **secure account on our website**. Ask the receptionist for a letter with your person pin and detailed information. It is important that you check your email for notices from the practice portal regularly. Please be aware that using email without an account through our website may not be secure; therefore, we recommend that you only communicate with us through our practice portal.

By signing below, I authorize **Medical Colleagues of Texas** to use and disclose my medical information for the Purpose of Treatment, Payment, and Health Care Operations and agree that **Medical Colleagues of Texas** may send medical related correspondence to me via practice portal if I decide to participate.

Signature of Patient or Authorized Representative

Date

Printed Name of Patient

Patient's Date of Birth

Name: _____

DOB: ____/____/____

Date: ____/____/____

Primary Care Physician: _____

Referring Physician:

Why are you here to see the lung doctor?

Check all that apply:

- Unable to catch your breath
- Wheezing
- High blood pressure
- Unable to sleep lying flat or with one pillow
- Sudden onset of shortness of breath
- Night Sweats
- Chest Pain
- Chest pressure
- Shortness of breath
- Dizziness
- Swelling of legs
- Heart Failure
- Blue lips or fingers
- Leg cramps

Have you ever had:

- An EKG
- A Treadmill Stress test
- A Bicycle Stress test
- Breathing Test
- Lung Surgery
- Heart Surgery
- Pneumonia
- Blood Clot
- Exposure to Tuberculosis (TB)

Medical problems requiring treatment:

Surgery Operations:

- Tonsillectomy
- Thyroidectomy
- Appendectomy
- Gallbladder removal
- Other: _____

Family medical history: (Immediate family)

- Heart problems including blood pressure
- Stroke
- Asthma
- Diabetes
- Cancer
- Leukemia
- Emphysema
- Eczema
- Clotting disorder
- TB
- Hepatitis
- Allergic reaction to anesthetics

Whom do you live with?

Are you:

- Married
- Single
- Divorced
- Widowed

What kind of hobbies do you have?

Do any pets live in the home?

- Birds
- Dogs
- Cats
- Other: _____

What type of employment risks if any?

- Work with toxic chemicals
- Asbestos
- Silica

Smokers (Present or Past)

- Still smoking
How old were you when you started?

- Quit smoking
How old were you when you quit smoking?

What is the greatest amount that you smoked in a day?

Do you drink alcohol?

Quantity per day, week, month

- Beer _____ cans
- Wine _____ 4 ounce glasses
- Liquor _____ 1 ounce shots

Name: _____

DOB: ____/____/____

Date: ____/____/____

Primary Care Physician: _____

Do you use other substances or have you used:

- Marijuana
- Crack/Cocaine
- Heroin
- Other: _____

ALLERGIES Medications:

Food:

VACCINATIONS

- Flu Shot
Year _____
- Pneumonia Vaccine
Year _____
- Tetanus
Year _____
- Hepatitis
Year _____

ACTIVITY LEVEL

Do you exercise?

- Yes
- No

How much?

- Shopping without assistance

- Cooking without assistance
- Grooming without assistance

Current Medications- Name, Dose, & Frequency Include over the counter preparations and supplements:

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

SYSTEM REVIEW

In general is your energy level?

- Decreased
- Normal

Do you have?

- Constitutional
 - Fever
 - Chills

- Sweats
- Night sweats
- Weight loss

Ophthalmic

- Difficulty with vision
- Glaucoma
- Diabetic eye problems

ENT

- Difficulty with hearing
- Sinus drainage
- Dental pain
- Recently had a sore throat
- Stiff neck

Pulmonary

- Wheezing
- COPD
- Emphysema
- Pulmonary Fibrosis
- Cough (Dry or Productive)
- Blood tinged

Cardiac

- Chest pain
- Rapid heart rate
- Angina
- Irregular heart beat
- Wake up short of breath
- Swelling
- Fluid retention
- Sleep on more than 1 pillow

GI

- Nausea
- Vomiting
- Diarrhea
- Constipation
- Hepatitis A B or C
- Ulcers
- Hemorrhoids
- Diverticulitis
- Appendicitis
- Gallbladder Disease
- Irritable Bowel
- Spastic Colon
- Crohn's
- Ulcerative colitis

Name: _____

DOB: ____/____/____

Date: ____/____/____

Primary Care Physician: _____

GU

- Problems urinating
- Incontinence
- Bloody urine
- Kidney Failure

Endocrine

- Diabetes
- Thyroid Disease
- Cholesterol abnormalities

Musculoskeletal

-Arthritis

- Arms
- Shoulders
- Hips knees
- Hands
- Feet
- Back

Dermatology

- Rash
- Eczema
- Abnormal nails

Hematology

- Easy bruising
- Blood clots in legs or lungs
- Blood loss
- Blood transfusions

Has your blood ever been rejected from the blood bank?

- Yes
- No

Neurologic

- Seizures
- Stroke
- Muscle weakness
- Tremors
- Difficulty staying awake
- Trouble with speech

Psychiatry

- Depression
- Suicide attempts