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

Dr. Paul Bing
Dr. Jack Zhu
21700 Kingsland Blvd. Ste. 201
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

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 acknowledge that I have access to this information and 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.

Patient Contact Numbers	**May we leave a message?**
Cell #: ______________________________	☐ Yes ☐ No
Home #: ______________________________	☐ Yes ☐ No
Work #: ______________________________	☐ Yes ☐ No

Email Address: ____
Email to be used for Patient Portal registration purposes

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

Name: ______________________________ Relationship: ______________________
Cell #: ________________ Home #: ________________ Work #: ________________

Name: ______________________________ Relationship: ______________________
Cell #: ________________ Home #: ________________ Work #: ________________

Name: ______________________________ Relationship: ______________________
Cell #: ________________ Home #: ________________ Work #: ________________

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.

______________________________ ______________________
Signature of Patient or Authorized Representative **Date**

______________________________ ______________________
Printed Name of Patient **Patient's Date of Birth**

Financial Policy of Medical Colleagues of Texas, LLP

Thank you for placing your trust in us as your health care provider. Our primary concern is to provide you with the best medical care possible. In order to prevent misunderstanding, we ask that you read and sign our financial policy. If you have any questions or concerns about our policies, please do not hesitate to ask.

1. Our physicians are contracted with certain health plans; **it is your responsibility to make sure your particular plan is in network with your physician.** Although some insurance companies provide their members with an electronic copy of your insurance card, it is preferred that we have a hard copy of your card so that we can scan it into your account to help avoid any billing issues. If we are unable to verify your insurance prior to your appointment, you may be required to be self-pay for your visit. If you have a change in your coverage, please provide us with your new coverage information **before your visit** so that we can verify your eligibility and benefits and file your claim in a timely manner. Insurance plans have filing deadlines. We will not file claims if your insurance is provided outside of the plan's deadlines.

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

2. YOUR INSURANCE COMPANY REQUIRES COPAYS TO BE COLLECTED AT THE TIME OF YOUR VISIT. Inability to make payment at that time may require us to reschedule your visit. Deductibles, copays, coinsurance, and non-covered services must be paid at the time the service is provided.
3. Charges subject to a yearly deductible are due at the time of service. Deductibles and coinsurance amounts are determined and due prior to procedures. Any overpayment will be promptly refunded.
4. MEDICARE PATIENTS: It can be considered Medicare fraud to waive deductibles and copayments. Therefore, deductibles and copayments will be collected at the time of service.
5. MISSED APPOINTMENTS: We require at least a 24-hour notice to cancel appointments. If you cancel or miss your appointment without this advanced notice, a "missed appointment fee" of $50.00 will be charged.
6. 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 credit card, cash, or money order 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.
7. There will be a minimum of $25.00 prepayment for completion of forms such as "FMLA", disability, etc.
8. We do not accept third party insurance plans such as Worker's Comp or motor vehicle accident insurance.
9. **It is your responsibility to know and understand your insurance benefits. Ultimately, all charges are your responsibility.**

Medical Colleagues of Texas offers electronic statements and payment options. Electronic statements will be sent to a primary email address for all patients on one financial account.

Would you like to opt in to receive e-statements? ☐ **Yes** ☐ **No**
If yes, please list your preferred email:

____

____	_________________________
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