



Registration Form

Please complete this form entirely. You will also need to bring your photo ID and insurance card with you to your appointment.

How did you hear about us? _____

Patient Information

Patient's Name: (Last) _____ (First) _____ (Middle) _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: ____/____/____ Age: _____ Sex: _____ Marital Status: Single Married Widowed Divorced

Employer: _____ Status: Part-Time Full-Time Not Employed Student

Email: _____ Social Security #: _____ - _____ - _____

Referring Doctor: _____ Primary Care Doctor: _____

Emergency Contact: Name _____ Phone#: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Insurance Information

Primary Insurance: _____ Group # : _____

Subscriber's Name: _____ Subscriber's Date of Birth: ____/____/____

Social Security #: _____ - _____ - _____ ID/Member/Subscriber #: _____

Subscriber's Employer (if different than above): _____

Subscriber's Address (if different than above): _____

Subscriber's Home Phone: _____ Address _____ City _____ State _____ Zip _____

Work or Cell Phone: _____

Responsible Billing Party (if other than patient)

Name: _____ Home Phone #: _____

Address _____

Street/P.O. Box _____ City _____ State _____ Zip _____


YOUR PERMISSION IS REQUIRED TO RELEASE YOUR MEDICAL INFORMATION (lab results, appointment information, etc.) TO ANOTHER PERSON. If you are 18 yrs of age or older, we must have your written permission to release any medical information to ANY person other than yourself. If you would like to give consent for us to speak to someone else (spouse, significant other, family member, etc.) concerning you, please fill in their names below. Please check the box and WRITE THEIR NAME in the blank space. This authorization shall remain valid until revoked in writing. By signing at the bottom of this page, you give consent to release your medical information to the person(s) listed below.

Spouse _____ Parent _____ Other (name/relationship) _____

FINANCIAL RESPONSIBILITY: You will be billed for any charges not paid by your insurance company within 180 days. You agree to pay for such charges within 30 days. You will be responsible for a 35% collection fee if payment is not received within a timely manner. Charges for office services are payable at the time of service. Copayments, deductibles, and co-insurance amounts are payable at the time of service. Texas Sleep Medicine does not accept payment from third party payors such as PIP (Personal Injury Protection or from attorneys for accidents). You are financially responsible for all charges not covered under your health insurance benefits. Your insurance policy is a contract between you and your insurance company. Your doctor is not involved. Any checks returned by the bank will be subject to a \$35.00 handling fee and that future visits will be on cash/credit basis. **You may be billed \$35.00 for a Late Cancellation/No Show fee for office visits, and a \$250 Late Cancellation/No Show fee for sleep studies.**

I understand that I have the right to receive/review a written description of how Texas Sleep Medicine will handle health information about me. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered. This authorization shall remain valid until revoked by me in writing.

I have read all the information provided to be by Texas Sleep Medicine. By signing this document I agree to and understand all the information listed above.

X  _____ /____/____
Signature Relationship Date

TEXAS SLEEP MEDICINE OFFICE POLICIES

(Please read and initial each item. You will also need to sign at the bottom.)

Policy regarding controlled substances

Controlled substance medications are very useful but have a high potential for misuse and are closely regulated by both state and federal governments. Examples of controlled substances include most prescription sleep medications (Ambien, Lunesta, etc.) and stimulants (Provigil, Adderall, Ritalin, etc.) For this reason we require all patients who are receiving controlled substances from Texas Sleep Medicine (TSM) **be seen every 90 days**. Refills will not be provided beyond this time period.

Medications will not be replaced if they are misplaced or destroyed. If your medications have been stolen and you complete a police report regarding the theft, an exception may be made at the discretion of the TSM provider. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies our office must be informed in writing. Failure to do so may result in immediate termination from practice. Prescriptions may be issued earlier if the provider or patient will be out of town when a refill is due. These prescriptions will contain specific instructions to the pharmacist regarding when the prescription is allowed to be refilled.

Refills should be requested through your pharmacy first. TSM requires one business day to complete all refill requests. Timely requests for medication refills are solely the patient's responsibility.

Schedule II medications require a written prescription and cannot be called or faxed into your pharmacy. **TSM requires four (4) business days advanced notice for refill requests on Schedule II medications.** The patient may either come by the office to pick up the prescription when ready or it can be mailed. It is the patient's responsibility to ensure that TSM possesses the correct mailing address. If anyone other than the patient is sent to pick up the prescription, TSM requires a signed document from the patient releasing the prescription into the other person's possession. Without written consent, the prescription will not be release to another person. If this release is revoked by the patient, it must be done in writing and submitted to TSM to be placed in the patient's chart.

The medications prescribed will be used at a rate no greater than the prescribed rate unless it is discussed directly with a TSM provider. Early refills requests will not be granted. The patient is responsible for using the medications as prescribed. No unauthorized increase in medications will be allowed. Failure to adhere to this policy may result in immediate termination from the practice.

Initial:

_____ Changes in prescriptions/refills will be made only during scheduled appointments and not via phone.

Policy regarding office visits

It is very important that patients arrive for their appointments on time. At TSM, we strive to provide timely service and to minimize wait times for all patients. For this reason we will reschedule appointments if patients arrive more than 10 minutes late. All new patients must arrive 15 minutes before their scheduled appointment times with their registration form and new patient questionnaire completed. If these forms are not completed in their entirety, the visit will be rescheduled.

Initial:

Policy regarding participation of mid-level providers

Nurse practitioners and physicians assistants have completed graduate-level education and are qualified to provide care to patients in all office settings. Typically, these providers have also completed extensive training and received additional education specific to the branch of medicine in which they operate (such as sleep medicine). They work in collaboration with physicians to diagnose and treat a wide range of acute and chronic illnesses. In the state of Texas, nurse practitioners and physicians assistants are also able to prescribe medications to treat various illnesses. At TSM, these types of providers will participate in the care of every patient.

Initial:

I have read and I understand Texas Sleep Medicine's policy regarding prescription distribution, office visit protocol, and the participation of mid-level providers in one's care.



X _____
Signature

_____/_____/_____
Date