Texas Lung Associates

Internal Medicine, Pulmonary Medicine,
Sleep Medicine, Allergy/Immunology, Critial Care

☐ Dr. Jamal Mubarak
☐ Dr. Abdul Memon
☐ Dr. Saima Memon

New Patient Information

Name:_____ SS#:____-____-_____ Date of Birth:____/____/_____

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_(_____)_____-_____ Cell Phone:_(_____)_____-_____ Work Phone:_(_____)_____-_____

E-mail Address:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Prefer not to answer

Race: ☐ White ☐ Black ☐ Hispanic ☐ American Indian ☐ Other ☐ Prefer not to answer

Emergency Contact:_____ Relationship to Patient:_____ Phone:_(____)_____-_____

Reason for Visit

Referred by:_____ Reason for visit:_____

Primary Care Physician (if any): _____

Other Physicians:_____

Employer

Employer:_____ Occupation:_____ ☐ Retired

Address:_____ City:_____ State:_____ Zip:_____

Insurance

Name of Insured:_____ SS#:_____-_____-_____ Date of Birth:_____/____/_____

Address:_____ City:_____ State:_____ Zip:_____

Relationship to Patient:_____ Employer:_____ Phone:_(____)_____-_____

Primary Insurance:_____ Phone:_(____)_____-_____

ID#_____ Group#:_____

Secondary Insurance:_____ Phone:_(_____)_____-_____

ID#_____ Group#:_____

TEXAS LUNG ASSOCIATES
JAMAL MUBARAK, M.D.

LEGAL IRREVOCABLE ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND SUMMARY PLAN DOCUMENTS

Patient Name: _____ Patient SS#: _____ Date: _____

In considering the amount of expenses to be incurred, I _____, the undersigned, have insurance and/or employee health care benefits coverage with _____(insurance co. information), and hereby irrevocably assign and convey directly to _____MD/business_____ (hereafter "provider") all right, title and interest in all medical benefits payable and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider /practice. Said irrevocable assignment and transfer shall be for the purpose of granting the provider and practice an independent right of recovery against such responsible parties, but shall not be construed to be an obligation of the provider and practice to pursue any such right to recovery. I hereby authorize all responsible parties to pay directly to the provider and practice all benefits and amount due for services rendered by the physician.

I understand that if the provider and practice is not paid in full by proceeds for any benefits, then this assignment does not release my obligation and liability to the provider and practice for payment and all services and items provided to me or by my insurance company or employee health benefit plan, then I agree to pay provider and practice for all charges in excess of the benefits paid. All payments will be made to provider and practice at: _____(address)_____.

I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the provider to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider and practice any and all summary plan documents, insurance policy and/or settlement information upon written request from such provider and practice in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named provider to the full extent permissible under the law and under any applicable insurance policies and/or employee health care plan any claim, chosen action, or the right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named provider and practice and to the extent permissible under law to claim such benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such provider and practice in any attempts by such provider and practice to pursue such claim, chosen action or right against any insurers and/or employee health care plan, including, if necessary, bring suit with such provider and practice against any insurers and/or employee health care plan in my name but at such provider and practice's expense.

This lifetime assignment of benefits will remain in effect until revokes by me in writing. A photocopy of this assignment of benefits is to be considered as valid as the original.

The terms and consequences of these irrevocable assignments and financial responsibilities have been fully explained to me to my understanding and I have signed this document freely and without inducement other than the rendition of services by the physician.

NAME of Insured / Responsible Party	Signature of Insured / Responsible Party	Date

NAME of Patient or Guardian	Signature of Patient or Guardian	Signature of WITNESS

PRACTICE ADDRESS & CONTACT DETAILS

Patient Name:

Medical History (Check all that apply)

- ☐ COPD/Empysema
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Cancer (type):_____
- ☐ Asthma
- ☐ Allergies
- ☐ Seizure Disorder
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Depression
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Irregular Heart Beat
- ☐ Congestive Heart Failure
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Hormone Problem
- ☐ Glaucoma
- ☐ Sleep Disorder
- ☐ Obstructive Sleep Apnea
- ☐ CPAP/BiPAP
- ☐ Diverticulosis
- ☐ Ulcer
- ☐ Gout
- ☐ Tuberculosis
- ☐ Anemia
- ☐ STD/Venereal Disease
- ☐ Sexual Dysfunction

Other Medical History:_____

_____

Medical Tests

Check any tests already done. List dates and locations, if available:

- ☐ Pulmonary Function Test _____
- ☐ Sleep Study _____
- ☐ Chest Xray _____
- ☐ CT Scan of Chest _____
- ☐ Mammogram _____
- ☐ Bone Density Scan _____
- ☐ Colonoscopy _____
- ☐ Pap Smear _____

Have you been hospitalized recently? If yes, please list location and dates.

_____

_____

Surgical History (Check all that apply)

- ☐ Heart Bypass
- ☐ Gallbladder
- ☐ Hysterectomy
- ☐ Ovaries Removed
- ☐ Colon Surgery
- ☐ Lung Surgery
- ☐ Appendectomy
- ☐ Tonsillectomy
- ☐ Cataract Removal
- ☐ Prostate Surgery
- ☐ Thyroid Surgery
- ☐ Bronchoscopy
- ☐ C-Section
- ☐ Fracture Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Lap Band or Gastric Bypass
- ☐ Thoracentesis

Other Surgical History:_____

_____

Patient Name:

Social History

☐ Non-smoker ☐ Former smoker ☐ Smoker ☐ Dates of smoking:_____
(ex: 1953-1986 or age 18-47)

☐ Cigarettes Packs per day:_____ ☐ Cigars How many per day:_____

☐ Chewing tobacco Cans per day: _____ ☐ Tobacco Pipe How often: _____

Interested in quitting smoking? ☐ Yes ☐ No

Alcohol ☐ Yes ☐ No Type *(if yes)*:_____ How much:_____How often: _____

Illegal Drug Use ☐ Yes ☐ No Describe *(if yes):* _____

Environmental exposures *(describe)*: _____

Pets ☐ Yes ☐ No Type (s): _____

Family History

Biological Father: ☐ Alive ☐ Deceased Age: _____

Medical conditions: _____

Biological Mother: ☐ Alive ☐ Deceased Age: _____

Medical conditions: _____

Siblings: ☐ Yes ☐ No How many *(if yes)*: _____

☐ Brother ☐ Sister ☐ Half-sibling Illnesses: _____
☐ Brother ☐ Sister ☐ Half-sibling Illnesses: _____
☐ Brother ☐ Sister ☐ Half-sibling Illnesses: _____
☐ Brother ☐ Sister ☐ Half-sibling Illnesses: _____

Other Family History: _____

_____

Biological children: ☐ Yes ☐ No How many *(if yes):* _____

☐ Daughter ☐ Son ☐ Illnesses:_____
☐ Daughter ☐ Son ☐ Illnesses:_____
☐ Daughter ☐ Son ☐ Illnesses:_____
☐ Daughter ☐ Son ☐ Illnesses:_____

Other Family History: _____

_____

Patient Name:

Current Medications

Drug Allergies: _____

Describe reaction: _____

Preferred Pharmacy: _____ **City:** _____

Drug Name	Dosage (in mg)	Frequency

Confidential Communication Compliance

In effort to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) including Protected Health Information (PHI), Texas Lung Associates would like to ensure the privacy of your medical information when using alternate 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 cellular phones
- ***Electronic communication***: e-mail or online patient portal

Please answer the following questions:

May we leave messages on a home, cellular or work voicemail or send you a e-mail 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 we discuss your appointments and/or treatment with your children?

☐ Yes ☐ No ☐ N/A

May we share your pertinent medical information with other physicians and/or specialists that you may be seeing?

☐ Yes ☐ No ☐ N/A

If you would like for us to discuss your care with someone other that 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 the the following individual(s):

1)_____, relationship _____

2)_____, relationship _____

3)_____, relationship _____

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

Printed Name: _____

Signature: _____ Date: _____

Staff Signature:_____ Date: _____

Office Policy

Thank you for selecting Texas Lung Associates for your healthcare needs. We understand that you have a choice when it comes to a healthcare provider 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.

PLEASE READ AND SIGN

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 $50.00 charge to patients that fail to cancel appointments prior to the date of the scheduled appointment.

INSURANCE AND ADDRESS CHANGES:
It is your responsibility to notify our office immediately if your insurance or address has changed. You will be held financially liable for charges incurred while you are not covered. If your insurance requires a referral, you must obtain one from your primary care physician (PCP) prior to making an appointment. Referrals can be emailed to doctor@texaslung.com or faxed to (940) 382-3939.

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. Our fax number is (940) 382-3939.

LABS:
If you have blood drawn or any other type of test 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 mailed by request only.

CONTACTING OUR OFFICE:
Our office hours are Monday through Thursday 9AM-5PM and Friday 9AM-12:30PM. We are closed for lunch from 11:45AM-12:45PM. Our office phone number is (940) 382-5864; for the Receptionist press 1, Billing press 2, Practice Manager press 3, Nurse press 4 and Allergy Clinic press 5. If you need immediate assistance during office hours you and reach voicemail, press "0" to be transferred to the receptionist. ***Keep in mind, we generally do not treat patients over the phone; therefore, you must schedule an appointment for a office visit.***

By signing this document you acknowledge receipt and understanding of the Texas Lung Associates office

Patient Signature:_____ Date: _____

Staff Signature:_____ Date: _____

Texas Lung Associates
Jamal Mubarak, MD
3120 Medpark Drive, Suite 150 Denton, TX 76208
Tel: (940) 382-5864 Fax: (940) 382-3939
Email: doctor@texaslung.com Web site: texaslung.com

Authorization to Release Medical Information to Texas Lung Associates

I, _____, *hereby authorize*
(Name of patient or legal representative)

_____
(Name of person/entity who should release records)

_____
(Address of person who should release records)

to release the following information to:
Texas Lung Associates
Dr. Jamal Mubarak
209 N. Bonnie Brae st Ste 300
Denton, TX 76201
(940) 382-5864
Fax (940) 382-3939

From the Health Records of: _____
(Name of person whose records will be disclosed)

_____ _____
(Date of Birth) *(Social Security Number)*

*The purpose of this release:*_____

*Limitations to this release (to include but not limited to release of information regarding AIDS or HIV status):*_____

*Signature*_ J Mubarak _____ *Date*_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY**.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, be kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. You may request a copy of this notice at any time.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information, and how we may use and disclose your health information.

We may use and disclose your medical records for each of the following purposes:

- **Treatment** means providing, coordinating or managing health care and related services by one or more health care providers. For example, if your provider refers you to a specialist, we will provide the appropriate medical information to that physician to facilitate your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example is sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer services. An example is an internal quality assessment review.

Disclosures That Can Be Made Without Your Authorization

There are situations in which we are permitted by law to disclose or use your medical information without your written consent or an opportunity to object. In other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization in writing to stop future uses and disclosures. However, any revocation will not apply to disclosures or uses already made or taken in reliance on
that authorization.

- Public Health, Abuse or Neglect, and Health Oversight
  We may disclose your medical information for public health activities as authorized.
- Legal Proceedings and Law Enforcement
  We may disclose your medical information in the course of judicial or administrative proceedings, in response to an order of the court (or the administrative decision-maker) or other appropriate legal process. Certain requirements must be met before the information is disclosed.
- Workers' Compensation
  We may disclose your medical information as required by the Texas Workers' Compensation Act.

- Inmates
  If you are an inmate or under the custody of law enforcement, we may release your medical information to the correctional institution or law enforcement official.
- Military, National Security, Intelligence Activities and Protection of the President
  We may disclose your medical information for authorized governmental functions.
- Research, Organ Donation, Coroners, Medical Examiners and Funeral Directors
  We may release medical information to researchers for research purposes if authorized; to organ procurement organizations for the purpose of facilitating organ, eye or tissue donation; to a coroner or medical examiner to identify a deceased or cause of death; or to a funeral director where such a disclosure is necessary for the director to carry out his duties.
- Required by Law
  We may release your medical information where the disclosure is required by law.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your authorization.

Your Rights Under Federal Privacy Regulations

Requested Restrictions

You may request that we restrict or limit how your protected health information is used or disclosed for treatment, payment, or healthcare operations. We do **not** have to agree to this restriction, but if we do agree, we will comply with your request except under emergency circumstances. To request a restriction, submit the following in writing;
a) the information to be restricted, **b)** what kind of restriction you are requesting, and **c)** to whom the limits apply. You may also request that we limit disclosure to family members, other relatives, or close personal friends that may or may not be involved in your care.

Right To Inspect and Copy

You have the right to inspect and request copies of health information that is within the designated record set, which is information that is used to make decisions about your care. You must submit your request in writing to the Privacy Officer. HIPAA permits us to charge a fee for copies of medical records. We can refuse to provide access to or copies of some information for certain reasons, when we provide a review of our decision on your request. Another licensed health care provider who was not involved in the prior decision to deny access will make any such review. We are required to respond or provide copies within 15 days of your request.

Right to Amend Your Protected Health Information

You may request an amendment of your medical information in the designated record set. Requests must be in writing using the designated *Texas Lung Associates* form, and presented to the Office Manager. You must provide a reason that supports your request for amendment. We will respond within 60 days of your request. We may refuse to allow the amendment in the following circumstances: **a)** is not part of the designated record set, **b)** information was not created by health providers in this practice, **c)** is not available for inspection because of an inappropriate denial, or **d)**

if the information is accurate and complete. Even if we refuse to allow an amendment, we will inform you in writing. If we approve the amendment, we will also inform you in writing, allow the amendment to be made, and notify others involved in your health care.

Right to an Accounting of Disclosures
The HIPAA privacy regulations permit you to request, and us to provide, an accounting of disclosures that are other than for treatment, payment, healthcare operations, or made via any authorization signed by you or your representative. Requests must be submitted in writing on the designated *Texas Lung Associates* form, and presented to the Office Manager. Your first request of accounting within a 12 month period is free. For additional requests within that period, we may charge you for providing the list. We will notify you of the charge, and you may withdraw or modify your request before any costs are incurred.

Appointment Reminders, Treatment Alternatives, and Other Health Related Benefits
We may contact you by telephone, postal mail, or electronic mail to provide appointment reminders, information about treatment alternatives, or other health related benefits and services that may be of interest to you.

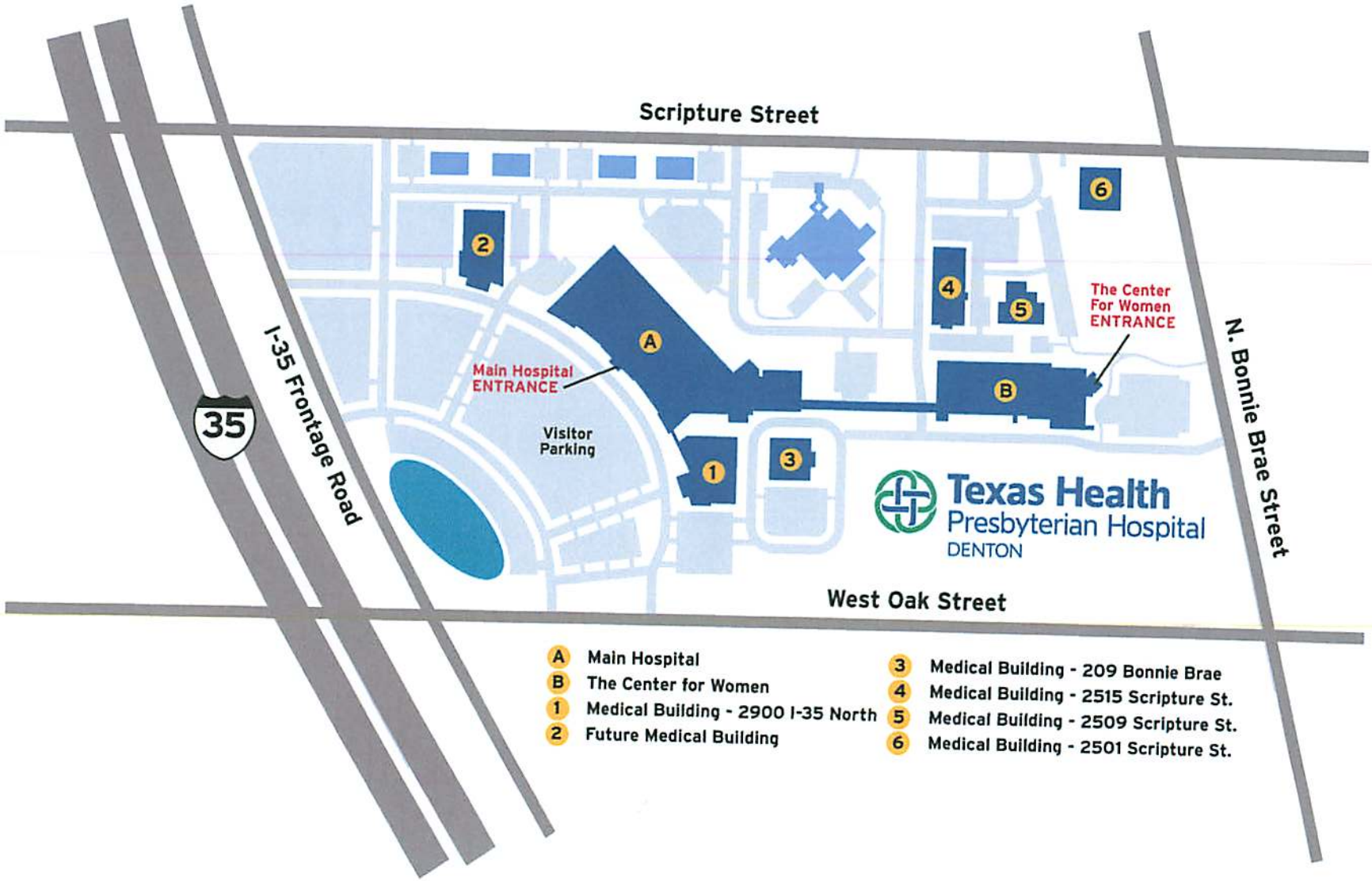
We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make a new notice provision effective for all protected health information that we maintain. We will post it, and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Office of Civil Rights in the Department of Health and Human Services about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information about the HIPAA law or to file a complaint:

The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave. SW
Washington, DC 20201
(202) 619-0257


Scripture Street
I-35 Frontage Road
35
N. Bonnie Brae Street
West Oak Street
Main Hospital ENTRANCE
The Center For Women ENTRANCE
Visitor Parking
Texas Health
Presbyterian Hospital
DENTON
A Main Hospital
B The Center for Women
1 Medical Building - 2900 I-35 North
2 Future Medical Building
3 Medical Building - 209 Bonnie Brae
4 Medical Building - 2515 Scripture St.
5 Medical Building - 2509 Scripture St.
6 Medical Building - 2501 Scripture St.