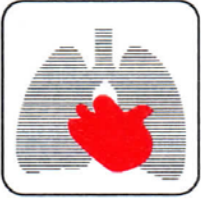

Mukesh C. Saraiya, M.D., P.A.

Lung Diseases and Internal Medicine

Diplomate American Board of Internal Medicine & Pulmonary Diseases

3200 Colorado Blvd., Suite 200, Denton, Texas 76210

Phone: (940)381-0971 Fax: (940)387-2563

Policies & Consents

Please read and review carefully, then sign and date.

Thank you for selecting Mukesh C. Saraiya, M.D., 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 your office as pleasant as possible.

FINANCIAL POLICY*:** As a courtesy to you, Mukesh Saraiya, M.D. 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 physician (PCP) prior to making an appointment. Referrals can be faxed to (940)387-2563.

***FORM FEE*:** There is a $15 fee for processing forms which require more than 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 preformed. 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.

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 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 address 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. Our fax number is (940)387-2563.

(Policies & Consents continued on page 2)

Policies & Consents Continued

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 Practice carefully. It provides more detail on how Mukesh Saraiya, M.D., may use and disclose your information. The Notice of Privacy Practices may change. A current copy may be requested from Mukesh Saraiya, M.D.

If you would like to request a restriction, please do so in writing. However, Mukesh Saraiya, M.D., 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 options. Refer to the Notice of Privacy Practice for further information.

CONTACTING OUR OFFICE: Our office hours are Monday through Friday, 9:00AM-5:30PM. We are closed for lunch from 11:30AM-1:00PM. Our office phone number is (940)381-0971.***Keep in mind, we generally do not treat patients over the phone; therefore you must schedule an appointment for an office visit.***

I have read, understand and agree to all of the policies and consents listed above.

______________________	______________________	________
Patient Name	Patient Signature/Responsible Party	Date

Mukesh Saraiya, M.D., P.A.
Lung Diseases and Internal Medicine
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New Patient Information

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

Address: ______________________________________ City: ________________ State: ________ Zip:_________

Home Phone: (____) _____-______ Cell Phone: (____) _____-_______ Work Phone: (____) _____-_______

Email Address: ____

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 ☐American Indian ☐Other ☐Prefer not to answer

Emergency Contact:___________________________ Relation to Patient: _____________________

Phone: (____)_____-______

Employer: _________________________________ Occupation: __________________________ ☐Retired

Address: ______________________________________ City: ________________ State: ________ Zip:_________

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 #: ______________________________________

Referred by: _____________________________________ Reason for visit: ________________________________

Primary Care Physician (if any): ____

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Medical History *(Check all that apply)*

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

Other Medical History:

____

____

Medical Tests

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

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

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

____

____

Surgical History *(Check all that apply)*

☐Heart Bypass ☐Appendectomy ☐C-Section

☐Gallbaldder ☐Tonsillectomy ☐Fracture Repair

☐Hysterectomy ☐Cataract Removal ☐Hip Replacement

☐Ovaries Removed ☐Prostate Surgery ☐Knee Replacement

☐Colon Surgery ☐Thyroid Surgery ☐Lap Band/Gastric Bypass

☐Lung Surgery ☐Bronchoscopy ☐Thoracentesis

Other Surgical History:

____

____

Social History

☐Never Smoked ☐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 Describe (*if yes*): ____

Environmental exposures (*describe*): ____

Pets: ☐Yes ☐No Types (*if yes*): ____

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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: ___________________________________

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Epworth Scale

Name: ______________________________________ Date of Birth: _____________ Gender: Male / Female

Weight (pounds): ________ Height: _____ ft ______in Neck Size (Inches): ___________

Have you been diagnosed or treated for any of the following conditions?

High Blood Pressure	☐Yes ☐ No	Stroke	☐Yes ☐ No	Sleeping Medication	☐Yes ☐ No
Heart Disease	☐Yes ☐ No	Depression	☐Yes ☐ No	Narcolepsy	☐Yes ☐ No
Diabetes	☐Yes ☐ No	Sleep Apnea	☐Yes ☐ No	Morning Headaches	☐Yes ☐ No
Lung Disease	☐Yes ☐ No	Nasal Oxygen Use	☐Yes ☐ No	Pain Medications	
Restless Leg Syndrome	☐Yes ☐ No	Insomnia	☐Yes ☐ No	e.g. Vicodin, Oxycotin	☐Yes ☐ No

Epworth Sleepiness Scale: How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to mark the most appropriate box for each situation.

0 = would never doze 2 = moderate chance of dozing

1 = slight chance of dozing 3 = high chance of dozing

Sitting and reading	**0**	**1**	**2**	**3**
Watching TV	**0**	**1**	**2**	**3**
Sitting, inactive, in a public place (theater, meeting, etc.)	**0**	**1**	**2**	**3**
As a passenger in a car for an hour without a break	**0**	**1**	**2**	**3**
Lying down to rest in the afternoon when circumstances permit	**0**	**1**	**2**	**3**
Sitting and talking to someone	**0**	**1**	**2**	**3**
Sitting quietly after lunch without alcohol	**0**	**1**	**2**	**3**
In a car, while stopped for a few minutes in traffic	**0**	**1**	**2**	**3**

Frequency 0-1 times/week 1-2 times/week 3-4 times/week 5-7 times/week

On average in the past month, how often have you snored or been told that you snored?

__Never __ Rarely (+1) __ Sometimes (+2) __ Frequently (+3) __ Almost Always (+4)

Do you wake up choking or gasping?

__Never __ Rarely (+1) __ Sometimes (+2) __ Frequently (+3) __ Almost Always (+4)

Have you been told that you stop breathing in your sleep or wake up choking or gasping?

__Never __ Rarely (+1) __ Sometimes (+2) __ Frequently (+3) __ Almost Always (+4)

Do you have problems keeping your legs still at night or need to move them to feel comfortable?

__Never __ Rarely (+1) __ Sometimes (+2) __ Frequently (+3) __ Almost Always (+4)

Signature	Area Code Phone #	Total (for office use)	

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Current Medications

Drug Allergies: ____

Describe reaction: ____

Preferred Pharmacy: ______________________________ City: ______________

Drug Name	**Dosage (*in mg*)**	**Frequency**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

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Patient's Name: ____

Information and Assignment of Benefits

I authorize the release of any medical information necessary to process claims for services rendered and for medical treatment. I permit a copy of this authorization to be used in place of the original.

Signature: ____ Date: __________________

I herby authorize Mukesh C. Saraiya, M.D., to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Mukesh C. Saraiya, M.D. (or the party who accepts this assignment).

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or by my insurance company at any time in writing.

Signature: ____ Date: __________________

Notice of Privacy Practices Acknowledgment

I have reviewed the Notice of Privacy Practices of Mukesh C. Saraiya, M.D., which explains how my confidential medical information will be used and disclosed.

Signature: ____ Date: __________________

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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), Mukesh C. Saraiya, M.D., 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 an 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 we may discuss your care with someone other than yourself, please indicate below:

________ I do not with 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):

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 acknowledgement of receipt of your Notice of Privacy Practices.

Printed Name: ____

Signature: ____ Date: ________________

Staff Signature: ____ Date: ________________

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