Alexander N. Stadnyk, M.D.
4801 Woodway Dr., Suite 369W
Houston, TX 77056

Registration Form

Date: ______________________ Referred By: ______________________

Patient Name: ______________________ Marital Status: [ ]S [ ]M [ ]D [ ]W

Date of Birth: ______________________ Age: __________ Sex: [ ]M [ ]F

Driver's License Number: ______________ State: ______ Social Security Number: ______________

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Address, City, State, Zip: ______________________________________

E-mail Address: ______________________ Occupation: ______________________

Employer: ______________________ Employer Phone: ______________________

Emergency Contact (name, relationship, phone#)

Race: (please circle one or more) *1.American Indian/Alaskan Native 2.Asian 3.Native Hawaiian 4.Black/African American 5.White 6.Hispanic 7.Other Pacific Islander 8.Other Race 9.Decline to Answer*

Ethnicity: (please circle one) *1.Hispanic or Latino 2.Not Hispanic or Latino 3.Decline to Answer*

Primary Insurance: ______________________________________

Member ID# ______________________ Group# ______________________

Policyholder's name and relationship to Patient: ______________________

Policyholder's date of birth: ______________________

Secondary Insurance: ______________________________________

Member ID# ______________________ Group# ______________________

Policyholder's name and relationship to Patient: ______________________

Policyholder's date of birth: ______________________

Do you have a living will, health proxy or a person designated for health decisions in the event of a major illness:

[ ]No [ ]Yes, name/relationship to patient ______________________

Assignment of Benefits and Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to Alexander N. Stadnyk, M.D. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I authorize Alexander N. Stadnyk, M.D. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. A photocopy of this agreement shall be as valid as the original.

Signature: ______________________ Date: ______________________

GENERAL MEDICAL INFORMATION:

DESCRIBE THE CURRENT MEDICAL PROBLEM/REASON FOR TODAY'S VISIT: ________________

____

OTHER PHYSICIANS CURRENTLY TREATING YOU: ________________________________

ALLERGIES (TO MEDICATIONS): ________________________________

____

PREVIOUS SURGERIES OR HOSPITALIZATIONS: ________________________________

____

FOR FEMALES: ARE YOU PREGNANT, PLANNING ON BECOMING PREGNANT OR NURSING A CHILD? :

____

DO YOU **SMOKE**? □ YES □ NO IF YES, HOW LONG? _____HOW MANY PER DAY? ___

Have you ever smoked? Yes or No

DO YOU CONSUME **ALCOHOL**? □ YES □ NO IF YES, HOW MUCH PER DAY? ________________

DO YOU CONSUME **CAFFEINE** (COFFEE/SODA)? □ YES □ NO IF YES, MUCH PER DAY? ____________

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING?

□ Sleep Apnea
□ Sinusitis
□ Shortness of Breath
□ Asthma
□ Bronchitis
□ COPD
□ TB/Lung Disorder
□ Chest Pain/Pressure/Tightness
□ Heart Attack
□ Diabetes
□ Hypertension
□ Cholesterol
□ Stroke
□ Seizures
□ Migraine/Headaches
□ Depression
□ Anxiety
□ Memory Loss
□ Hearing Difficulty
□ Cataract
□ Glaucoma
□ Eczema
□ Skin Disorders
□ Thyroid Disease
□ Acid Reflux/Heartburn
□ Ulcers
□ Digestive Disorder
□ Hepatitis/Liver Disease
□ Hemorrhoids
□ Blood in Stool
□ Urinary Tract Infection
□ Kidney Stone/Disease
□ Deep Vein Thrombosis
□ Arthritis/Gout
□ Bleeding/Clotting Disorder
□ Cancer: ____________

Others: ____

FAMILY HISTORY CHECK ALL THAT APPLY:

	FATHER	MOTHER	SIBLINGS	GRANDPARENTS
HIGH BLOOD PRESSURE	□	□	□	□
EPILEPSY	□	□	□	□
CANCER	□	□	□	□
ECZEMA/PSORIASIS	□	□	□	□
HEART ATTACK / STROKE	□	□	□	□
DIABETES	□	□	□	□
ASTHMA	□	□	□	□
HAY FEVER	□	□	□	□
OTHER: ____________	□	□	□	□

MEDICATION RECORD

Patient Name: ______________________________ D.O.B.:______________

Name of Medication	Dosage (gm/mg/mcg)	Frequency

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Date: ______________________

Patient Name and Date of Birth: ____

MY CONTACT PHONE NUMBERS AND E-MAIL INFO

Home: ________________________ Cell: ______________________ Work: __________________

E-Mail: ____

PHARMACY INFORMATION

Local Pharmacy Name and Phone Number: ____

Mail Order Pharmacy/Phone Number/Member ID# (optional):

____

I authorize contact from this office to **confirm appointments, treatments and billing information** in the following sequence (check one):

Primary	[ ]home [ ]cell [ ]work [ ]e-mail
Second	[ ]home [ ]cell [ ]work [ ]e-mail
Third	[ ]home [ ]cell [ ]work [ ]e-mail

I authorize information **about my health be conveyed via** (check one):

Primary	[ ]home [ ]cell [ ]work [ ]e-mail
Second	[ ]home [ ]cell [ ]work [ ]e-mail
Third	[ ]home [ ]cell [ ]work [ ]e-mail

Please list any other **parties who can have access to your health information** (this **includes relatives, friends and any care takers** who can have access to this patient's records and receive test results by phone):

Name and Phone#: Relationship to patient:

____

____

____

____

____

N

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FINANCIAL POLICY

ANY CHANGES IN INSURANCE COVERAGE, ADDRESS, AND TELEPHONE OR OTHER DEMOGRAPHICS MUST BE GIVEN TO THE FRONT DESK WHEN YOU SIGN IN FOR YOUR APPOINTMENT.

To assist us in establishing your account please provide the following:

1) Current insurance information on your registration form
2) Please present your insurance card so that a copy can be made for your chart.
3) A separately ***signed consent disclosure*** for authorization for the release of information necessary for filing your insurance claim(s), faxing orders, releasing medical information to other physicians and/or for insurance pre-certifications.
4) All ***co-pays and deductibles*** designated by your PPO or HMO will be **PAID UPON CHECK IN**.

INSURANCE

Insurance is a contract between you and your insurance company. We are not a party to your contract though we may have a contractual fee schedule agreement with the insurance company. We will not become involved in disputes with your insurance company regarding deductibles, non-covered/covered expenses, co-insurance or "reasonable and customary" charges other than to supply factual information as necessary. Payment plans are available but arrangements must be made in advance with our Practice Manager or Patient Account Manager. We accept checks, cash and credit cards (Visa, MasterCard and American Express).

Medicare: We are a participating provider with Medicare. We will also file with your secondary or supplementary policy. Please make sure that you provide our front desk with your Medicare and supplementary cards. You will be asked to sign a Waiver of Liability Form in the event that a service is provided, which we know is not covered by Medicare.

Indemnity/Fee for Service: As a courtesy to our patients we will file with your insurance provided you have met your annual deductible and pay your coinsurance at the time of service. *If you have not met your yearly deductible you must pay at the time of service and a claim will be filed with your insurance, upon request.*

Contracted Managed Health Care: (HMO's, PPO's, EPO's) **It is your responsibility to make sure that OUR physician is currently enrolled with your plan. All necessary referrals must have been obtained prior to each visit.** If your referral has not been completed prior to your arrival in the office it may mean a delay in being seen by the physician and the possible rescheduling of your appointment. You are obligated by your insurance company to pay the copay at the time of your visit.

PROCEDURES

Insurance will be verified including deductible and co-insurance prior to your pre-operative visit. Payment in full is required in advance if insurance benefits are not assigned or in the event there is no insurance. Any overpayment by the insurance will be promptly refunded to the patient (or responsible party). Other financial arrangements may be discussed with our Patient Account Manager.

MINORS/UNACCOMPANIED MINORS

The parent accompanying a child of a divorced family will be responsible for payment of charges incurred for that date of service regardless of insurance or divorce decree status. Unaccompanied minors must have authorization for medical treatment signed by his/her parent or legal guardian and is responsible for providing current insurance information and any necessary payment at the time of service.

PRIVATE PAY

If you have no health insurance, payment is expected in full at the time of service.

Returned Check Fee: There will be a $25.00 charge on all returned checks.

I understand and agree that (REGARDLESS OF MY INSURANCE STATUS) I am ultimately responsible for the balance of my account for any professional services rendered. I authorize payment of insurance benefits to be paid directly to the physician. I authorize the release of any medical information necessary to process my claims. I have read and certify that all the above information is true, complete and correct to the best of my knowledge. I will notify the office staff of any changes in my health status or the above information.

Printed Name and Date of Birth: ____

Signature and Date: ____

Alexander N. Stadnyk, M.D.
4801 Woodway Dr., Suite 369W
Houston, TX 77056

Consent to Disclose Private Healthcare Information for Treatment and Healthcare Operations

I authorize and consent for Dr. Alexander N. Stadnyk and staff to release any and all medical, including, but not limited to, medical notes, physician narratives, office notes, operative notes, discharge summaries, doctor's orders, nurse's notes, lab reports, test results, physical therapy progress notes, patient progress notes, diagnosis, post operative reports, post operative diagnosis, pathology reports, x-rays, CT scans, any diagnostic studies, laboratory studies, clinical abstract, historical charts, any records reflecting treatment for substance abuse, mental illness, AIDS, HIV virus, alcohol abuse and other information contained therein, any documents and opinions relevant to past, present or future physical and mental condition, care or hospitalizations, and any other personal health information regarding my medical care as necessary to carry out treatment, obtain payment and conduct other healthcare operations.

This includes released by fax, telephone requests, mail and e-mail to self, other physicians, healthcare providers and insurance provider.

The release of the matters listed above is being authorized for purposes of obtaining medical treatment, payment for such services and other healthcare operations.

A copy of this authorization is agreed by me to have the same effect and force as an original.

Any person, firm or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters.

I understand that I may request restrictions and I may revoke this consent in the future if I should so desire.

Printed Name and Date of Birth: ____

Signature and Date: ____

Special Restrictions:

Notice of Privacy Practices
I have received and reviewed a copy of the currently effective notice of privacy practices for this healthcare facility which explains how my medical information will be used and disclosed. A copy of this signed and dated document shall be as effective as the original.

Printed Name: ____

Signature: ____

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 and 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, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

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 only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be 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 service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

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 actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or an alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain paper copy of this notice from us upon request.

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 June 10, 2002, 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 the new notice provisions effective for all protected health information that we maintain. We will post and you may request a 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 formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, 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.

Please contact us for more information,
by asking to speak to our Privacy Officer
or for written inquiries, note
"Attention Privacy Office".

For more information about HIPAA or to file a complaint:

The U.S. Departments of Health & Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Alexander N. Stadnyk, M.D.
Pulmonary Diseases
Fellow, American College of Physicians
Fellow, American College of Chest Physicians
Fellow, Royal College of Physicians and Surgeons of Canada

MEDICAL RECORD RELEASE FORM

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records or a summary or narrative of my protected health information to the physician listed below.

My medical records may contain test results for AIDS or HIV infection and I consent to the release of this information. **Initial**_______ **Date**________

PATIENT NAME: ______________________________________

DATE OF BIRTH: ______________________________________

The information you may release subject to this signed release form is as follows:
[ ] Complete medical record (do not check items below if this box is checked)
[ ] Pulmonary function tests;
[ ] Radiology and imaging reports;
[ ] Pathology reports;
[ ] Hospital reports
[ ] Other (specify):______________________________________

Release my protected health information to the following physician within 15 days from receipt of my request:
Alexander N. Stadnyk, MD
4801 Woodway Drive, Ste. 369W
Houston, TX 77056
Fax 713-799-9917

I understand that a fee for preparing and furnishing this information may be charged according to rulings set forth by the Texas State Board of Medical Examiners.

Signature: ______________________________ **Date:** ____________

Patient Name: ___________________________ **DOB:** ____________