PULMONARY CRITICAL CARE AND SLEEP ASSOCIATES P.A

ASHESH DESAI, M.D.

WELCOME TO OUR OFFICE

Patient's Name: First: _____ Last: _____ Middle: _____ Date: _____

DOB: _____ Age: _____ Sex: _____ SSN#_____

Home Address: _____

City: _____ State: _____ Zip: _____

Telephone: Home: (_____) _____

Cellular :(_____) _____

Work: (_____) _____

May we leave a message? Yes or No – Home/ Cell / Work

E-Mail Address (Required for Patient Portal):_____

Driver's License#_____ Occupation: _____

Referring Physician (or whom may we thank for referring you to this office?):_____

Primary Care Physician: _____

Insurance Information (Please present insurance card to Medical Secretary)

Name of Primary Insurance Company_____

Member ID _____ **Group Number** _____

Secondary Insurance Company _ (If Any) _____

SINGNATURE: _____ DATE: _____

Pulmonary Critical Care and Sleep Associates
Ashesh Desai, MD
600 South Conroe Medical Drive, Suite 101, Conroe, TX 77304
Phone: (936) 242-6957

Name: _____ ***DOB:*** _____

CURRENT MEDICATIONS (Please provide list if available otherwise type in below)

Name	Dosage/Strength	How often do you take it?

Do you have Allergies to any Medication: _____

PREFERRED PHARMACY: Name: _____ Phone:_____ _____

Address: _____

IMMUNIZATION:

Pneumonia Vaccine: _____Month/Year Flu Vaccine: _____Month/Year

Shingles: _____Month/Year others: _____

PAST HOSPITALIZATION:

Year	Reason	Year	Reason

PAST SURGICAL HISTORY:

Year	Reason	Year	Reason

Pulmonary Critical Care and Sleep Associates
Ashesh Desai, M.D.

CONSENT FOR TREATMENT

Patient Name: _____ DOB_____

Street: _____ City_____ Zip_____

Primary Phone No: _____ Alt. Phone No: _____

Social Security Number: _____

E-Mail:_____

I voluntarily give my permission to the health care providers of Pulmonary Critical Care and Sleep Associates, PA as they may deem necessary to provide medical care services to me. I understand that by signing this form, I am authorizing them to treat me as long as I seek care from Pulmonary Critical Care and Sleep Associates providers, or until I withdraw my consent.

_____

Signature of Patient or Guardian Date

_____

Printed Name of Patient or Guardian Relationship to Patient

Please list any family member(s) and or loved one(s) that you authorize Pulmonary Critical Care and Sleep Associates to disclose information to regarding your condition, diagnosis, medications, financial information, dates of services, appointments and all other concerns:

Name	Relationship	Phone	Initial
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____

PLEASE NOTE:
There will be times this office will call and leave messages regarding appointments and/or returned phone calls to the patient.

_____ _____

Signature **Date**

Any outside requests for medical records or other pertinent information will require a signed consent form by the patient.

HIPAA Authorization for Release of Information Form

I hereby authorize use or disclosure of protected health information about me as described below.

The following specific person or class of persons or facility is authorized to make the requested use or disclosure: _____

_____

_____

_____

The following person or class of persons may receive disclosure of protected health information about me.

RECORDS FAXED/MAILED TO: Pulmonary Critical Care and Sleep Associates, P.A
Ashesh Desai, MD

600 S Conroe Medical Drive, Suite 101

Conroe, TX 77304 // Phone: 936-242-6957

FAX: 936-242-6958

RECORDS ON (PATIENT NAME)_____(DOB)_____

PHONE NUMBER_____

Specific description of information to be released (must include date(s) of service):

_____

_____

I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke or withdraw this authorization by notifying **Pulmonary Critical Care and Sleep Associates, P.A** in writing of my desire to revoke it. However, I understand that any action already taken in advance of this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

This authorization will expire on _____, or 1 (one) year after the date of said authorization.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.

Signature of Individual	Date of Signature	Date of Birth or SS Number

-- OR, if applicable --

Signature of Guardian	Date of Signature	Description of Guardian's Personal Representative's Authority to Act for the Individual

A copy of this completed, signed and dated form must be given to the Individual or person signing on the Individual's behalf.

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

MHiE Memorial Hermann Information Exchange

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Health System. Exchange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____ [Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Health System providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFORMATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEALTH RECORDS, AND YOUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Members of the MHiE are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the time frame in which your Consent was active.

INDIVIDUAL'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include this Consent in the individual's records.

Official Use Only:

MEMORIAL HERMANN

Information Exchange Patient Consent For The Use And Disclosure

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