FINANCIAL POLICY

Razzack & Associates believes that communicating our financial policy is good healthcare practice. **CHARGES INCURRED FOR SERVICES RENDERED ARE THE PATIENT’S RESPONSIBILITY REGARDLESS OF INSURANCE COVERAGE. YOUR INSURANCE COVERAGE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY, NOT YOUR INSURANCE COMPANY AND OUR PRACTICE.**

We will file your primary and secondary insurances as a courtesy. Please realize that having a secondary insurance does not necessarily mean that your services are covered 100%. Secondary insurances typically pay according to a coordination of benefits with the primary insurance. It is your responsibility to provide us with accurate insurance information and to inform us of any changes in your coverage as they occur.

**YOU ARE RESPONSIBLE FOR ALL COPAYS, COINSURANCES, DEDUCTIBLES AND NON-COVERED SERVICES.** We are obliged to collect your copay at the time of service per your insurance company. Statements are sent out every other month. We require the balances due, to be paid when you receive your statement.

Patient payments are typically applied to the oldest balances first, except for copayments and coinsurances, they are applied to the current date of service. There is a $25.00 Charge for a check that does not clear with your bank. Payment will then need to be made by cash, money order or credit card for the balance due.

When you receive healthcare services from us and we bill your insurance, it is the same as though we are extending credit to you. You receive the service and we await payment from you and/or your insurance company. Due to the high cost of rendering care and the lowering reimbursements by many insurers, including Medicare & Medicaid, we simply cannot afford to carry large balances. Further action will take place if balances are not paid within 90 days. Payment arrangements can be made with our account specialist representative by calling 281-949-7023.

**Form Requests:**
Completing disability forms, FMLA forms and other requested supplemental insurance forms requires time away from patient care and day to day business operations. Prepayment of $25.00 is required. Please understand that in order to complete forms your medical records must be reviewed, forms completed and signed by the physician and scanned into your medical record. Some of the forms can be quite complicated and tedious to complete. Please provide us with pertinent information, especially dates of disability and return to work. We request that you allow 5-7 business days for this process.

I have had the opportunity to read/receive a copy of the Financial and Privacy Policies of Razzack & Associates and hereby authorize any licensed physician, practitioner, hospital, clinic or other medical facility or it’s representatives to release any and all information with respect to any illness or injury, medical history, consultation, prescription(s) or treatment and copies of medical records to The Physicians of Razzack & Associates. I also authorize Razzack & Associates, its physician’s and providers to release medical records to the insurance company responsible for my health coverage should it become necessary for payment of services provided.

___________________________________________________________   ________________________
Patient/ Guardian-Responsible Party                                Date
I hereby assign benefits and authorize payment to go directly to Razzack & Associates for any medical services provided but not to exceed the reasonable and customary charges for these services.

THIS OFFICE IS NOT RESPONSIBLE FOR INCORRECT BENEFIT INFORMATION GIVEN TO US BY YOUR HEALTHCARE INSURANCE CARRIER OR FOR CHANGES IN COVERAGE. A DESCRIPTION OF BENEFITS IS NOT A GUARANTEE OF COVERAGE AND CANNOT BE RELIED UPON AS SUCH. IN THE EVENT OF NONPAYMENT BY YOUR INSURANCE COMPANY THE CHARGES ON YOUR ACCOUNT WILL BE YOUR RESPONSIBILITY.

I understand that I am financially responsible to the physician for all charges not covered by this agreement. PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.

KNOWING YOUR INSURANCE BENEFITS ARE THE RESPONSIBILITY OF THE INSURED AND DEPENDENTS. WE ARE ONLY PROVIDING INFORMATION GIVEN TO US BY YOUR INSURANCE COMPANY. THIS INFORMATION MAY NOT BE CORRECT AND SHOULD NOT BE RELIED UPON. PLEASE CONTACT YOUR INSURANCE COMPANY TO INSURE COVERAGE AND BENEFITS.

We accept cash, debit card, check, (except starter checks and not from new patients), Master Card, Visa and American Express.

___________________________________________________________                               ________________________
Patient/ Guardian-Responsible Party                                                                                                    Date

___________________________________________________________                               ________________________
Print Patient Name                                                                                                                      D.O.B
HIPAA STATEMENT:

This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act. Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws. Covered entities, as the term is defined by HIPAA and Texas Health and Safety, must obtain a signed authorization from an individual or the individual’s legally authorized representative to disclose that individuals Protected Health Information (PHI). The Authorization provided by use of the form means the organization, entity or person authorized can disclose, communicate, or send named individuals PHI to the organization, entity or person identified on the form, including through use of any electronic means.

Due to HIPAA regulations, do we have permission to?

YES  NO  Leave a detailed message on your answering machine or voice mail at home?
YES  NO  Leave a detailed message at you place of employment?
YES  NO  Discuss your medical condition with family member?
YES  NO  Discuss your account with any person answering your home phone?

Due to HIPAA we are required to have permission to discuss your health information with anyone beside yourself. If we can discuss your health information with anyone else please list their information below.

1. ____________________________________________  ____________________________________________  ____________________________________________
   Name        Phone #        Relations

2. ____________________________________________  ____________________________________________  ____________________________________________
   Name        Phone #        Relations

3. ____________________________________________  ____________________________________________  ____________________________________________
   Name        Phone #        Relations

4. ____________________________________________  ____________________________________________  ____________________________________________
   Name        Phone #        Relations

Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

**OR**

I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records
☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment
☐ Other (please specify): _____________________________________________________________

I hereby declare that I have read and understand this office’s Procedure Policy and HIPAA regulations. I authorize Dr. Razzack & Associates to implement the above regulation of the office and honor my noted request. This form is valid for one year after signature date.
SIGNATURE AND AUTHORIZATION: I have read this form in its entirety and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of PHI that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities. **Date signed is the effective date of this authorization**

Razzack & Associates participates in the Community Connect EHR system, pursuant to which physicians and other providers such as Medical Group share access with Houston Methodist’s electronic health record system, so that multiple providers can access and update a single medical record for each individual patient.

_________________________                           ______________________________
Printed Name of Parent/Guardian                                     Signature of Patient/Guardian

_________________________
Relationship to Patient

_________________________
Date

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by sending Razzack & Associates a letter via mail, email or fax. Your letter must also include the patient’s full name, address, and phone number. The authorization will have no effect on actions Razzack & Associates took in good faith before receiving a letter to withdraw authorization.
Authorization for Disclosure of Protected Health Information

Patient Name ___________________________ D.O.B ___________ Phone # ______________
Address ______________________________________________________________________
I hereby authorize ______________________________ to release my medical information to the following
TO: _______________________________________________________
FAX #: ___________________ PHONE #: _____________________

Treatment dates: ___________________ to ___________________ for continuing medical care.

Please send:
[ ] Lab/ Pathology
[ ] Imaging/ Radiology
[ ] Emergency Room
[ ] H & P/ Discharge
[ ] Consultations
[ ] Cardiac Studies
[ ] Pulmonary
[ ] Doctor Progress Notes/ Doctor Orders
[ ] Operative/ Procedure Report

[ ] Other ____________________________________________________________

This authorization is valid until the 365th day after the date it is signed, unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment(s) for the dates specified above.

I, the undersigned, have read the above and authorize the staff of MPSDA to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject re-disclose by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damages resulting from the lawful release of my Protected Health Information.

Signature of Patient: _____________________________________________ Date: _________________
Relationship to Patient: ____________________________________________
Signature of Witness: ______________________________________________ Date: _________________

www.dreamMD.com
PATIENT INFORMATION FORM

Last Name: ___________________________ First Name ________________________ M.I. ______________

Home Address: ______________________________________________________________________

Home Phone: __________________________ Work Phone: ________________________________

Email ______________________________________________________________________________

Employer Name and Address: __________________________________________________________________________

Date of Birth: ______________________ Social Security Number: __________________________

Emergency Contact and Phone Number: _________________________________________________

Referring Doctor and Phone Number: ______________________________________________________

Primary Care Physician and Phone Number: ______________________________________________

Primary Insurance: ___________________________ Phone Number: __________________________

Billing Address: ________________________________________________________________________

Name of Insured and Relation to Patient: ___________________________________________________

ID Number: ___________________________ Group Number: _________________________________

Secondary Insurance: ___________________________ Phone Number: __________________________

Billing Address: ________________________________________________________________________

Name of Insured and Relation to Patient: ___________________________________________________

ID Number: ___________________________ Group Number: _________________________________

I hereby authorize payment of medical benefits billed to my insurance _______________________. I hereby accept responsibility for payment for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made by insurance, if the Practice does not participate with my insurance.

I agree to pay all copayments, coinsurance, and deductibles at the time the service visit rendered.

_________________________________________________   _________________________________
SIGNATURE OF PATIENT OR GUARDIAN                   DATE
# THERAPEUTIC RECORD (Medications)

**PATIENT NAME:**

**PHARMACY NAME:**

**PHARMACY PHONE NUMBER:**

**CROSS STREETS:**

**LIST ALL MEDICINES YOU ARE CURRENTLY TAKING:** Prescription medication

Including those taken as needed.

<table>
<thead>
<tr>
<th>DATE</th>
<th>MEDICATION NAME &amp; DOSE</th>
<th>DIRECTIONS</th>
<th>DATE STOPPED</th>
<th>REASON FOR TAKING &amp; DR. NAME</th>
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</table>

**MEDICAL HISTORY:** *(Please check and give date of occurrence on space provided)*

- [ ] Pneumonia ______
- [ ] Heart Failure ______
- [ ] Depression ______
- [ ] High Cholesterol ______
- [ ] Diabetes ______
- [ ] Anxiety ______
- [ ] Bronchitis ______
- [ ] High Blood Pressure ______
- [ ] Tuberculosis ______
- [ ] Asthma ______
- [ ] Cancer ______
- [ ] Seizures ______
- [ ] Tonsillitis ______
- [ ] Stroke ______
- [ ] Heart Attack ______
- [ ] Thyroid Problems ______
- [ ] Rheumatic Heart ______
- [ ] Lupus ______
- [ ] Blood Clots ______
- [ ] Congenital Heart ______
- [ ] Any other health condition

**ALLERGIES TO MEDICATION OR FOOD**

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<tr>
<th>REACTION</th>
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<td>DATE</td>
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</tbody>
</table>

**FAMILY HISTORY:** Mainly list mother, father, and siblings health conditions. *(Please check and give relationship on space provided. *If grandparents, please use maternal or paternal)*

Mother: [ ] Alive [ ] Deceased
- [ ] Stroke ______
- [ ] High Cholesterol ______
- [ ] Asthma ______
- [ ] Lung Fibrosis ______
- [ ] Emphysema ______

Father: [ ] Alive [ ] Deceased
- [ ] Diabetes ______
- [ ] Cancer ______
- [ ] Lung Cancer ______
- [ ] Lupus ______
- [ ] Other Cancer ______

**SOCIAL HISTORY:**
Do you live with your [ ] Spouse [ ] Significant Other [ ] Children [ ] Other Family [ ] Roommate
Name: ________________________________________________________________

How many children do you have? __________________________________________

What is your occupation? _________________________________________________

Have you ever been exposed to a significant amount of...?
- [ ] Toxic chemicals or gases
- [ ] Asbestos
- [ ] Sandblasting dust
- [ ] Organic dust

Do you smoke cigarettes/cigars? [ ] YES [ ] NO
- [ ] Cigarette
- [ ] Cigar pipe
- [ ] Chewable

If so, how many packs per day? __________________________

How many years have you smoked? __________________________

How long ago did you quit? __________________________

Do you consume alcohol? [ ] YES [ ] NO
- [ ] Bottles of beer
- [ ] Glasses of wine
- [ ] Liquor

If so, how many drinks per week? __________________________

Do you consume caffeine? [ ] YES [ ] NO
- [ ] Coffee
- [ ] Tea
- [ ] Soda

If so, how many drinks per day? __________________________

Have you ever used illicit drugs? [ ] YES [ ] NO
- [ ] Cocaine
- [ ] Crack
- [ ] Crystal Meth
- [ ] Marijuana

If so, what type and how often? __________________________

Have you ever been exposed to person(s) infected with Tuberculosis (TB)? [ ] YES [ ] NO

Have you had a blood transfusion? [ ] YES [ ] NO

If yes, when? __________________________
RESPIRATORY

Have you noticed any shortness of breath?  [ ] YES  [ ] NO
   If YES, How long have you noticed this for? _____________________
   [ ] When sitting or resting?
   [ ] When walking slowly?
   [ ] When walking fast?
   [ ] Only when doing heavy work or physical activity?
   [ ] When climbing stairs? How many flights of stairs? _______

When you breathe, do you notice a wheeze or whistling in your chest?  [ ] YES  [ ] NO
If YES, How long have you noticed this wheezing?
   [ ] All my life
   [ ] Over 10 years
   [ ] Over 1 year
   [ ] Just recently

Are you having a cough?  [ ] YES  [ ] NO  Do you cough up sputum or phlegm?  [ ] YES  [ ] NO
   [ ] Dry cough
   [ ] Productive cough
   [ ] Yellow or green
   [ ] Brownish
   [ ] Blood or red-streaked

Allergy History

Please rate your symptoms from 1-5 (1 is being the low degree of symptom, 5 is bring the high degree of symptom)

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>EYES:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>(itchy, watery or swelling)</td>
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<td></td>
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<tr>
<td>EARS:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>(itchy, draining or congested)</td>
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<td></td>
<td></td>
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<tr>
<td>NOSE:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>(runny or congested)</td>
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<tr>
<td>HEADACHES:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>(allergy related)</td>
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<tr>
<td>POSE NASAL DRIP:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>COUGH:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
<td>(allergy related)</td>
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<td></td>
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<td></td>
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<tr>
<td>SNEEZING:</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

______________________________________________________________________

SIGNATURE OF PATIENT OR GUARDIAN  DATE
SLEEP INTERVIEW QUESTIONNAIRE

Section I: Patient Information
Patient Name: __________________________ Social security #: __________________________
Height: ______________ Weight: ______________

Section II: Main Complaint
1. List your main sleep complaint: ____________________________________________________
2. How long has this been a problem? _________________________________________________
3. Were there any events associated with the initial onset of your complaint: (Stress, illness, weight gain/loss, HBP, etc. __________________________
4. How often do you wake up at night to urinate? _______________________________________
5. Have you had a previous sleep study or screen? [ ] YES [ ] NO
   If yes, when and where? ________________________________________________

The following information will help us obtain a better understanding of your sleeping and waking behavior. Please answer all questions to the best of your ability. If possible, complete this questionnaire with your spouse of someone familiar with your sleep/wake habits.

Section III: History of Sleep/ Wake Disorder

<table>
<thead>
<tr>
<th>Do you?</th>
<th>NEVER</th>
<th>SOMETIMES</th>
<th>OFTEN</th>
<th>ALWAYS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Take intentional naps</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Experience short periods of muscle weakness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>or loss of muscle control during anger, laughter, or excitement?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Experience vivid, dreamlike episodes after falling asleep or on awakening?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Feel unable to move or paralyzed when falling asleep or waking up?</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Section IV: Sleep Habits
1. What time do you go to bed on weekdays? _______AM / PM  weekends? _______AM / PM
2. How long does it take you to fall asleep? __________________________________________
3. What percentage do you sleep on your back? _______ Stomach  _______ Right side
   _______ Left side  _______ Back
4. How often do you awaken at night? ________________________________________________
   How often do you stay awake? ____________________________________________________
   For what reason do you awaken? ________________________________________________
5. What time do you awaken on weekdays? ______________  weekends? ___________________
6. How many hours of sleep do you normally get? ______________________________________
Section V: General Information
1. Are you having any family or marital problems? [ ] Yes [ ] No
2. Are you currently experiencing problems with your memory or concentration? [ ] Yes [ ] No
   If yes, please explain: ____________________________
3. Have you noticed any changes in your mood or irritability levels lately? [ ] Yes [ ] No
   If yes, please explain: ____________________________
4. Have you been depressed lately? [ ] Yes [ ] No
   If yes, explain why? ____________________________
5. Have you had serious thoughts of suicide or attempts at suicide? [ ] Yes [ ] No
   If yes, please explain: ____________________________
6. Are you having any sexual problems? (Impotency, premature ejaculation, etc.) [ ] Yes [ ] No
   If yes, please explain: ____________________________
7. Are you having any other problems with stress, anxiety, life’s pressure? [ ] Yes [ ] No
   If yes, please explain: ____________________________
8. Do you work nights or a rotating shift? [ ] Yes [ ] No
   If yes, please explain: ____________________________
9. Do you often travel across time zones, which affect your sleep/wake schedule? [ ] Yes [ ] No

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

<table>
<thead>
<tr>
<th>Situation:</th>
<th>Chance of dozing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sitting and reading</td>
<td>0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing</td>
</tr>
<tr>
<td>Watching TV</td>
<td></td>
</tr>
<tr>
<td>Sitting, inactive in a public place (e.g. a theatre or a meeting)</td>
<td></td>
</tr>
<tr>
<td>As a passenger in a car for an hour without a break</td>
<td></td>
</tr>
<tr>
<td>Lying down to rest in the afternoon when circumstances permit</td>
<td></td>
</tr>
<tr>
<td>Sitting and talking to someone</td>
<td></td>
</tr>
<tr>
<td>Sitting quietly after a lunch without alcohol</td>
<td></td>
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<tr>
<td>In a car, while stopped for a few minutes in the traffic</td>
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</tbody>
</table>

Total: ____________________________

I acknowledge that the above statements are true and correct.

________________________________________
SIGNATURE OF PATIENT OR GUARDIAN

________________________________________
DATE