Texas Sinus, Allergy, Snoring & Sleep Institute
Khetarpal Facial Plastics Institute

Umang Khetarpal, M.D.

How did you hear about us? □ Internet □ Radio □ Radio □ Google □ ZocDoc □ Referral □ Other: _____

Who do we thank for referring you to us? _____

Referring Physician: _____ Date: _____

Primary Physician: _____ Referral Required: □ Yes □ No

Patient Information

Last Name: _____ First: _____

Address: _____ City/State/Zip Code: _____

Home Telephone: _____ Work: _____ Cell: _____

Date of Birth: _____SSN: _____ Single/Married/Divorced/Widowed (Circle One)

Employer Name: _____ Phone Number: _____ Full/Part/Retired (Circle One)

Emergency Contact Name: _____ Relationship: _____

Phone Number: _____Pharmacy Name/Number: _____

Complete for Children/Minors

Father's Name: _____ SSN: _____ Employer: _____

Mother's Name: _____ SSN: _____ Employer: _____

Insurance Information

Name of Insurance: _____ Address**:** _____

Name of Insured:_____Policy/Group: _____

Name of Secondary Insurance:_____Address: _____

Name of Insured:_____Policy/Group:_____

Authorization of Payment and Release of Information

I hereby authorize payment of medical benefits to the Provider for Professional Services rendered by Dr. U. Khetarpal. I also promise to pay all charges incurred by me at Dr. Umang Khetarpal's request regardless of insurance coverage with the understanding that I will be refunded any money overpaid. I authorize release of information from my medical records to the following. My insurance company(s) your billing agency primary care/ referring/ consulting physicians and to some of your vendors.

Patient Signature or Guardian's Signature: _____

Email Address: _____

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Patient Name: _____ Date: _____

Member ID: _____ Date of Birth: _____

Name of Primary/Referring Physician: _____

Person filling out this form: _____

Reason for your visit (Please list all ear, nose, and throat issues): _____

_____

Please list all your Medical Conditions:

_____

Please list all your surgeries:

_____

Please list all your current medications including dosages and quantities per day:

_____

Are you allergic to any medications? Please list here:

_____

What reactions, if any, do you get from the above medications? Please circle: Hives Rash

Diarrhea, Upset Stomach, Shortness of Breath or list any other reaction:

_____

Family Medical History:

Father: Alive/Deceased Issues: High blood pressure, stroke, cancer, diabetes, other: _____

Mother: Alive/Deceased Issues: High blood pressure, stroke, cancer, diabetes, other: _____

Brother(s): Alive/Deceased Issues: High blood pressure, stroke, cancer, diabetes, other: _____

Sister(s): Alive/Deceased Issues: High blood pressure, stroke, cancer, diabetes, other: _____

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Social History:

Do you smoke? Yes/No If yes, number per day: _____ How many years? _____

Marital Status: Married Single Divorced Widowed Other: _____

Do you drink alcohol? Yes/No Daily/Socially: _____How much? _____

Have you ever used recreational drugs? Yes/No

What is your Profession/Work? _____

Please be advised that failure to show for a visit or canceling an appointment less than 24 hours of scheduled arrival time, will result in a $50 no show/cancellation fee added to your account.

Surgery cancellations within one week of surgery will be charged $500. If a medical reason is provided, a letter from your physician will be required to waive the fee.

Two no show appointments without a valid reason will result in termination of the doctor patient relationship.

_____ _____
Patient Signature Date

_____
Patient Printed Name

_____ _____
Staff Witness Signature Date

_____
Staff Printed Name

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Advance Beneficiary Notice of Non-coverage (ABN)

A. Patient Name: _____ **DOB:** _____

NOTE: If Medicare does not pay for **D.**_____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____ listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare does not pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I do not want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Texas Sinus, Allergy, Snoring, and Sleep Institute, or his office staff, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Texas Sinus, Allergy, Snoring, and Sleep Inst., or his office staff, Notice of Privacy Practices prior to signing this consent. Texas Sinus, Allergy, Snoring, and Sleep Inst., or its office staff reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practice may be obtained by forwarding a written request to Texas Sinus, Allergy, Snoring, and Sleep Inst.

With my consent, Texas Sinus, Allergy, Snoring and Sleep Institute may call my home or designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out clinical care, including laboratory results among others.

With my consent, Texas Sinus, Allergy, Snoring, and Sleep Institute may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request the Texas Sinus, Allergy, Snoring, and Sleep Institute use and disclosure of my PHI to carry out TPO, by allowing this medical practice to carry out any operations of its practice such as billing, taking to my Insurance Company or other providers.

I understand I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent Texas Sinus, Allergy, Snoring, and Sleep Inst., may decline to provide treatment to me.

I acknowledge that I have been provided with a Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996. (HIPAA).

Patient Name	Date
Signature of Parent or Legal Guardian	Date

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COVID-19 QUESTIONNAIRE

Patient Name: _____ Date: _____

DOB: _____

Have you been in contact with someone that has or had Covid-19	Yes	No
Have you been treated for Covid-19	Yes	No
Have you traveled outside the city or Internationally in the past 3 weeks	Yes	No
Have you had any of the following symptoms in the past 1-2 week		
Malaise	Yes	No
Fever	Yes	No
Cough	Yes	No
Shortness of Breath	Yes	No
Chest pain	Yes	No
Headache	Yes	No
Loss of smell or taste	Yes	No
Diarrhea	Yes	No
Blood clot	Yes	No

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PATIENT RELEASE OF LIABILITY

Given the circumstances surrounding the spread of Covid-19 and the data available thus far, we want you to understand that 80- 85% of all Covid-19 infected patients are either without symptoms or mildly symptomatic. This means that they may not recognize that they have had Covid-19 or are currently infected with Covid-19. These symptoms may be as subtle as runny nose, mild sore throat or occasional cough, mild malaise or smell changes without any fever or shortness of breath or significant cough. The last three are cardinal symptoms of Covid-19 but may be absent in early Covid-19 or in asymptomatic or mild Covid-19. Given that background, some patients will not have fever on screening and are negative on the screening questionnaire, there is potential exposure to Covid-19 in our office. We maintain safe distancing and cleaning protocols in our office as per guidelines including patients and employees wearing masks.

By signing this form, you agree to release this office and Dr. Umang Khetarpal of any liability from getting infected by Covid-19 in our office.

_____
Patient Name (Printed)

_____ _____
Patient Signature Date

_____ _____
Parent or Legal Guardian Signature Date