Breathing Center of Houston

Patient Intake

First Name**:** _____ Last Name**:** _____ Initial: _____

Home Address: _____City: _____ State: _____ Zip:_____

Home Phone: _____Work Phone: _____

Cell Phone: _____ Email: _____

Social Security #: _____Birth Date: _____ Age: _____ Sex: ☐ Male ☐ Female

Occupation: _____ Employer's Name: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

***A copy of your insurance card(s) and photo ID will be required at your first visit.**

Primary Insurance: _____ I am the policy holder: ☐ Yes ☐ No

Secondary Insurance: _____ I am the policy holder: ☐ Yes ☐ No

If yes, skip the Policy Holder Information Section and provide a copy of the current insurance card to Breathing Center of Houston. If no, please complete Policy Holder Information Section below and provide current insurance card to Breathing Center of Houston.

POLICY HOLDER INFORMATION - If other than self

First Name**:** _____ Last Name**:** _____ Initial:_____

Home Address: _____City: _____ State: _____ Zip:_____

Home Phone: _____Work Phone: _____

Cell Phone: _____ Social Security #: _____Birth Date: _____

Authorization & Assignment

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the medical facility. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. You further authorize Breathing Center of Texas, LLC, if it chooses, to pursue on your behalf any appeals of the denial of your insurance benefits, and to release your medical records as required to determine benefits payable. You certify that you have disclosed any and all health insurance coverage information with the Breathing Center of Houston.

Patient's Signature: _____ **Date:** _____

FINANCIAL AGREEMENT/ ASSIGNMENT OF BENEFITS

(Effective May 24, 201)
We are dedicated to providing you with the best possible medical treatment and regard your complete understanding of your financial responsibilities as an important element of your care. We have established the following financial policy to help reduce confusion and misunderstanding about billing issues. If you have any questions after reading this policy, please discuss your concerns with the office manager.

Unless other arrangements are made PRIOR to an appointment, any applicable co-pays, co-insurance amounts, deductibles, or past due balances are due at the time of service. For your convenience, we accept cash, check, or money order.

For Medicare Beneficiaries: You hereby authorize payment of Medicare benefits to be made on your behalf to the Breathing Center of Houston, LLC. You further authorize Breathing Center of Houston, LLC, if it chooses, to pursue on your behalf any appeals of the denial of your insurance benefits, and to release your medical records as required to determine benefits payable. You certify that you have disclosed any and all health insurance coverage information with the Breathing Center of Houston.

Patient Acknowledgement of Billing Practice: Breathing Center of Houston has many facets of care for patients and their respiratory needs. A patient may be treating with the professionals and clinicians in one or more of the facets of the Breathing Center of Houston. The treating doctors, physical therapists, and clinicians include, but are not limited:

Dr. Jason Jorgensen D.O.
Christopher Brown PT, DPT, MS, CSCS
Kelly Hampton PT

Due to the multiple disciplines utilized for patient care, Breathing Center of Houston is under the direction of Medical Director, Dr. Jason Jorgensen D.O. All claims for patient care are submitted to insurance companies under the direction of our Medical Director, Dr. Jason Jorgensen D.O. The Breathing Centers of Texas are in-network on most major medical insurance plans and it will be the above mentioned specialist which will be seen on all explanation of benefits and correspondence from the insurance company. During patient care, the benefit levels that will be utilized on insurance plans are the specialist and physical therapy benefits.

By signing this acknowledgement, the patient understands the billing practices for Breathing Center of Houston.

Patient Signature: _____ **Date:** _____

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.

Breathing Center of Texas uses health information about you for treatment, to obtain payment for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health
Information is contained in a medical record that is the physical property of Breathing Center of Houston.
How we may use or disclose your health information
For Treatment: We may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider such as a physician, therapist, nurse or other person providing health services to you will record information in your record related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond.
For Payment: We may use and disclose health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations: We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to members of the medical staff, risk or quality improvement personnel, and others to:

- •Evaluate the performance of our staff;
- •Assess the quality of care and outcomes in your case and similar cases;
- •Learn how to improve our facilities and services;
- •Determine how to continually improve the quality and effectiveness of the health care we provide.

Appointments: We may use your information to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Required by Law: We may use and disclose information about you as required by law. For example, we may disclose information for the following purposes:

- •For judicial and administrative proceedings pursuant to legal authority;
- •To report information related to victims of abuse, neglect or domestic violence;
- •To assist law enforcement officials in their law enforcement duties.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities. Health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law. Health information may be disclosed to funeral directors or coroners to enable them to carry out their lawful duties.

Government Functions: Your health information may be disclosed for specialized government functions such as protection of public official or reporting to various branches of the armed services.

Workers' Compensation: Your health information may be used or disclosed in order to comply with laws and regulation related to Workers' Compensation.

Other uses: Other uses and disclosures will be made only with your written authorization and you may revoke the authorization except to the extent our facility has taken in reliance on such.

Your Health Information Rights: You have the right to:

- • Request a restriction on certain uses and disclosures or you information proved by 45 C.F.R. § 164.522; however, our facility is not required to agree to a requested restriction;
- •Obtain a paper copy of the notice of information practices upon request;
- •Inspect and obtain a copy of your health record as provided for in 45 C.F.R. § 164.524;
- •Request that your health record be amended as provided in 45 C.F.R. § 164.526;
- •Request communications of your health information by alternative means or at alternative locations;
- •Receive an accounting of disclosures made of your health information as provided by 45 C.F.R. § 164.528.

Concerns / Complaints: You may complain to our facility and / or to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a concern. To register a concern with our facility, please contact the Administrator to complete and return a Patient Concern Form to our facility.

Our Obligations: Our facility is required by law to:

- • Maintain the privacy of protected health information;
- • Provide you with this notice of its legal duties and privacy practices with respect to your health information;
- • Abide by the terms of this notice;
- • Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed;
- • Accommodate reasonable request you may make to communicate health information by alternative means or at alternative locations.

This office reserves the right to change information practices and to make the new provisions effective for all protected health information it maintains. Revised notices will be made publicly available and posted at the facility.

PATIENT AGREEMENT

I consent to the procedures, which may be performed during the duration of this outpatient treatment, including emergency treatment. I understand that if I fail to carry out the follow¬-up medical care, I do so at my own risk.

I understand that those individuals who attend to patients at this facility may include licensed medical personnel, Physical Therapist, Occupations Therapist, and other healthcare personnel in training who, unless requested otherwise, may be present during patient care or may provide care as part of their education.
I also understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls, and other similar injuries, and that the only alternative to entirely avoid these risks would be to forego rehabilitation all together.

Passive Modalities
Passive modalities consist of the following treatments: hot packs, cold packs, ultrasound electrical stimulation, massage, traction, and paraffin.

The primary risk associated with passive modalities is skin irritation due to exposure to heat, cold or agents used in the application of modalities, i.e. lotions, pads, and paraffin). If you have experienced skin sensitivity to heat, cold temperatures, and/or lotions or similar products in the past or are aware of any skin allergies, please inform our staff prior to treatment so proper precautions can be made prior to initiating treatment.

Therapeutic Interventions
Therapeutic interventions consist of the following types of treatments: stretching, flexibility exercises, strengthening exercises, joint mobilizations and myofascial release.

Therapeutic interventions are generally quite safe though there are risks associated with each of these procedures. The primary risk is potential aggravation of your current condition and/or underlying condition. As with any physical activity and/or exercise there is also the risk of injury. Though this risk is minimal as you are under the direct supervision of experienced clinical staff, it may still exist.

Some responses to therapeutic interventions are muscle soreness, muscle fatigue, increased discomfort, overall tiredness and/or joint stiffness and/or pain. It is important that you inform your treating staff member of any of these responses following your treatment and more importantly it is crucial that you continue to attend your appointments as scheduled so your condition can be documented and your symptoms effectively managed.

Patient Understanding and Acceptance Of Risks Associated With Treatment

As your doctor it is our responsibility to inform you of the potential risks and benefits of your treatment, but we also want to assure you that we strive to minimize these risks by providing thorough clinical examination and by performing diagnostics as clinically indicated. Furthermore, we continually review medical literature pertaining to current trends within our profession as well as throughout the entire medical community to ensure the safest and most effective care.
I have reviewed the information provided regarding the benefits and risks of treatment provided at The Breathing Center of Houston. I have been given the opportunity to discuss my questions and/or concerns and by signing below I acknowledge that I understand and accept the risks associated with my treatment.

Patient Signature: _____ Date: _____

New Patient History

Has your doctor given you a medical diagnosis related to your lungs/breathing difficulty? ☐ YES ☐ NO

If YES, please list your medical diagnosis here: _____

To the best of your memory, when did you receive this diagnosis? _____

When did you first begin having symptoms/problems related to your diagnosis? _____

Have you had a test/procedure related to your lungs or breathing in the past year? ☐ YES ☐ NO
(Examples: Pulmonary Function Test (PFT), Bronchoscopy, Lung Biopsy, Thoracentesis/Drain fluid off lungs, MRI, CT scan, X-ray, or other imaging of the lungs)

If YES, please list:_____

Are you currently in any type of clinical research study related to your lungs? ☐ YES ☐ NO

If YES, please list: _____

Are you currently being evaluated for, or are on a lung transplant list? ☐ YES ☐ NO

If YES, which hospital system is your transplant team affiliated with? _____

Have you been placed on the transplant list? ☐ YES ☐ NO

Other Medical or Surgical/Procedure History

Please list below, Include date of diagnosis, if known (If you aren't sure of the date, give approximate date).
(Please write "I don't know", or "None", if either are the case)

a) Other Pulmonary/Lung: _____
(Examples: Asthma, Pulmonary Hypertension, recent Pneumonia, Tuberculosis, Sleep Apnea)

b) Cardiac/Heart: _____
(Examples: prior Heart Attack/Coronary Artery Disease/Angina, Heart failure, Arrhythmia)

c) Orthopedic/Bone, Joint, Muscle or Tendon: _____
(Examples: Osteoarthritis, prior fracture, joint replacement surgery, torn muscle/tendon)

d) Spine Injury or Surgery to Neck, Mid-Back, Low-Back: _____
(Examples: Compression fracture, Herniated disk, Fracture, Degenerative changes, Laminectomy, Fusion)

e) Neurological/Brain/Nerve: _____
(Examples: Prior Stroke, Brain Injury, Dementia, Parkinson's, Spinal Cord Injury, Nerve damage, Migraines)

f) Psychiatric/Behavioral: _____
(Examples: Depression, Anxiety-disorder, Prior Substance Abuse/Problem)

g) Gastrointestinal/Digestive System: _____
(Examples: Inflammatory Bowel Disease, Crohn's Disease, Ulcerative Colitis)

h) Renal/Kidney: _____
(Example: Chronic Kidney Disease, End-Stage Renal Disease)

i) Eyes, Ears, Nose, or Throat: _____
(Example: Any loss of reduction in vision, hearing, or speech, Chronic Sinus Problems)

j) Hematological/Blood: _____
(Examples: Anemia, Sickle Cell Disease, Record of other abnormal blood test results)

k) Integumentary/Skin Diseases: _____
(Examples: Scleroderma, Prior burn injury, Prior Skin Grafting, any existing wounds)

l) Oncological/Cancer:_____
(Include any active cancer, or previous cancer diagnosis)

m) Immune System Diseases: _____
(Examples: HIV(+)/AIDS, Chronic Fatigue Syndrome, Sarcoidosis, Rheumatoid Arthritis, Psoriasis)

n) Endocrine/Metabolic Diseases: _____
(Examples: Diabetes insipidus, Diabetes mellitus; Thyroid disorders, Cushing's Syndrome)

o) Lymphatic System Disorders:_____
(Example: Lymphedema)

PLEASE LIST ANY PRIOR SURGICAL PROCEDURES BELOW (WITH DATES) TO THE BEST OF YOUR MEMORY

Surgery	Date

Home Health Episode/ Previous Treatment

Are you currently seeking any type of treatment from a home health agency? ☐ YES ☐ NO

If yes what is the agency's name: _____ Phone _____ Contact _____

Are you being visited by a nurse at your home at this time? ☐ YES ☐ NO

Does anyone come to your home to provide any type of assistance to you? ☐ YES ☐ NO

Have you had any type of home assistance within the last 6 months? ☐ YES ☐ NO

Have you received benefits from a home health agency in the past? ☐ YES ☐ NO

If yes provide dates: _____

Previous Treatment/ History

History of smoking? ☐ YES ☐ NO

If YES, what age or year at did you start smoking? _____

Age or year at which you quit smoking? _____

Average/typical number of packs per day you smoked during that time? _____

Do you have a history of environmental/occupational exposure to the lungs? ☐ YES ☐ NO

If YES, what type of exposure? (Include dates):_____

Do you use supplemental oxygen at any point in the day or night? ☐ YES ☐ NO

If YES, circle which oxygen delivery systems you own or rent?

☐ Home concentrator ☐ Portable Concentrator ☐ Large Tanks ☐ Mini-Tanks ☐ CPAP

☐ Continuous regulator ☐ Pulsed/On demand system

Please estimate what percent of the day you use oxygen: _____

What oxygen flow rates do you use: (1) At rest: _____ (2) With exertion: _____

Occupational History

I am currently: ☐ Employed ☐ Unemployed ☐ Retired ☐ On Disability

What is your current (or former) occupation? _____

Are you currently (or previously) being treated by any of the following healthcare professionals?

☐ Physical Therapist ☐ Chiropractor ☐ Dietitian/Nutritionist ☐ Smoking Cessation Program

☐ Psychologist/Psychiatrist/Mental Health Professional

Other? _____

Exercise/Physical Activity/Sport History

Have you ever participated in a formal exercise program? ☐ YES ☐ NO

If YES, have you ever worked with an exercise professional or personal trainer? ☐ YES ☐ NO

Did you exercise at ☐ Home ☐ Outdoors ☐ Gym

Which of the following types of exercise(s) have you previously or currently engaged in:

Aerobic exercise/Cardio? ☐ YES ☐ NO If yes, how often? _____

Strength training/Lifting weights? ☐ YES ☐ NO If yes, how often? _____

Stretching/Yoga? ☐ YES ☐ NO If yes, how often? _____

Other exercise? ☐ YES ☐ NO If yes, how often? _____

HAVE ANY OF YOUR PHYSICIANS GIVEN YOU ANY PHYSICAL ACTIVITY/EXERCISE PRECAUTIONS/LIMITATIONS?

☐ YES ☐ NO If yes, describe: _____

Medication list

(We simply ask it to be brought in so that it may be scanned into the system) Prescription, Over-The-Counter, Herbals, and Supplements

Pain

Are you currently experiencing PAIN as a result of an injury, surgery, chronic condition, other reason? ☐ YES ☐ NO

If YES, is this chronic pain? ☐ YES ☐ NO

How are you currently managing your pain? ☐ Ignore the pain/Tolerate it ☐ Medication ☐ Hot/Cold Pack

☐ TENS ☐ Massage ☐ Acupuncture

Below, describe the Location/region of your pain (including which side of the body) and please rate the severity/ intensity of the pain today, or recently FROM 0-10 (0=NO PAIN, 10=EXTREME)

Pain site	Severity/Intensity:	AT WORST	NOW	AT BEST
1. _____		_____	_____	_____
2. _____		_____	_____	_____
3. _____		_____	_____	_____

*** If there is more information regarding pain, please notify your physical therapist ***

Fall History

*** Includes "any UNPLANNED loss of balance to the ground, into a wall, or other object with, or without, injury" ***

Considering the above, have you ever fallen? ☐ YES ☐ NO

If YES, how many times? _____ Were you injured? ☐ YES ☐ NO

Have you ever been diagnosed with any of the following medical conditions?

☐ Orthostatic hypotension (Low blood pressure upon sitting or standing) ☐ Vertigo

☐ Other balance-related disorder? Please list:_____

Medical Equipment

Do you own, rent, or use any medical equipment? ☐ YES ☐ NO

☐ If YES, please list:_____

For mobility/walking? _____
(Examples: wheelchair, rollator, walker, cane)

For any of your activities of daily living? _____
(Examples: elevated toilet seat, bedside commode, reacher)

Do you use an orthotic or prosthetic device? ☐ YES ☐ NO If yes, please list: _____
(Examples: ankle-foot orthosis, prosthetic limb)

MRC Dyspnea Scale

Please circle the number that best describes your condition:

0 Breathless only with strenuous exercise.
1 Short of breath when hurrying on the level or walking up a slight hill.
2 Slower than most people of the same age on the level because of breathlessness or have to stop for breath when walking at my own pace on the level.
3 Stop for breath after walking about 100 meters or after a few minutes at my own pace on the level.
4 Too breathless to leave the house or I am breathless when dressing

Lastly, please share with us what your personal goals for participating in our program:

_____

_____

_____

RoBE Breathing Disorders Self-Effi cacy Scale.

This questionnaire considers how controllable your symptoms are. It provides information helpful for focusing your treatment on what would be useful for you. There are no good/bad or right/wrong answers. Circle the number that best describes how confi dent you feel for each statement.

		1	2	3	4	5	6	7	8	9
The guidelines for the numbers are:		**Not at all confident**								**Very confident**
How confident are you that you can:										
1.	do the tasks you need to without being affected by your symptoms	1	2	3	4	5	6	7	8	9
2.	talk without being affected by your symptoms	1	2	3	4	5	6	7	8	9
3,	enjoy recreational activities without being affected by your symptoms	1	2	3	4	5	6	7	8	9
4.	feel calm and achieve a good breathing pattern when you want to	1	2	3	4	5	6	7	8	9
5.	identify what triggers your symptoms	1	2	3	4	5	6	7	8	9
6.	improve your symptoms with what you do	1	2	3	4	5	6	7	8	9
7.	manage your symptoms (without introducing medication) in the future	1	2	3	4	5	6	7	8	9
8.	go into siutations that might bring on your symptoms, and still control these symptoms	1	2	3	4	5	6	7	8	9
9.	improvements you make by improving your breathing will be useful and valuable	1	2	3	4	5	6	7	8	9
10.	persist at improving your breathing pattern, even on bad days or when it is difficult	1	2	3	4	5	6	7	8	9

Mood:

My mood today	1	2	3	4	5	6	7	8	9
	Very low								Very positive
My mood over the last 6 months (generally)	1	2	3	4	5	6	7	8	9
	Very low								Very positive

The Nijmegen Questionnaire

The Nijmegen questionnaire gives a broad view of symptoms associated with dysfunctional breathing patterns. It is only a preliminary guide to breathing training.

Please ring the score that best describes the frequency with which you experienced the symptoms listed

Symptom	Never	Seldom	Some-times	Often	Very often
Chest pain	0	1	2	3	4
Blurred vision	0	1	2	3	4
Dizziness	0	1	2	3	4
Confusion or loss of touch with reality	0	1	2	3	4
Fast or deep breathing	0	1	2	3	4
Shortness of breath	0	1	2	3	4
Tightness across chest	0	1	2	3	4
Bloated sensation in stomach	0	1	2	3	4
Tingling in fingers and hands	0	1	2	3	4
Difficulty breathing or taking deep breaths	0	1	2	3	4
Stiffness or cramps in fingers and hands	0	1	2	3	4
Tightness around the mouth	0	1	2	3	4
Cold hands or feet	0	1	2	3	4
Palpitations in the chest	0	1	2	3	4
Anxiety	0	1	2	3	4
Totals					

Grand Total Score

A grand total score of over 20 indicates significant hyperventilation.
A grand total score of between 10 and 20 suggests mild hyperventilation.
If your score is under 10 your breathing may not be causing you any serious health problems. However with any score over zero you should do the other checks on your breathing.