Arizona Pulmonary Specialists, Ltd.
ENDOCRINOLOGY DIVISION
9700 N. 91st Street, Suite A200, Scottsdale, AZ 85258
480-614-2000/ FAX 480-614-1751

Welcome to Arizona Pulmonary Specialists, Ltd.! Thank you for utilizing our website and choosing us for your health care needs. Dr. Sawalha looks forward to meeting you.

Please read our forms thoroughly. As a reminder, you must arrive in our office 30 minutes before your appointment time with your new physician. Time with the physician has been reserved for you and is valuable. If you are unable to keep this appointment for any reason, we require that you provide us with 48 hours notice to avoid a charge of $300. Unfortunately, we will be unable to reschedule your appointment until that charge is paid.

Our physicians prefer that you print our new patient forms and complete them in ink rather than completing them online. Please be sure you are filling out the Scottsdale forms if you have an appointment at the Scottsdale office. Our office and the Phoenix office do not use the same forms.

When checking in to the office, please present:

- ❑ Your insurance card(s), your photo ID, and your referral (if applicable).
- ❑ Your **completed forms**: demographic form, office policy agreement, new patient questionnaire (all pages please) and physicians involved in your care form. **Any forgotten or incomplete forms will require that we reschedule your appointment.**
- ❑ Your most recent thyroid or adrenal scan if you have had one done. **If so, it is imperative that we have your x-ray or CT disc in the office at the time of your appointment.** If imaging was done at SMIL (Scottsdale Medical Imaging) films/discs are not needed.
- ❑ **Pharmacy phone number and a complete list of your current medications** including prescription and nonprescription medications as well as their dosages and frequency. **Please note: an accurate med list is required at every office visit.**
- ❑ Your blood sugar log book and your glucose meter (if applicable).
- ❑ Your copayment, if applicable. We accept VISA , Mastercard, Discover, and American Express as well as checks and cash.

Every patient is different. The length of time it takes to complete your medical care is individualized based on **your** needs. Please understand that we make every effort to see you at your appointed time; however, **delays do occur**. We appreciate your patience.

We look forward to seeing you! Welcome to our practice!

ARIZONA PULMONARY SPECIALISTS, LTD.
9700 N. 91ST STREET, SUITE A200
SCOTTSDALE, ARIZONA 85258

SASSIA BRAVE, M.D.
ADITYA GUPTA, M.D.
MICHAELA LESSLER, M.D.
JORIDA LULAJ, FNP-BC
EWA LUPA-LASKUS, M.D.
BRIDGETT RONAN, M.D.
JONATHAN D. RUZI, M.D.
FIDA SAWALHA, M.D. endocrinologist
HEEMESH SETH, D.O.
LAWRENCE SLAMA, M.D.

PATIENT'S NAME _____ SOCIAL SECURITY # ___/___/___
last first middle initial

BIRTHPLACE _____ BIRTH DATE ___/___/___ AGE _____ SEX ☐ M ☐ F
month day year

HOME ADDRESS _____
number street apt city state zip code

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____ MARITAL STATUS _____

EMPLOYED BY _____ OCCUPATION _____

EMPOYER'S ADDRESS _____

AT WHICH NUMBER MAY WE LEAVE A MESSAGE? ☐ HOME ☐ WORK ☐ CELL ☐ NONE

NAME OF SPOUSE _____ BIRTH DATE ___/___/___ AGE _____
month day year

CLOSEST RELATIVE (other than spouse) IN CASE OF EMERGENCY:

NAME _____ RELATIONSHIP _____ PHONE _____

WITH WHOM MAY THE DOCTOR DISCUSS YOUR MEDICAL CONDITION?

_____ _____ _____ _____
name relationship name relationship

REFERRED BY _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____ GROUP NAME _____

NAME OF INSURED _____ RELATIONSHIP _____

SUBSCRIBER OR CERTIFICATE NUMBER _____ GROUP NUMBER _____

BILLING ADDRESS _____

CITY, STATE, & ZIP CODE _____

SECONDARY INSURANCE COMPANY _____ GROUP NAME _____

NAME OF INSURED _____ RELATIONSHIP _____

SUBSCRIBER OR CERTIFICATE NUMBER _____ GROUP NUMBER _____

BILLING ADDRESS _____

CITY, STATE, & ZIP CODE _____

*** I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES OF ARIZONA PULMONARY SPECIALISTS, LTD. I HEREBY AUTHORIZE ARIZONA PULMONARY SPECIALISTS, LTD., OR ITS APPOINTED AGENTS, TO FURNISH INFORMATION TO INSURANCE CARRIERS OR OTHER 3RD PARTY PAYORS CONCERNING MY ILLNESS AND TREATMENT, TO INCLUDE REVIEW ACTIVITIES RELATED TO MY PHYSICIAN'S PARTICIPATION WITH MY HEALTH PLAN. I FURTHER AUTHORIZE MY INSURANCE CARRIER TO PAY DIRECTLY TO SAID PHYSICIAN GROUP ALL MEDICAL AND SURGICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY, AS PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY, IN A CURRENT MANNER, ANY BALANCE OF SAID PROFESSIONAL SERVICE CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS EFFECTIVE AND VALID AS THE ORIGINAL.*

SIGNATURE _____ DATE _____

Office Policies

FINANCIAL POLICY:

Please bring your insurance card to each visit. If your insurance changes, please confirm that we are contracted with your new plan. If your insurance requires a copayment for office services, it is due at the time of service. NO EXCEPTIONS. We accept cash, checks and credit cards (VISA, Mastercard, Discover, American Express). Your appointment may be cancelled if you are unable to pay your copay upon arrival.

If your insurance requires an authorization or a referral, it is **your** responsibility to be aware of this and obtain the referral from your primary care physician. If a referral has not been received 48 hours prior to your appointment, your appointment will be cancelled or rescheduled.

CANCELLATION POLICY:

Patients are seen by appointment only. When you schedule an appointment with one of our specialists, that time is reserved for YOU. When you fail to show or cancel at the last minute, it is not only a financial loss to the practice, but it is a time slot we could have given to another patient, perhaps someone who was sick and needed to be seen. For this reason, if you are a new patient and cancel with less than 48 hours notice, you will be charged a $300 fee and your appointment may not be rescheduled. If you are an existing patient and fail to appear for your appointment or you cancel or reschedule with less than 24 hours notice, we will assess a $50 fee to your account.

REFILLS AND AFTER HOURS CALLS:

The physician on call is caring for our critically ill patients in the hospital and cannot always respond promptly. He/she is unable to handle many matters over the phone. If you have a life-threatening issue, please call 911. Calls of a non-urgent nature should be made during normal business hours which are 9am-12pm or 1pm-4:30pm Monday through Friday. If you are an existing patient and you are sick, please call our office as early as possible. We will make every effort to accommodate you. **Refills are handled during office hours only**. Please have your pharmacy contact us by phone or fax. Allow 2 business days for your request to be filled and longer if the medication requires prior authorization from your insurance carrier. **The doctor on call will not authorize refills at night or on the weekend.** Please call your primary care physician.

SWITCHING DOCTORS:

If you have a specific request for a particular physician at Arizona Pulmonary Specialists, Ltd., you must tell us when scheduling your first office visit. Every attempt will be made to accommodate your request at that time. In order to maintain continuity of care, avoid opinion shopping within the practice, and provide seamless care to you if you are hospitalized, subsequent requests for switching doctors will generally be denied. All physicians at Arizona Pulmonary Specialists, Ltd. are experienced in the practice of pulmonary medicine and all deliver the highest quality care to our patient population.

STANDARDS OF CONDUCT:

At Arizona Pulmonary Specialists, Ltd., we embrace a culture of service delivered in an atmosphere of respect, civility and empathy. These values are expected of everyone including physicians, staff, patients, and families. Failure by our staff to follow this policy will result in corrective action and potential loss of employment. Offensive or demeaning behavior by a patient or family member toward our staff or physicians will result in our withdrawal from a patient's medical care.

FORMS:

Your primary care physician is the best resource to complete forms including but not limited to FMLA, disability, etc. Physicians at APS reserve the right to charge a $40/page fee (paid in advance) for form completion.

Your signature below signifies your understanding and willingness to comply with these office policies as well as the Arizona Pulmonary Specialists, Ltd. Privacy Policy.

_____/_____ _____/_____/_____

Patient or Responsible Party Signature/ Print name please Date

ARIZONA PULMONARY SPECIALISTS, LTD.
Endocrinology Division, New Patient Questionnaire
Fida Sawalha, M.D.

Name:	DOB:
Referring doctor:	PCP:
Reason for visit:	

Medications & supplements: **Pharmacy Name:** **Phone:**

Drug name	Dose	How many x a day	Started

Allergies:

1.	**3.**	**5.**
2.	**4.**	**6.**

Past Medical Conditions

☐diabetes	☐neurologic disorder	☐thyroid tumor/mass
☐high cholesterol	☐obesity	☐thyroid problems
☐pancreas tumor/mass	☐celiac disease	☐parathyroid problems
☐pituitary tumor/mass	☐high blood pressure	☐menstrual cycle issues
☐kidney stones	☐adrenal tumor/mass	☐osteoporosis
☐heart attack	☐prostate problems	☐PCOS

☐head and neck radiation

Prior surgeries:

1.	**3.**	**5.**
2.	**4.**	**6.**

Recent hospitalizations:

1.
2.
3.

Recent imaging & location it was done:

1.	**3.**
2.	**4.**

Family History:	**Relation**	**Age of onset / death**
Diabetes mellitus		
Stroke		
Heart disease		
Heart attack		
Hypertension		
Pancreatic tumor/cancer		
Pituitary tumor / cancer		
Thyroid tumor/ cancer		
Cancer		
Parathyroid/ calcium problem		
Celiac disease		
Drug abuse		
Alcohol abuse		
Premature menopause		
Osteoporosis		
Hip fracture		
Thyroid disease		
Iron overload disease		
Seizures		
High cholesterol		
Obesity		

Social History:

Have you ever smoked? ☐yes ☐no How many packs a day?_____
At what age did you begin? _____ At what age did you quit? _____
How often do you drink alcohol? _____ What kind?_____How many?_____
Are you married? _____ How long?_____
Is someone living with you? _____ How long?_____
Do you have children? _____ How many?_____
Do they live in Arizona? _____
How long have you lived in Arizona? _____
What kind of work do/did you do? _____
Your spouse? _____
Do you have any pets? _____ What kind? _____
Have you traveled in the past year outside of the southwest? _____

Previous history of steroid use (oral, injections, inhaled, topical):

_____

_____

_____

Previous history of chronic pain medications:

_____

_____

_____

General		
☐fever	☐chills	☐fatigue
☐night sweats	☐difficulty w/ sleep	☐snoring
☐weight gain	☐weight loss	☐how much_____
Eyes		
☐blurry vision	☐double vision	☐burning in eyes
Ear/ nose/ throat		
☐food gets stuck	☐choking with food	☐hoarse voice
Respiratory		
☐chronic cough	☐short of breath	☐wheezing
Gastrointestinal		
☐abdominal pain	☐nausea	☐vomiting
☐diarrhea	☐heartburn	☐ constipation
☐blood in stool	☐bloating	
Kidney		
☐difficulty w/ urination	☐kidney stones	☐blood in urine
☐frequent urination		
Genital -women		
☐irregular periods	☐no period	☐lack of sex drive
☐infertility	☐children_____	☐miscarriages_____
☐1st menstrual period___	☐last menses	☐breast mass ☐nipple discharge
Genital-men		
☐enlarged breasts	☐lack of sex drive	☐infertility
☐problems with erection	☐bumps on testicles	
Skin		
☐rash	☐acne	☐purple/red stretch marks
☐hair loss	☐excessive hair growth	
Musculoskeletal		
☐muscle weakness	☐thin bones	☐painful joints
Neurological		
☐frequent headaches	☐tremor	☐feet burning/ numbness
☐poor memory	☐dizziness	☐spinning sensation
Endocrine		
☐excessive urination	☐excessive thirst	☐change in shoe/ring size
☐hot flushes	☐mood swings	☐hungry all the time
☐thirsty all the time	☐heat intolerance	☐cold intolerance
☐increased sweatiness	☐dry skin/hair	☐increased thirst
Hematologic		
☐easy bruising	☐enlarged lymph nodes	
Psychiatric		
☐depression	☐anxiety	
Cardiovascular		
☐chest pain	☐palpitations	

This entire questionnaire was reviewed with the patient. DATE:_____SIG:_____

ARIZONA PULMONARY SPECIALISTS, LTD.
Fida Sawalha M.D.
Endocrinology, Diabetes and Metabolism

Patient name _____ Date of birth _____

If you have diabetes, please complete this form prior to your appointment.
Diabetes Type: _____ Initial diagnosis date: _____

How was it first diagnosed? _____

Brand name of the glucometer you use: _____

Please list all Diabetes medications including insulin with the exact dose and time of the day that it is taken:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

If you use insulin: Do you use an insulin vial or insulin pen: _____

If you are using an insulin pump: Please list brand/model _____

If you use injections do you rotate the site of injection? Y N

Do you wear a medical alert bracelet? Y N
Do you have glucagon at home? Y N
Do you have sugar raising supplies in the car? Y N
Do you check your feet regularly? Y N
List the date of your last eye doctor's appointment: _____
Do you have any history of diabetic ketoacidosis? Y N If so when was the last? _____
Do you have any history of severe hypoglycemia? _____
Do you have any history of hospitalization for severe low or high blood sugar? When and where?_____

Any recent blood sugars below 80 in the last 6 weeks? _____

Most likely time of the day to have a low sugar? _____

Have you ever seen a Diabetic Educator/ Nutritionist: Y N
If yes, who was it and when was the last time: _____
Last podiatry exam _____
Do you have a history of neuropathy? Y N
Do you have a history of foot ulcers? Y N
Do you have a history of stroke Y N
Do you have a history of coronary artery disease? Y N
Do you have a history of peripheral vascular disease? Y N

ARIZONA PULMONARY SPECIALISTS, LTD.

Patient Name: _____

Date of Birth: _____

Physicians involved in my care

Physician: _____
Specialty: _____
Address: _____
_____
Phone: _____

Physician: _____
Specialty: _____
Address: _____
_____
Phone: _____

Physician: _____
Specialty: _____
Address: _____
_____
Phone:

Physician: _____
Specialty: _____
Address: _____
_____
Phone:

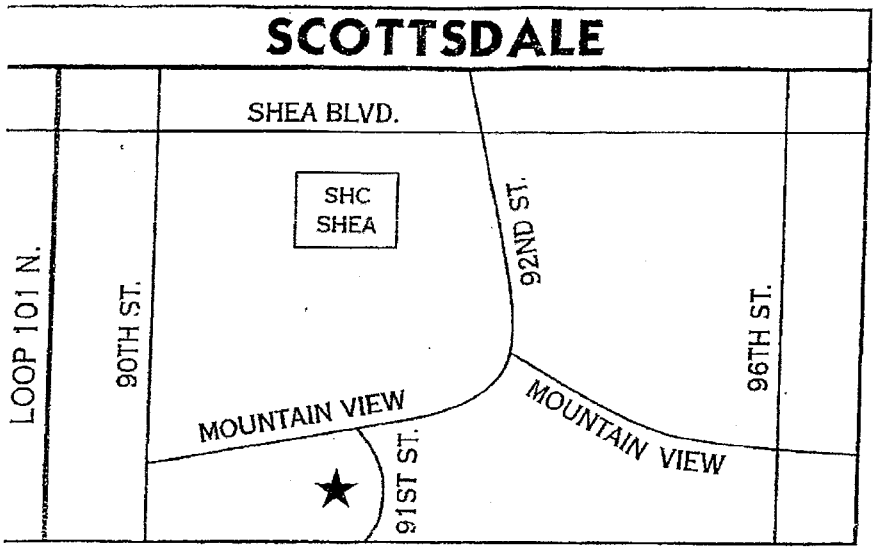
Physician: _____
Specialty: _____
Address: _____
_____
Phone:

Physician: _____
Specialty: _____
Address: _____
_____
Phone:

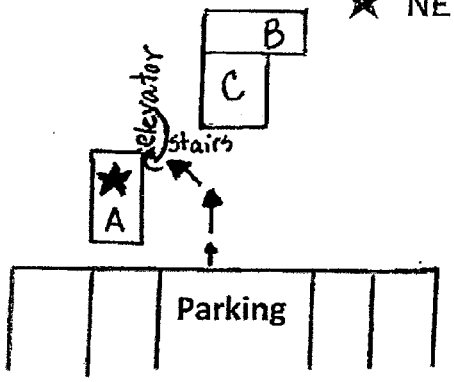
Physician: _____
Specialty: _____
Address: _____
_____
Phone:

Physician: _____
Specialty: _____
Address: _____
_____
Phone:

9700 N. 91st Street
Suite A 200
Scottsdale, AZ 85258
PH: 480-614-2000



★ NEW OFFICE



Directions from the East or South part of the Valley:

101 North
Exit **#42, Pima/90th Street**
Merge onto North 90th St., **to the right**
Right on Mountain View
Right on 91st St.

Directions from the North or West:

101 South
Exit **#41 Shea Blvd, slight left** onto Shea
Right on 90th Street
Left on Mountain View
Right on 91st St.

Turn into **Mountain View Medical Plaza** (your first **right**)
Immediately go **left** once you enter into the parking lot
Building A is the last building on your **right**
Park in **"Arizona Pulmonary"** designated spaces or any open spaces
Walk to the **center of the courtyard** and proceed to the **elevator**
The elevator is located directly behind the stairs
Our second floor suite is on your left as you exit the elevator.

See you soon!

ARIZONA PULMONARY SPECIALISTS, LTD.

Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

ARIZONA PULMONARY SPECIALISTS, LTD.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Medical Records Department at Arizona Pulmonary Specialists, Ltd., at the office address. You may call the office for more information.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Arizona Pulmonary Specialists, Ltd., at the office address. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Officer at Arizona Pulmonary Specialists, Ltd. at the practice address. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.