ARIZONA PULMONARY SPECIALISTS, LTD

Hello, and welcome to Arizona Pulmonary Specialists, Ltd. You are scheduled to see _____ on _____ at _____.
Please plan to arrive 30 minutes prior to this time. **If you are unable to keep this appointment for any reason, we require that you provide us with at least 24 hours advance notice. We require a working telephone number to confirm your appointment. If we are unable to speak with you to confirm your appointment, we will assume you no longer require to be seen and your appointment will be assigned to a different patient. <u>We reserve the right to charge for appointments missed or cancelled within 24 hours!!</u>**

Our address is:

9060 E Via Linda, Suite 250
Scottsdale, AZ 85258
Phone: (480) 614-2000
Fax: (480) 614-1751

Please bring the following items with you:

- ❑ The Patient Registration form, Medical History and Pulmonary Questionnaire completed (attached)
- ❑ Your most recent chest x-rays, films or disc, unless other arrangements have been made
- ❑ Your insurance card(s)
- ❑ A list of your current medications including dosages
- ❑ Your copayment, if applicable (we accept all major credit cards as well as cash or check)
- ❑ Any pertinent medical records
- ❑ Any recent lab results

If you have any questions about your appointment, what you need to bring, or need specific directions, please call our office at (480) 614-2000, during normal business hours, which are Monday through Friday, 9:00 AM to noon and 1:00 PM to 4:30 PM. We look forward to seeing you!

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.

CHECKED PATIENTS PHOTO ID ☐

ARIZONA PULMONARY SPECIALISTS, LTD

PATIENT'S NAME _____ ***DATE*** _____
last first m.i.

BIRTHPLACE _____ BIRTH DATE _____ SEX ☐M ☐F AGE _____

HOME ADDRESS _____
number street apt # city state zip code

HOME # _____ CELL# _____ WORK # _____

PRIMARY LANGUAGE: _____SOCIAL SECURITY # _____MARITAL STATUS _____

EMPLOYED BY _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____ BUS. PHONE _____

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

EMAIL ADDRESS: _____

NAME OF SPOUSE _____ AGE _____ BIRTH DATE _____

SOC.SEC.# _____BUS. PHONE _____

EMPLOYED BY_____OCCUPATION_____

EMPLOYER'S ADDRESS _____

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

NAME_____RELATIONSHIP_____PHONE_____

ADDRESS _____
number street city state zip code

WITH WHOM MAY THE DOCTOR DISCUSS YOUR MEDICAL CONDITION?

_____ _____ _____ _____
name relationship name relationship

REFERRED BY: _____

PRIMARY CARE PHYSICIAN_____Phone: _____

PHARMACY:_____ Phone: _____

BY PROVIDING THE ABOVE INFORMATION I AUTHORIZE ARIZONA PULMONARY SPECIALISTS, LTD, ITS EMPLOYEES OR ITS APPOINTED AGENTS TO CONTACT ME REGARDING MY CARE. 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**_____

ARIZONA PULMONARY SPECIALISTS, LTD.

INSURANCE INFORMATION

(TO BE COMPLETED ONLY IF YOU DO NOT HAVE YOUR INSURANCE CARDS)

PATIENT NAME: _____

DOB: _____

MEDICARE NUMBER _____

PRIMARY INSURANCE COMPANY _____

NAME OF INSURED _____ RELATIONSHIP _____

BILLING ADDRESS _____

CITY, STATE, & ZIP CODE _____ GROUP NAME _____

SUBSCRIBER OR CERTIFICATE NUMBER _____ GROUP NUMBER _____

SECONDARY INSURANCE COMPANY_____

NAME OF INSURED _____ RELATIONSHIP _____

BILLING ADDRESS _____

CITY, STATE, & ZIP CODE _____ GROUP NAME _____

SUBSCRIBER OR CERTIFICATE NUMBER _____ GROUP NUMBER _____

OTHER INSURANCE _____

NAME OF INSURED _____ RELATIONSHIP _____

BILLING ADDRESS _____

CITY, STATE, & ZIP CODE _____ GROUP NAME _____

SUBSCRIBER OR CERTIFICATE NUMBER _____ GROUP NUMBER _____

ARIZONA PULMONARY & MEDICAL SPECIALISTS

INFECTIOUS DISEASE

NAME: _____ DOB_____ AGE____ Date:_____

MEDICAL HISTORY

Reason for your Visit (Present Illness)

_____

_____

_____

_____

_____

Past Medical History: If you answered yes below, when diagnosed?

High Blood Pressure	Yes	No	_____	
Diabetes	Yes	No	_____	
Asthma	Yes	No	_____	
Tuberculosis	Yes	No	_____	
Lung Disease	Yes	No	_____	
Heart Disease	Yes	No	_____	
Heart Murmer	Yes	No	_____	
Increased Lipids	Yes	No	_____	
Kidney Disease	Yes	No	_____	
Arthritis	Yes	No	_____	
Seizures	Yes	No	_____	
Stroke	Yes	No	_____	
Infectious Diseases	Yes	No	_____	
Crohns Disease	Yes	No	_____	
Ulcerative Colitis	Yes	No	_____	
Cancer	Yes	No	_____	Type _____
Blood disorder	Yes	No	_____	Type _____
Thyroid Disease	Yes	No	_____	
Valley Fever	Yes	No	_____	
Venereal Diseases	Yes	No	_____	Type _____
Hepatitis A, B, C	Yes	No	_____	
Other			_____	

NAME: _____ DOB_____ AGE____ Date:_____

Past Surgical History

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

Past Hospitalizations

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

Social History

Smoking _____ Packs per day_____ week _____ month_____

Drinking _____ Amount ingested _____

Drug use Yes/No drug of choice_____

Pets _____ Type_____

Traveled in the past 6 months Yes/No where?_____

Do you eat raw meat or fish? Yes/No

Single/Married/Divorced/Widowed

Sexual Preference: Heterosexual/Same Sex/Bisexual

NAME: _____ DOB_____ AGE____ Date:_____

Review of Systems: If you answered yes to any of the questions below, please explain.

Fever	Yes	No	_____Degrees
Chills	Yes	No	_____
Night Sweats	Yes	No	_____
Weight loss or gain	Yes	No	How much? _____
Fatigue	Yes	No	_____
Headaches	Yes	No	_____
Seizures or convulsions	Yes	No	_____
Fainting or loss of Consciousness	Yes	No	_____
Dizziness	Yes	No	_____
Double Vision	Yes	No	_____
Sore throat	Yes	No	_____
Swollen Glands	Yes	No	_____
Runny Nose	Yes	No	_____
Nose Bleed	Yes	No	_____
Sinus Drainage	Yes	No	_____
Ear Ache	Yes	No	_____
Cough	Yes	No	_____
Sputum Productions	Yes	No	_____
Coughing up Blood	Yes	No	_____
Cough on Swallowing	Yes	No	_____
Shortness of Breath	Yes	No	_____
Chest Pain	Yes	No	_____
Palpitations	Yes	No	_____
Abdominal Pain	Yes	No	_____
Nausea	Yes	No	_____
Vomiting	Yes	No	_____
Vomiting Blood	Yes	No	_____
Constipation	Yes	No	_____
Reflux	Yes	No	_____
Diarrhea	Yes	No	_____
Blood in Stool	Yes	No	_____

NAME: _____DOB_____AGE____ Date: _____

Review of Systems (continued): If you answered yes to any of the questions below please explain.

Frequency of Urination	Yes	No	_____
Burning on Urination	Yes	No	_____
Blood in Urine	Yes	No	_____
Urethral Discharge	Yes	No	_____
Menstrual abnormalities	Yes	No	_____
Presently pregnant	Yes	No	_____
Menopause	Yes	No	_____
Joint Pain	Yes	No	_____
Joint Swelling	Yes	No	_____
Muscle Pain	Yes	No	_____
Muscle Weakness	Yes	No	_____
Decreased Sensation in Feet/hands	Yes	No	_____
Pain	Yes	No	_____

Medications and supplements:

Drug name	Dose	How many x a day	Started

Allergies:

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

Immunizations:

☐ Pneumonia _____ ☐ Flu _____

Date Date

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

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

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

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

FAMILY HISTORY

DATE: _____

PATIENTS NAME: _____ DOB:_____

CHECK **YES** IF YOUR FAMILY MEMBERS HAVE HAD ANY OF THE FOLLOWING:
(IF RECENTLY COMPLETED, PLEASE CHECK IF A CHANGE IN FAMILY HISTORY HAS OCCURRED)

DIAGNOSIS	FATHER	MOTHER	BROTHER	SISTER	CHILDREN	GRANDPRTS
ASTHMA	○	○	○	○	○	○
EMPHYSEMA	○	○	○	○	○	○
HEART ATTACK	○	○	○	○	○	○
HEART FAILURE	○	○	○	○	○	○
HYPERTENSION (SYSTEMIC)	○	○	○	○	○	○
STROKE SYNDROME	○	○	○	○	○	○
DIABETES MELLITUS	○	○	○	○	○	○
SLEEP APNEA	○	○	○	○	○	○
CANCER, NOS	○	○	○	○	○	○
CONNECTIVE TISSUE DISORDER	○	○	○	○	○	○
HEART DISEASE	○	○	○	○	○	○
LUNG DISEASE	○	○	○	○	○	○

NAME:_____ **DOB:** _____

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. 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 no referral has 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 fee and your appointment may not be rescheduled. If you are an existing patient and fail to appear for your appointment or cancel with less than 24-hour notice, we will assess a 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 8am-5:00pm 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 or you may request a refill through our portal. 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.**

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 Date