Arizona Pulmonary Specialists, Ltd.
9060 E Via Linda, Suite 250, Scottsdale, AZ 85258
480-614-2000 / Fax 480-614-1751

Hello and welcome to Arizona Pulmonary Specialists, Ltd. You are scheduled to see

_____ on _____ at _____.

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-hour advance notice. We require a working telephone number to confirm your appointment. We reserve the right to charge for appointments that have been missed or not cancelled within 48 hours.

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.**
- ☐ **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 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.
9060 E Via Linda, Suite 250
Scottsdale, Arizona 85258

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

BIRTHPLACE _____ BIRTHDATE _____ AGE _____ SEX ☐ M ☐ F

HOME ADDRESS _____
number street apt city state zip

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

EMAIL _____ MARITAL STATUS _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER'S ADDRESS _____

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

NAME OF SPOUSE _____ BIRTH DATE ___/___/___ AGE _____

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

_____ _____ _____
name relationship phone

WITH WHOM MAY THE DOCTOR DISCUSS YOUR MEDICAL CONDITION?

_____ _____ _____ _____
name relationship name relationship

REFERRED BY _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

PHARMACY _____ ADDRESS _____

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY _____ GROUP NAME _____

NAME OF INSURANCE _____ RELATIONSHIP _____

SUBSCRIBER OR CERTIFICATE NUMBER _____ GROUP NUMBER _____

BILLING ADDRESS _____

CITY, STATE, ZIP _____

INSURANCE INFORMATION

SECONDARY INSURANCE COMPANY _____ GROUP NAME _____

NAME OF INSURANCE _____ RELATIONSHIP _____

SUBSCRIBER OR CERTIFICATE NUMBER _____ GROUP NUMBER _____

BILLING ADDRESS _____

CITY, STATE, ZIP _____

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 PHYSICIANS 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 THE INSURANCE PAYMENT. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS EFFECTIVE AND VALID AS THE ORIGINAL.

SIGNATURE _____ DATE _____

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 hours 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

ARIZONA PULMONARY SPECIALISTS, LTD.

NEW PATIENT QUESTIONNAIRE

NAME _____ **DOB** _____ **AGE** _____ **DATE** _____

REASON FOR YOUR VISIT TODAY? _____

_____

How long has it been going on? _____

PAST MEDICAL PROBLEMS	**YES**	**NO**	**WHEN?**
Heart Problems	☐	☐	_____
Stroke	☐	☐	_____
Emphysema	☐	☐	_____
Asthma	☐	☐	_____
GERD	☐	☐	_____
Thyroid Disease	☐	☐	_____
Liver Problems	☐	☐	_____
Kidney Problems	☐	☐	_____
Arthritis	☐	☐	_____
Glaucoma	☐	☐	_____
Brittle Bones	☐	☐	_____
Cancer	☐	☐	_____
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Cholesterol	☐	☐	_____
Sleep Apnea	☐	☐	_____
Allergic Rhinitis	☐	☐	_____

MAJOR SURGERIES AND HOSPITALIZATIONS (Include year of illness/surgery)

_____

_____

_____

MEDICATION ALLERGIES _____

_____

PHARMACY NAME AND PHONE _____ **/** **( )** _____
(BOTH REQUIRED)

MEDICATIONS YOU ARE TAKING *(or attach a complete list including prescription and non-prescription medications)*

Name	Strength	Frequency	Name	Strength	Frequency

SOCIAL HISTORY

Have you ever smoked? ☐ Yes ☐ No

At what age did you begin? _____

At what age did you quit? _____

How many packs a day? _____

How often do you drink alcohol? _____ How many? _____

Are you married? ☐ Yes ☐ No How long? _____

Is someone living with you? ☐ Yes ☐ No How long? _____

Do you have children? ☐ Yes ☐ No How Many _____

Do they live in Arizona? ☐ Yes ☐ No

How long have you lived in Arizona? _____

What kind of work do/did you do? _____

What kind of work does/did your spouse do? _____

Do you have any pets? ☐ Yes ☐ No What Kind? _____

Have you traveled in the past year outside of the southwest? ☐ Yes ☐ No

If yes, where? _____

FAMILY HISTORY *(please note if deceased and age at death)*

	Mother	Father	Siblings	Children
Asthma	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Heart Attacks	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Strokes	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐
Cancer	☐	☐	☐	☐

Types of Cancer: _____

SLEEP QUESTIONS

What time do you typically GO to bed? _____ AM PM *(circle one)*

What time do you typically GET OUT of bed? _____ AM PM *(circle one)*

Do you snore? ☐ Yes ☐ No

Have you been told that you stop breathing when you sleep? ☐ Yes ☐ No

On average, how much of these beverages do you drink:

		During a typical day	Within 2 hours of bedtime
Coffee (caffeinated)	Cups	_____	_____
Starbucks (caffeinated)	Cups	_____	_____
Tea (caffeinated)	Cups	_____	_____
Soda (caffeinated)	Cups	_____	_____
Beer	Cups	_____	_____
Wine	Cups	_____	_____
Other alcoholic drinks	Cups	_____	_____

Are you presently using CPAP? ☐ Yes ☐ No If so what is the pressure? _____

EPWORTH SLEEPINESS SCALE

Rate the chance that you will doze off or fall asleep during the following routine daytime situations

0 = would never doze off	2 = moderate chance of dozing off
1 = slight chance of dozing off	3 = high chance of dozing off

SITUATION	CHANCE OF DOZING OFF (0-3)
Sitting & Reading	
Watching TV	
Sitting inactive in a public place *(ex: theatre or meeting)*	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch *(when you've had no alcohol)*	
In a car, while stopped in traffic	

REVIEW OF SYSTEMS

Have you had any of the following in the last 6 months *(check yes or no - if yes then circle answer)*

Constitutional:	☐ Yes	☐ No	Fever	Chills	Night Sweats	Unexplained weight loss	Loss of appetite
Eye:	☐ Yes	☐ No	Vision Changes	Cataracts	Double Vision		
ENT:	☐ Yes	☐ No	Hoarseness	Nasal Drip	Seasonal Allergies		
Respiratory:	☐ Yes	☐ No	Cough Sputum	Shortness of Breath	Coughing Blood		
Cardiac:	☐ Yes	☐ No	Chest Pain	Shortness of Breath When Lying Down			
GI:	☐ Yes	☐ No	Nausea	Vomiting	Diarrhea		
GU:	☐ Yes	☐ No	Painful Urination	Frequent Urination at Night - How Often: _____			
Endo:	☐ Yes	☐ No	Frequent Urination	Frequent Thirst			
Skin:	☐ Yes	☐ No	Rash				
Heme/Lymph	☐ Yes	☐ No	Abnormal Bleeding	Leukemia/Lymphoma	Hx of Blood Clots		
Neuro:	☐ Yes	☐ No	Vertigo	New Headaches	Seizures		
Musc/Skeletal:	☐ Yes	☐ No	Arthritis - what type? _____	Gout			
Infectious:	☐ Yes	☐ No	Ever Had a TB Skin Test?	Positive	Negative		

X-RAY

When was your last chest X-Ray? ____/____/____

Where was it taken? _____

Have you ever had a chest CAT Scan? ☐ Yes ☐ No

Where? _____

IMMUNIZATIONS

☐ Pneumovax

If yes, when? _____

☐ Flu

☐ Shingles

This entire questionnaire was reviewd with the patient. Comments as noted above.

☐ **Yes** ☐ **No**

PHYSICIAN SIGNATURE: _____ **DATE:** ____/____/____

NAME:_____ **DOB:** _____

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:

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 or 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.