Arizona
LUNG, SLEEP & VALLEY FEVER INSTITUTE

Patient Name: _____ Gender: Male Female (circle)

Primary Address _____
City State Zip

Alternate Address _____
(Summer) City State Zip

Primary Phone: _____ Alternate Phone: _____

Messages: I authorize any medical information regarding myself to be left on the following

Primary Phone Voicemail Secondary Phone Voicemail I do not authorize

DOB: ___/_____/_____ SSN: _____

Marital Status: Single Married Widow Divorced

Ethnicity: _____

Employer: _____ Occupation: _____ How Long? _____

Email Address: _____

Please note all no show/cancellation appointments LESS than 24 hours will be charged a $25.00 fee.

Emergency Contact _____ Relationship _____

Phone: _____ Pharmacy Name &Location_____

Primary Care Doctor: _____ Referring Physician: _____

Primary Insurance Company _____

Street Address _____ Phone: _____

ID# _____ Group# _____

Policy Holder's Name _____ Relationship to Patient _____ DOB _____

Policy Holder's Employer: _____ Phone: _____ SSN: _____

Secondary Insurance Company _____

Street Address _____ Phone: _____

ID# _____ Group# _____

Policy Holder's Name _____ Relationship to Patient _____ DOB _____

Policy Holder's Employer: _____ Phone: _____ SSN: _____

_____ _____
Responsible Party Signature Date

14961 WEST BELL ROAD · SUITE 175 · SURPRISE, ARIZONA 85374 · OFFICE 623.242.9832 · FAX 623.243.6733
www.azlungsleepvalleyfever.com

Arizona Lung, Sleep and Valley Fever Institute

Name: _____ Date: _____

Please answer the following questions. It will help the doctor to know not only about your health, but also about your family history.

What is your main medical problem and how long have you had it? _____

_____

_____

Family History:

Heart Disease	Father	Mother	Siblings	Child
Hypertension	Father	Mother	Siblings	Child
Stroke	Father	Mother	Siblings	Child
Cancer	Father	Mother	Siblings	Child
Diabetes	Father	Mother	Siblings	Child
Deceased	Father	Mother	Siblings	Child
Alive	Father	Mother	Siblings	Child

Drug Allergies: _____ **Reaction:** _____

Please circle any illnesses, which you have had:

Headache Tuberculosis Valley Fever Rheumatic Fever Asthma

Liver Diseases Shortness of Breath High Cholesterol High Blood Pressure Heart Attack

Congestive Heart Failure Dizziness/Fainting Bronchitis GU Disorder (Urinary) Ulcer

Stroke/TIA's Heart Palpations Prostate Disease COPD/Emphysema Arrhythmia Diabetes

Congenital Heart Disease Pneumonia GI Disorders Heart Murmur Hemoptysis Seizures Anemia

Allergies Arthritis TB Skin Testing Chest Pain/Angina

Cancer Type (if any): _____

Habits:

Smoking: Packs daily _____ **How Long?** _____ **When Stopped?** _____

Alcohol: Type/Amount _____ **Drug Abuse? Past/Present** _____

Sleep: Difficulty falling asleep? _____ **Continuity of disturbances?** _____

Early morning awakening? _____ **Snoring?** _____ **Daytime Drowsiness?** _____

Exercise Routine: _____ **Coffee Daily?** _____ **Other Caffeine?** _____

Please list current medications

Medication	Dosage & Frequency

Patient Financial Agreement

Arizona Lung, Sleep and Valley Fever Institute

This is a Patient Financial Agreement for: _____

We require all patients to make financial arrangements with us before we provide treatment.

1. I understand that full payment is due at the time of service for me and any party for whom I am financially responsible.
2. I understand that it is solely my responsibility to confirm which treatments or procedures are covered and/or paid by my insurance (including, but not limited to, any applicable exclusions, deductibles, and annual or lifetime maximums.)
3. I understand that as a courtesy **Arizona Lung, Sleep and Valley Fever Institute** will attempt to verify my insurance coverage from
information that I provide and will file claims per appointment. I am required to pay in full my co-pay, before treatment is performed, or the estimated portion of any procedures or treatment that will not be covered by my insurance.
4. I understand that insurance claims will only be filed if I provide **Arizona Lung, Sleep and Valley Fever Institute** with my social security and insurance identification numbers (if applicable), and a copy of government-issued picture identification (driver's license)
5. I understand that although I pay my estimated patient balance on the date of services, the insurance estimate may differ from what my insurance carrier ultimately pays. I will be responsible for any amounts not paid by my insurance for any reason, and I may receive a bill/statement for a balance due which will be immediately payable upon receipt.
6. I understand that all account balances over 60 days will incur an interest charge at the maximum legal rate allowed and sent to collection.
7. I understand that I will be charged the maximum service charge allowed by law for any returned Check for NSF.
8. I understand that I must inform **Arizona Lung, Sleep and Valley Fever Institute**, in writing, of any concerns, questions, or disputes I
may have concerning my treatment or charges in a timely manner but not more than 30 days from either the completion of the procedure or awareness of dispute.
9. I understand that if I **fail to pay my account** upon it becoming due**, Arizona Lung, Sleep and Valley Fever Institute** may report my account to credit rating bureaus or to a collection agency and/or take legal action against me for full
payment, Including but not limited to all related reasonable attorney's fees, collection and/or court costs.
10. I understand, the charge for copies of medical records is $18.00 by law or my insurance carrier. These fees are subject to change without notice.
11. I understand that **Arizona Lung, Sleep and Valley Fever Institute** currently charges $25.00, or the amount allowed by insurance, for a
broken or cancelled appointment unless 24 hours advance notice is given. The fee for No Show for a Sleep Study is $100. (This fee is subject to change without notice.)
12. I understand that it is my responsibility to immediately notify **Arizona Lung, Sleep and Valley Fever Institute** of an changes to my
address, phone number, work contact information, work status, insurance changes, etc.

I have thoroughly read, understand and agree to the above terms and conditions.

_____ _____
Printed Name Date

_____
Signature of Patient (or authorized guardian)

_____
If authorized guardian, relationship to patient

HIPAA NOTICE OF PRIVACY PRACTICES
SUMMARY AND DISCLOSURE

Arizona Lung, Sleep and Valley Fever Institute

Effective Date: July 6, 2016

Our HIPAA Notice of Privacy Practices describes the privacy practices of Arizona Lung Clinic. We respect our legal obligation to keep health information that identifies you private, and by law, we are obligated to provide you a notice of our privacy practices.

We are required by law to maintain the privacy of your health information, to follow the terms of our Notice that are currently in effect, and if you request, to provide you a copy of our Notice regarding our privacy practices and legal duties in respect of you and the information we collect and maintain regarding your health information. Our Notice also describes your rights regarding your health information and certain obligations that mandate how we use and disclose your health information.

Your Rights – You may:

- Request to inspect any copy of your records.
- Request to amend incomplete or inaccurate information in your records.
- Receive an accounting of certain disclosures of your health information.
- Ask for additional privacy protections (although your request may be declined).
- Ask for confidential communications in a particular manner.
- Receive a paper copy of this Notice.
- File a complaint without penalty.

Use and Disclosures – We will not use or disclose your information unless you tell us to do so or unless the law allows or requires us to do so. We use and disclose your information:

- For treatment, payment and health care operations.
- Through patient scheduling; to notify family or a close friend you have entrusted with your care; or for notification after benefits and service.
- For certain activities when the law requires it, such as: public health, reporting of abuse, neglect, or domestic violence; health oversight; lawsuits and disputes; law enforcement activities; coroner; medical examiner, or funeral director purposes; organ donation; avoidance of a serious threat to health or safety; workers' compensation; and national security.
- With your authorization.

Changes to this Notice – We reserve the right to change this Notice at any time as allowed by law. Updated Notices will be in our office and paper copies will be available upon request.

Complaints – If you believe that we have not properly respected the privacy of your health information, you may file a complaint with our clinic by contacting an Office Manager by calling (623) 242-9830 or by sending a letter to our office address.

Please indicate below if we may discuss your health information, billing and/or scheduling with someone you trust:

☐ **Spouse:** _____ ☐ Yes, Health Info ☐ Yes, Billing Info ☐ Yes, Scheduling

☐ **Parent/s or Guardian/s:** _____ **Indicate Relationship:** _____

☐ Yes, Health Info ☐ Yes, Billing Info ☐ Yes, Scheduling

☐ **Relative/Friend/Other:** _____ **Indicate Relationship:** _____

☐ Yes, Health Info ☐ Yes, Billing Info ☐ Yes, Scheduling

Acknowledgment of Receipt of this Notice: As a patient of Arizona Lung Clinic, I acknowledge that I have received and seen this notice and understand that I may request a copy of the full HIPAA Notice Privacy Practices for additional information. I understand that Arizona Lung Clinic respects their legal obligation to keep health information private unless required by law. My signature below indicates that I agree to these conditions.

Printed Patient Name: _____

Signature of Patient: _____ Date: _____

(Signature of Parent/Guardian if Patient is a Minor)

Arizona
LUNG, SLEEP & VALLEY FEVER
INSTITUTE

Request for Release of Medical Records

Date: _____

To: _____

Phone: _____ Fax: _____

I, the undersigned, authorize the release of any and all medical records to Arizona Lung Clinic.

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.
I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire one (1) year from the date of my signature, unless I revoke the authorization prior to that time.

Patient's Signature: _____ Date: _____

Patient Name: _____ DOB: _____

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The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patien's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 2. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently, try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dosing = 0
- Slight chance of dozing = 1
- Moderate chance of dozing = 2
- High chance of dozing = 3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	Chance of Dozing
Sitting and reading	•
Watching TV	•
Sitting inactive in a public place (e.g. a theater or a meeting)	•
As a passenger in a car for an hour without a break	•
Lying down to a rest in the afternoon when circumstances permit	•
Sitting and talking to someone	•
Sitting quietly after a lunch without alcohol	•
In a car, while stopped for a few minutes in traffic	•

Total Score: _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.

8-9: You have an average amount of daytime sleepiness.

10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

16-24: You are excessively sleepy and should consider seeing medical attention.

Patient Name: _____ DOB: _____ Date of Service: _____