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: ____

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

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. I understand that it is my responsibility to updated any insurance changes prior to any appointment to allow to time for prior authorization if needed.
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 concerns about 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 $50.00, 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 $250. The fee for a No Show for a PFT is $80.00. I is also posted at the front desk, on our website (azlsvf.com), and during our appointment reminders. (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, Sleep and Valley Fever Institute**. 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, Sleep and Valley Fever Institute**, 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, Sleep and Valley Fever Institute** 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)

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, Sleep and Valley Fever Institute.**

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: ____________________

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: _______________

14961 W Bell Road, Suite 175, Surprise, AZ 85374

www.azlsvf.com

Phone : (623) 242-9830 Fax : (623) 243-6733

Order Processing

Oxygen Orders: **Process time: 2-3 weeks from the date DME company receives order (timeframe does not include processing with the insurance.)**

Overnight Oximetry: **Process time:1 week (Depends on when the patient sends testing back to DME company.)**

Biologic Injections: **Process time: 8 weeks__**These include: Dupixent, Fasenra, Nucala, Xolair

Cpap/Bipap/ASV Orders: **Process time: 6-8 weeks from the date DME company receives order.**

RX refill Request: **Process time: 2 weeks or sooner if electronic request. (Can vary; provider signature is required.)**

Pharmacy Rx Request: **Process time: 2 weeks or sooner if electronic request. (Can vary; provider signature is required.)**

Prior Auth: See below procedures that need auth

Medications: **1-7 business days**

Radiology/Labs: **1-14 business days (can vary if denied and insurance recommends an appeal)** **Appeals:** **30 business days.**

Sleep/Pft/HomeSleep: **14 business days (depends on the patient's insurance)**

Bronchs: **2 weeks**

Incoming Referrals: **2 weeks for processing**

Expired Referrals: **Often expire 6-12 months**

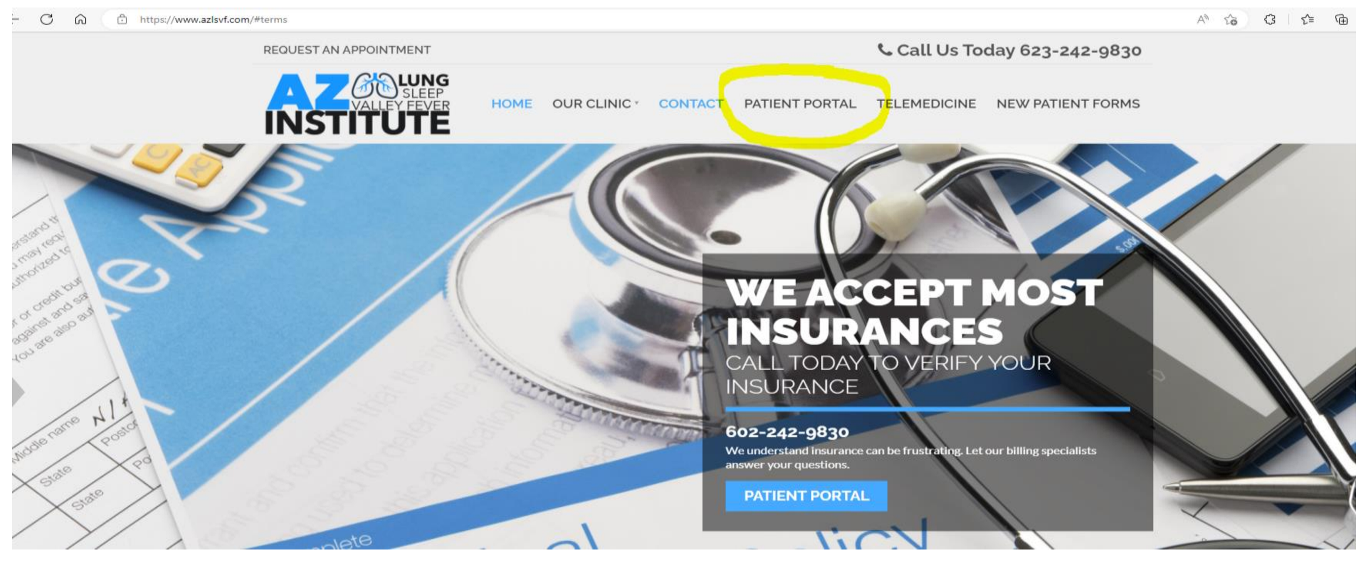
Please make sure patient requests an updated referral prior to their appointment.

In order for any orders to be sent you must have been seen by the Doctor within a year!

If you have read and agreed with the above information please sign and date.

Patient Signature:________________________________ Date:_____/______/_____

PATIENT PORTAL/HEALOW SET UP



Español
Healow App available on

Welcome

...tes better communication with your physician's office by providing convenient 24x7 access from the comfort and privacy of your own home or office.

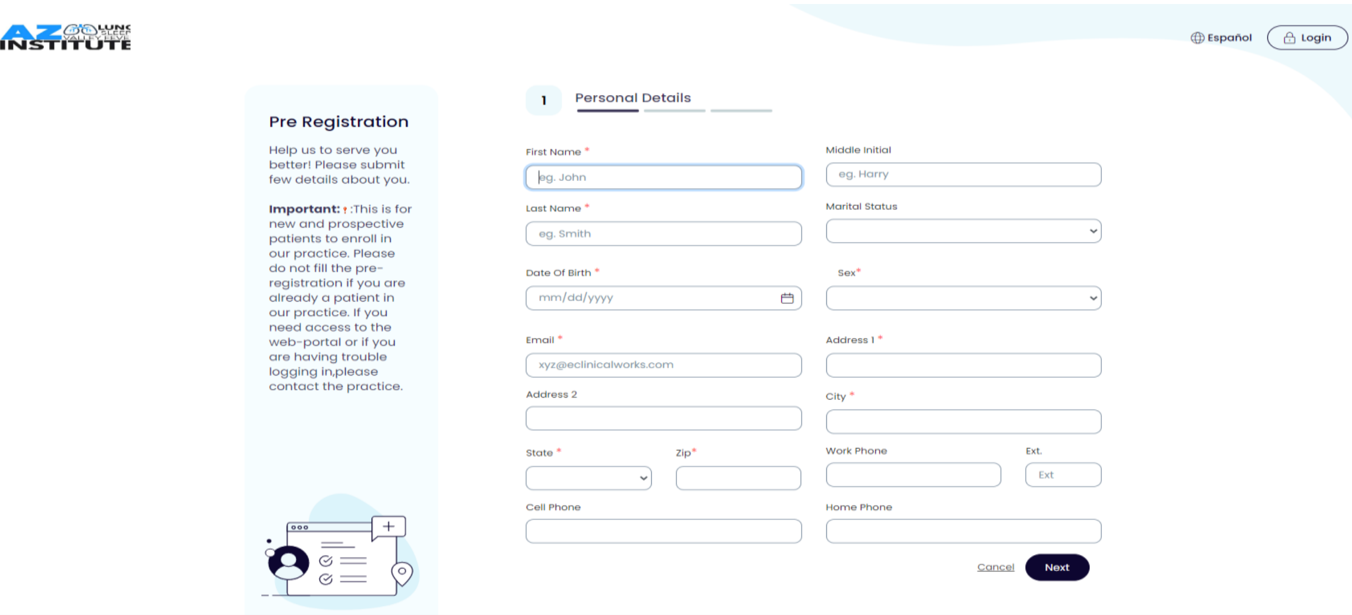
View your health record
Login to see your reports

Login to view your health record
User Credentials
Using Mobile Phone
User Name
Password
Login
Trouble logging in?

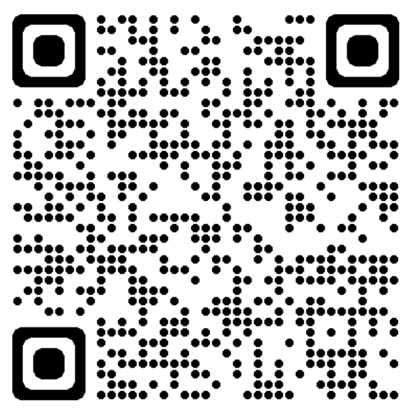
New to Practice?
Pre-register for hassle-free appointment booking and easy check-in for your first visit.
Pre Register

Download App
healow app is a secure and convenient way to manage what's important and puts YOU in control of your health.
Know More
Practice Code HEAIAA

FOR QUICKER ACCESS TO OUR PATIENT PORTAL PLEASE CALL THE OFFICE AT 623-242-9830 AND GIVE US YOUR EMAIL ADDRESS. YOU WILL THEN GET AN EMAIL FROM HEALOW TO REGISTER FOR YOUR PORTAL



Find your practice by entering a practice code (HEAIAA)



From the patient portal you can view your patient records, print patient records, sent messages to your doctor, schedule appointments, ect.

PREPARING FOR YOUR SLEEP STUDY

Our Sleep Center is located at 14961 west bell road suite 175 Surprise AZ 85374. You can park right in front of the building. COME TO THE FRONT DOOR. ON THE RIGHT SIDE OF THE FRONT DOOR THERE IS A BLUE SIGN WITH A DOOR BELL. Ring door bell and your sleep tech will let you in. There is a $250 NO SHOW FEE if you do not cancel or reschedule 24 hours prior to your scheduled sleep study. After 15 minutes late you will need to be rescheduled.

WHAT TO EXPECT:

- You will have sensors with gel/paste, and possibly tape, placed on your head, chin, around your eyes, legs, chest, and finger, to record sleep activity during your sleep study.
- Avoid napping on the day of the study.
- Avoid alcohol, stimulants, and caffeinated beverages (coffee, tea, and cola) for 24 hours before the study.
- Wear comfortable clothing to sleep in.
- We recommend you bring your favorite pillow and/or blanket to make you more comfortable.
- Bring your regularly scheduled medications and plan to take them as you normally would unless your physician instructs otherwise.
- Bring reading materials, laptop, or other activities to occupy your free time.
- Notify us if you require special assistance. You may be required to have a caregiver present during testing.
- If you are using positive airway pressure therapy (CPAP), bring your mask and headgear. If you have an oral appliance and are having a follow-up sleep study, please bring your oral appliance, adjustment key and/or bands.

AFTER THE SLEEP STUDY:

Your technologist **will begin waking you at 5:00 am and remove the sensors and equipment**. You will be ready for pick up or to leave latest by 6am.

Your sleep study results will be ready in 2 weeks. Please make sure you have a follow up scheduled as we fill up fast.

Preparing for your Bronch/EBUS

☐ **Banner Del E. Webb Medical Center**
14502 W. Meeker Blvd., Sun City West, AZ 85375

☐ **Banner Thunderbird Medical Center**
5555 W. Thunderbird Road Glendale AZ, 85306

☐ **Banner Boswell Medical Center**
10401 W. Thunderbird Blvd., Sun City, AZ 85351

☐ **Abrazo West Campus**
13677 W. McDowell Road Goodyear AZ 85395

1. **YOU WILL NEED TO BE OFF COUMADIN (WARFARIN), ELIQUIS, XARELTO, PLAVIX, LOVENOX, ASPIRIN, IBUPROFEN, OR ANY BLOOD THINNERS (INCLUDING FISH OILS AND VITAMIN E) FOR 7 DAYS PRIOR TO YOUR PROCEDURE.**

2. Please arrive **<u>1 hour</u>** prior to your scheduled appointment.

3. A driver must be available to take you home.

4. Check in at the **Outpatient Registration Desk.**

5. Do not consume food or beverages **8 hours** prior to your procedure.

6. Patients with heart valve problems or a pacemaker may require pre-procedure medications with antibiotics.

7. Risk(s) of procedure include but are not limited to:
    - **Bleeding**
    - **Infection**
    - **Collapsed Lung (If biopsy is performed)**

PREPARING FOR YOUR PULMONARY FUNCTION TEST

Pulmonary testing performed at: 14961 W Bell Road, Ste 175, Surprise, AZ 85374
13657 W. McDowell Rd, Ste210, Goodyear AZ 85395

DO NOT USE any short acting bronchodilator (rescue inhaler) at least **4 hours** prior to your test.

These include: Albuterol, Duoneb, Combivent, Xopenex, levalbuterol, Atrovent, ipratropium, ProAir, Ventolin, Proventil

DO NOT USE any long-acting inhaler (maintenance inhaler) at least **12 hours** prior to your test.

These include: Foradil, Servent, Advair, Spiriva, Symbicort, Dulera, Anoro, Breo, Alvesco, Brovana, Arcapta, Striverdi, Pulmicort, Tudorza, Flovent, Trelegy, Breztri

****STOP PREDNISONE 1 WEEK PRIOR TO PULMONARY FUNCTION TEST****

If you are on antibiotics for any lung issues/infections you will need to finish medication and schedule PFT 1 week after last dose.

NO SMOKING at least 1 hour prior to the appointment.

DO NOT eat a **heavy** meal prior to your appt. It is okay to have a **light** meal.

$80 FEE CHARGED FOR APPOINTMENTS CANCELLED LESS THAN 24 HOURS PRIOR TO APPOINTMENT TIME OR IF YOU DO NOT SHOW UP FOR APPOINTMENT.