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PULMONARY ASSOCIATES, P.A.

1112 EAST MCDOWELL RD • PHOENIX, AZ 85006 • TELEPHONE (602) 258-4951 • FAX (602) 340-1853
9225 NORTH THIRD STREET SUITE 200B • PHOENIX, AZ 85020 • TELEPHONE (602) 997-7263 • FAX (602) 944-4553
5750 WEST THUNDERBIRD RD BLDG E STE 500 • GLENDALE, AZ 85306 • TELEPHONE (602) 298-1932 • FAX (602) 862-1131
2450 EAST GUADALUPE ROAD BUILDING 1 SUITE 103 • GILBERT, AZ 85234 • TELEPHONE (480) 290-7000
4100 NORTH 108th AVENUE SUITE A101-102 • PHOENIX, AZ 85037 • TELEPHONE (602)997-7263
20940 NORTH TATUM BLVD SUITE 325 • PHOENIX, AZ 85050 • TELEPHONE (480)889-6020

The enclosed forms include a questionnaire to give your physician a clear picture of your medical history. Please complete all forms to the best of your knowledge and bring them in with you to your scheduled appointment. In addition, it is necessary that you also bring along the following items to your appointment:

a. Photo ID
b. Insurance Card(s)
c. Pharmacy Information (name and phone number is sufficient)
d. Medication List
e. X-rays or CD's pertinent to the reason you are being referred
f. Medical Records to include prior sleep studies, radiology reports, lab results, last chart notes or hospital records. They can also be faxed to us at (602) 340-1853.
g. Referral given to you by the primary care physician. This may also be faxed to us at (602) 346-4756.

All co-payments will be collected at the time of check in.

If you have any questions regarding your appointment or the paperwork enclosed, please contact us at (602) 258- 4951 and one of our Front Office staff members will gladly assist you. Thank you for scheduling with our practice and we look forward to meeting you!

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New Patient Medical History Questionnaire

Name____ Age____________

Why are you here today? ____

____

SLEEP

Do you snore or stop breathing during sleep witnessed by another? NO____ YES____
Do you have a feeling of being tired or fall asleep easily during the day? NO____YES____
Awaken with a headache, dry mouth, sore throat, or choking? NO____ YES____
Is your sleep restless NO____ YES____
Problem getting to sleep or staying asleep? NO___ YES___
If yes to any, please explain______________________

____

Bedtime is _______ AM/PM
Wake time is _______AM/PM
Arm or leg jerking during sleep witnessed by another? NO____ YES____
Feelings of restless legs day or night? NO____ YES____
Abnormal behavior during sleep witnessed by another? NO____ YES____
If yes to any, please explain______________________

____

SOCIAL HISTORY

Please list all types of work you have done: ____________

____

Arizona resident for how many years? __________
Other states or countries in which you've lived? __________

____

Do you smoke now or have you ever? NO____ YES____
Stopped? Year_________
If yes… How much?_____Packs per day
How long? ______Years
Do you drink alcoholic beverages? NO____ YES____
If yes, daily quantity______________

MEDICAL HISTORY

Past Medical History: Please list all major illnesses you currently have or have had in the past: ________________

____

____

Past Surgical History: Please list all surgeries you have had in the past: ______________________________

____

Any Respiratory complications from surgery: ____________

____

Have you received immunizations for:
Pneumonia (Pneumovax) NO____ YES____ When? ______
Influenza (Flu Shot) NO____ YES____ When? ______

Have you had a PPD (Tuberculosis skin test)?
NO____ YES____ If yes, result? _________ Date_________

Do you have any medication allergies NO____ YES_____
If yes, What? ______________________________

____

Family history: Please list major medical illnesses of your parents and siblings________________________

____

RESEARCH

Would you be interested in participating in research studies performed by Pulmonary Associates? ________________

____

Patient Name ______________________________

CONSTITUTIONAL

Are you having fever, chills, sweats, feeling poorly, or had a change in weight? NO____ YES____

If yes, please explain ______________________________

____

ALLERGY/IMMUNOLOGY

Besides medication, do you have any allergies?

NO____ YES____ If yes, please explain ______________

____

Do you have recurrent infections? NO____ YES____

If yes, please explain ______________________________

____

EYES, EARS, NOSE, THROAT

Do you have Headaches? NO____ YES____

Sinus Problems? NO____ YES____

Earaches, ringing, or hearing loss? NO____ YES____

Mouth Sore? NO____ YES____

Swallowing problems or choking? NO____ YES____

If yes to any, please explain______________________

____

CARDIOVASCULAR

Do you have chest pain? NO____ YES____

Palpitations or fast heart rate? NO____ YES____

Swelling in the extremities? NO____ YES____

If yes to any, please explain ____________________

____

PULMONARY

Cough? NO____ YES____

Worse at night? NO____ YES____

Wake you up at night? NO____ YES____

Phlegm production (Color, thickness) NO___ YES____

If yes to any, please explain______________________

____

Do you have shortness of breath? NO____ YES____

At rest? NO____ YES____

Exertion (What kind?) NO____ YES____

Worse at night? NO____ YES____

If yes to any, please explain ______________________

____

GENITOURINARY

Frequent Urination? NO____ YES____

More than twice a night? NO____ YES____

Painful urination? NO____ YES____

Blood in Urine? NO____ YES____

If yes to any, please explain______________________

____

GASTROINTESTINAL

Decreased appetite? NO____ YES____

Nausea or vomiting? NO____ YES____

Abdominal pain? NO____ YES____

Diarrhea or constipation? NO____ YES____

Black or bloody stools? NO____ YES____

If yes to any, please explain______________________

____

ENDOCRINE

Excessive sweating? NO____ YES____

Excessive thirst? NO____ YES____

Temperature intolerance? NO____ YES____

Hair loss? NO____ YES____

Change in sex drive? NO____ YES____

If yes to any, please explain______________________

____

HEMATOLOGIC/LYMPHATIC

Easy bruising? NO____ YES____

Lumps in neck, axilla, groin? NO____ YES____

If yes to any, please explain______________________

____

SKIN

Any rashes or skin lesions? NO____ YES____

If yes, please explain______________________________

____

MUSCULOSKELETAL

Any joint pain or swelling? NO____ YES____

Muscle aches? NO____ YES____

If yes to any, please explain______________________

____

NEUROLOGIC

Dizziness? NO____ YES____

Fainting or loss of consciousness? NO____ YES____

Seizures? NO____ YES____

Tremor? NO____ YES____

Weakness? NO____ YES____

Numbness, tingling, or burning sensation? NO____ YES____

If yes to any, please explain______________________

____

PSYCHIATRIC

Feeling depressed or anxious? NO____ YES____

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Patient Name:______________________________________ DOB:__________________

Pharmacy:__________________Address:__________________Phone:_________________

Medication	**Dosage**	Office Use Only

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New Office Policies:

Effective June 1, 2008:

1. **$25.00 FEE for No Shows and Late Cancellations (canceling with less than 24-hrs notice):** To avoid this fee, please call and cancel or reschedule all appointments within 24 hours of your scheduled appointment. If you need to cancel an appointment after business hours, please call our office number and leave a message with our answering service.

2. **$15.00 FEE for Form Completion:** We can no longer provide this service for free. There will now be a fee of $15.00 for all forms needing to be completed outside an office visit.

3. **FEES for Processing Medical Records Request Forms:**
   1-10 pages = $10.00
   11-20 pages = $15.00
   21 + pages = $25.00

4. **Administrative Collection Fees**
   Effective October 1, 2009, any outstanding balances sent to a third party collection agency will incur a 20% fee.

**YOUR INSURANCE REQUIRES YOU TO PAY YOUR COPAY
AT THE TIME OF SERVICE**

We regret the institution of these policies necessitated by increasing labor costs and the negative impact on our ability to provide quality care when appointments are no showed or cancelled late.

Please Sign and Date below acknowledging your notification of these FEES:

Name:______________________________ Date:______________

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, and for health care permitted or required by law. You have certain rights regarding the privacy of your protected health information and we also describe them in this notice.

Ways in Which We May Use and Disclose Your Protected Health Information:

The Following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure you that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

Treatment. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may from time to time disclose your health information to another physician who we have requested to be involved in your case. *For Example* – we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

Payment. We will use and disclose your protected health information to obtain payment for the health care services we provide you. *For Example* – we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed, and supplies used in rendering the service.

Health Care Operations. We will and disclose your protected health information to support the business activities of our practice. *For Example* – we may use medical information about you to review and evaluate our treatment and services or to evaluate our staff's performances while caring for you. In addition, we may disclose your health information to a third party business associates who performs billing, consulting, or transaction services for our practice.

Requests Amendment. You have the right to request that we amend your medical information if you feel that it is incomplete or in accurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate and your reasoning that supports your request.

We are permitted to deny your request if it is not in writing, or does not include a reason to support that request. We may also deny your request if:
- the information was not created by us, or the person who created it is no longer available to make the amendment;
- the information is not part of the record which you are permitted to inspect and copy;
- the information is not part of the designated record set kept by the practice; or if it is the opinion of the health care provider that the information is accurate and complete.

Request Restrictions. You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment, or health care operations. *For example* – you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for care. Your request must be made in writing to our privacy officer.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

An Accounting of Disclosures. You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for treatment, payment, or health care operations. Your request must be made in writing and must state the time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for the period of the time greater than six years (our legal obligation to retain information).

Your first request for the list of disclosure within a 12-month period will be free. If you request an additional list within 12 months of the first request, we may charge you a fee for the costs of providing the subsequent list. We will notify you of such costs and afford you the opportunity to withdraw your request before any costs are incurred.

Request Confidential Communications. You have the right to request how we communicate with you to preserve your privacy. For example – you may request that we call you only at your work number, or by mail at special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

File a Complaint. If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our privacy office or directly to the Secretary of Health and Human Services.

To file a complaint with our manager, you must make it in writing within 180 days of the suspected violation. Provide as much detail as you can about the suspected violation and send it to Pulmonary Associates, P.A., 1112 E McDowell Rd Phoenix, AZ 85006. You should know that there would be not retaliation for your filing a complaint.

Other Ways We May Use and Disclose Your Protected Health Information:

Appointment Reminders. We will use and disclose your protected health information to tell you about or to recommend possible alternative treatments or options that may be of interest to you.

Others Involved In Your Care. We will use and disclose your protected health information to a family member, a relative, a close friend, or any other person you identify that is involved in your medical care or payment of care.

Research. We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

As Required by Law. We will use and disclose your protected health information when required to by federal, state, or local law. You will be notified of any such disclosures.

To Avert a Serious Threat to Public Health or Safety. We will use and disclose your protected health information to public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury, or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

Worker's Compensation. We will use and disclose your protected health information for worker's compensation or similar program that provide benefits for work-related injuries or illness.

Inmates. We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care; to protect the health and safety of others; or for the safety and security of the correctional institution.

Your Health Information Rights

Although your health record is the physical property of the health care practitioner or facility that complied it, the information belongs to you. You have the right to:

A Paper Copy of This Notice. You have the right to receive a paper copy of this notice upon request. You may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

Inspect and Copy. You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. This designated record set includes your medical and billing records, as well as any other we use for making decisions about you. Any psychotherapy notes that may have been included in records we received about you are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing, or other supplies used in fulfilling your request.

If you wish to inspect or copy your medical information, you must submit your request in writing to our privacy officer, Pulmonary Associates P.A., 1112 E. McDowell Rd. Phoenix, AZ 85006. You may mail in your request, or bring it to our office. We will have 30 days to respond to your request for information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond but must inform you if this delay.
Privacy Practice Officer:
Allison Ross
(602) 258-4951

Uses or Disclosures Not Covered

Uses or disclosures of your health information not covered by this notice or the laws that apply to us may only be made with your written authorization. You may revoke such authorization in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.