PULMONARY ASSOCIATES

Dear Patient:

Thank you for choosing Pulmonary Associates. Welcome to our practice!

Our first priority is you, our patient. We strive to provide you with excellent quality care and to exceed your expectations in a comfortable and convenient manner. Our highly trained physicians and professional staff are always available to assist you with questions regarding your care, medications, insurance or billing.

The enclosed forms include a questionnaire to give your physician a clear picture of your medical history, office and financial policies, medication list, and our notice of privacy practices. 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. This ensures you get the most out of your consultation visit with us.

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

Your insurance requires that you pay your copay at the time of service. A $10 surcharge will be added to your account if your copay is not paid at time of service and both fees must be paid within 30 days.

If you have any questions regarding your appointment or the paperwork enclosed, please contact us at **(602) 346-4771** and one of our central scheduling staff members will gladly assist you. Thank you for scheduling with our practice and we look forward to meeting you!

J. BURR ROSS, M.D.
MARK H. GOTFRIED, M.D.
ROBERT A. COMP, M.D.
DAVID M. BARATZ, M.D.

STEPHEN R. ANTHONY, M.D.
THOMAS KUNELIS, D.O.
ANDREAS C. KYPRIANOU, M.D.
DA-WEI LIAO, M.D.

MANOJ MATHEW, M.D.
TERESA HEATLY, M.D.
TIMOTHY BICHLER, M.D.
CRISTIAN JIVCU, M.D.

JUDITH A. NEWELL, R.N., NP-BC
STACEY GOURDOUX, NP-BC
LYNDA HEAPHY, NP-BC
GRACE MELLEN, NP
LARISSA ANTHONY, PA-C

New Patient Medical History Questionnaire

Name _____ Age _____

Why are you here today? _____

_____

CONSTITUTIONAL

___Yes ___No Feeling tired
___Yes ___No Feeling poorly
___Yes ___No Fever
___Yes ___No History of chills
___Yes ___No History of sweating heavily at night
___Yes ___No History of recent weight loss (____lbs)
___Yes ___No History of recent weight gain (____lbs)

ALLERGY/IMMUNOLOGY

___Yes ___No Seasonal
___Yes ___No Contact
___Yes ___No Food
___Yes ___No Inhalation
___Yes ___No Immunology
___Yes ___No Recent infection

HEENT

___Yes ___No Vision problems
___Yes ___No History of headache
___Yes ___No History of sinus pain
___Yes ___No History of sinus pressure
___Yes ___No History of drip or drainage down throat from above
___Yes ___No History of nasal discharge drips down throat causing cough
___Yes ___No Sneezing
___Yes ___No History of nosebleeds
___Yes ___No Earache
___Yes ___No Hearing loss
___Yes ___No Ringing in the ears
___Yes ___No History of lightheadedness
___Yes ___No Mouth sores
___Yes ___No Bleeding gums
___Yes ___No History of hoarseness
___Yes ___No History of sore throat
___Yes ___No History of choking
___Yes ___No Difficulty swallowing

CARDIAC

___Yes ___No Chest pain or discomfort
___Yes ___No Fast heart rate
___Yes ___No Palpitations
___Yes ___No Cold hands or feet
___Yes ___No Swelling right lower extremity
___Yes ___No Swelling left lower extremity
___Yes ___No Swelling both lower extremities

CHEST WALL/BREAST

___Yes ___No Breast pain
___Yes ___No Nipple discharge
___Yes ___No Breast lump
___Yes ___No Axilla pain
___Yes ___No Axilla swelling
___Yes ___No Axilla lump

PULMONARY

___Yes ___No Shortness of breath
___Yes ___No Cough
___Yes ___No Coughing up blood
___Yes ___No History of chest pain made worse by breathing
___Yes ___No Wheezing

GU/GI

___Yes ___No Dysuria
___Yes ___No Increased urinary frequency
___Yes ___No Hematuria
___Yes ___No Genital lesion
___Yes ___No Incontinence
___Yes ___No Nocturia
___Yes ___No Appetite normal
___Yes ___No Heartburn
___Yes ___No Nausea
___Yes ___No Vomiting
___Yes ___No Abdominal pain
___Yes ___No Diarrhea
___Yes ___No Black or bloody stools
___Yes ___No Constipation
___Yes ___No Bright red blood per rectum
___Yes ___No Unable to restrain bowel movement

Name_____ Age_____

ENDOCRINE

___Yes ___No Excessive sweating
___Yes ___No Polydypsia
___Yes ___No Temperature intolerance
___Yes ___No Proptosis
___Yes ___No Hair symptoms
___Yes ___No Libido has changed

HEMATOLOGIC/LYMPHATIC

___Yes ___No Easy bleeding
___Yes ___No Easy bruising tendency
___Yes ___No History of lump or swelling in neck
___Yes ___No History of swollen glands in the neck
___Yes ___No Lumps in the groin area
___Yes ___No Lumps in the axillary regions

SKIN/MUSCLES/JOINTS

___Yes ___No Pruritus
___Yes ___No Lesions
___Yes ___No Rashes
___Yes ___No Nail symptoms
___Yes ___No Joint pain, localized
___Yes ___No Joint stiffness, localized
___Yes ___No Muscle aches

NEURO/PSYCH

___Yes ___No Dizziness
___Yes ___No Vertigo
___Yes ___No Fainting
___Yes ___No Seizures
___Yes ___No Paralysis
___Yes ___No Tremor
___Yes ___No Feelings of weakness
___Yes ___No Limb weakness
___Yes ___No Motor disturbances
___Yes ___No Sensory disturbances
___Yes ___No Anxiety
___Yes ___No Depression

SLEEP

___Yes ___No Snoring witnessed
___Yes ___No Periods of not breathing while asleep
___Yes ___No Non-restorative sleep
___Yes ___No Groggy for too long upon awakening
___Yes ___No Sleeping too much
___Yes ___No Suddenly falling asleep during the day
___Yes ___No Middle-night awakening with choking sensation
___Yes ___No Middle-night awakening with dry mouth
___Yes ___No Middle-night awakening with sore throat
___Yes ___No Restless movements during sleep
___Yes ___No Decreased concentrating ability

SOCIAL HISTORY

__Married __Divorced __Separated __Single
What is your living situation: _____
_____
Have you travelled recently? ___Yes ___No
Where? _____
What is your profession? _____
Are you currently working? ___Yes ___No

What are your daily activities? _____
_____
Do you exercise? ___Yes ___No How often? _____

Arizona resident for how many years? _____

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 Respiration complications from surgery:
_____
_____

Have you received immunizations for:
Pneumonia NO___ YES___ When? _____
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

Family history: Please list major medical illnesses of your parents and siblings and mark box _____
_____
☐ mother ☐ father ☐ brother ☐ sister

Comments: _____
_____
_____

PULMONARY ASSOCIATES

Medication List

Patient Name: _____ DOB: _____

Pharmacy: _____ Address:_____ Phone:_____

Medication	Strength / Mg	How Often

*PLEASE PROVIDE ALL MEDICATIONS INCLUDING OVER THE COUNTER, VITAMINS, INJECTABLES, HERBAL SUPPLEMENTS, ETC.

Pulmonary Associates Office and Financial Policies:

Thank you for choosing Pulmonary Associates, PA. for your medical needs. We are committed to providing you with the highest quality medical care and maintaining a good physician-patient relationship is our primary goal. Even when insurance is in place, patients are ultimately responsible for charges associated with their care. As your provider, we feel it is our responsibility to let you know in advance of our office and financial policies. This will allow for a good flow of communication and enable us to achieve our physician-patient relationship goal. We realize you have choices for your medical care, and we sincerely appreciate you choosing Pulmonary Associates, PA.

For our patient's convenience, we participate in most major health plans. Our business office will submit claims for services rendered and will assist you in any reasonable way in getting your claims paid. It is the patient's responsibility to provide all necessary information during the appointment scheduling process as well as ensuring there is an authorization and/or referral form from your PCP if it is required by your insurance.

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

FEES AND SURCHARGES

- **$25.00 Fee for No Shows and Late Cancellations (cancelling 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 are not able to get through or call after business hours, please leave a voicemail of your cancellation.

- **$15.00 Fee for Form Completion:**
  There will be a fee of $15.00 for all forms needing completion outside an office visit.

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

- **Administrative Collection Fees:**
  Any outstanding balances sent to a third party collection agency will incur a 20% fee. In addition, you may not be able to make future appointments until this balance is discussed with our billing department.

- **$10.00 Surcharge Fee:**
  Your insurance requires you to pay your co-payment at the time of service. Failure to pay in full at the time of service will result in a $10.00 surcharge fee.

- **$25.00 NSF Fee for Returned Checks:**
  All returned checks will incur an additional $25.00 fee, and we will require alternative payment for all future visits.

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

Print Name: _____

Signature:_____ **Date:** _____

PULMONARY ASSOCIATES

1112 E. McDowell Road
Phoenix, AZ 85006
Tel. 602.258.4951

9225 N. 3rd Street
Suite #205
Phoenix, AZ 85020
Tel. 602.997.7263

5750 W. Thunderbird Road
Building E500
Glendale, AZ 85306
Tel. 602.298.1932

2450 E. Guadalupe Road
Building 1, Suite #103
Gilbert, AZ 85234
Tel. 480.290.7000

10585 N. Tatum Blvd
Suite #D130
Paradise Valley, AZ 85253
Tel. 602.997.7263

Authorization to Release Information

The purpose of this form is for YOU (patient) to give Pulmonary Associates permission to release information regarding your care to the Family/Friend listed below. Please review, complete, sign & date and return to our front desk.
(Ex: prescription pick-up, appointment coordination, record retrieval, etc...)

Patient Name: _____ **Date of Birth:** _____ **SSN #:** _____

I, _____, authorize Pulmonary Associates, PA to communicate with the person/persons listed below regarding my care and treatment.

1. _____ _____
Name **Address**

Telephone #: (_____)_____ _____**85**_____
City/State **Zip Code**

2. _____ _____
Name **Address**

Telephone #: (_____)_____ _____**85**_____
City/State **Zip Code**

____ Verbal Communication

____ Other (Please Specify): _____

The purpose of this release: COORDINATION OF CARE

Pulmonary Associates, PA is hereby released from any and all legal liability that may arise from the disclosure of the information requested. I certify that this request for disclosure has been made freely and voluntarily. I understand that I may revoke this authorization at any time (in writing) with the exception that action has already been taken on the consent. Unless otherwise specified, this consent expires one year following date of signature.

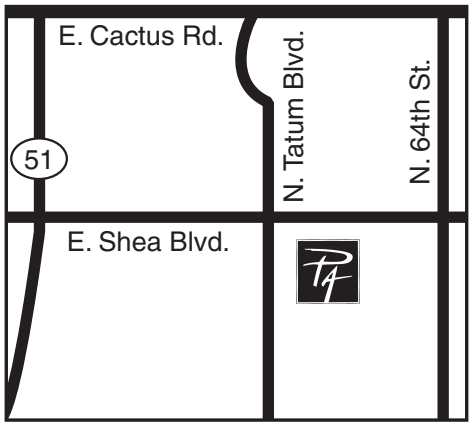
"This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization of the release of medical or other information for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient." I understand records or information in the records will not be covered under Federal Privacy Laws should the RECIPIENT of my records re-disclose them. Note: A photocopy and/or facsimile of this consent shall be considered valid as original.

_____ _____
Patient/Parent/Guardian Signature **Form to EXPIRE 1 year from original signed date**

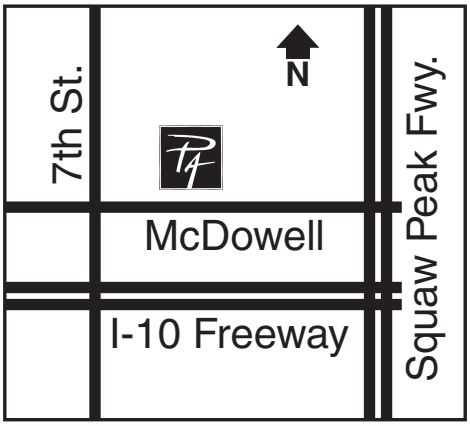
PULMONARY ASSOCIATES

OFFICE LOCATIONS

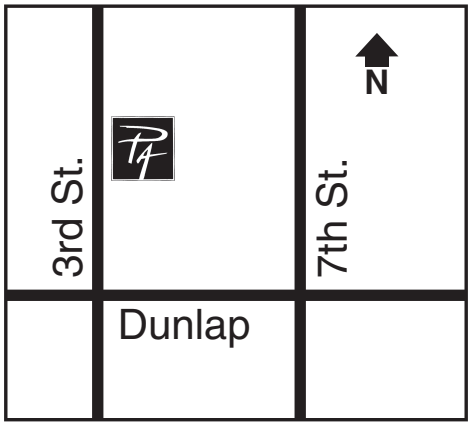
CENTRAL SCHEDULING: 602-346-4771



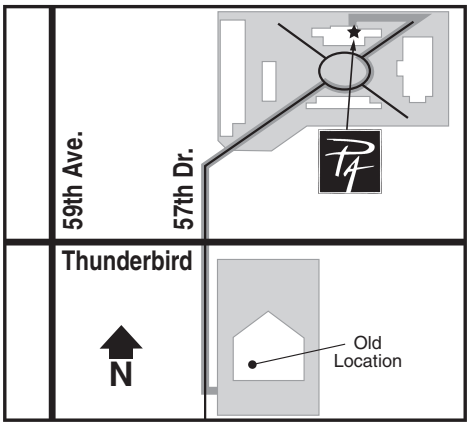
Paradise Valley/Scottsdale Office
10585 N. Tatum Blvd., Suite D130
Paradise Valley, AZ 85253
Ph. (602) 997-7263 Fax (602) 944-4553



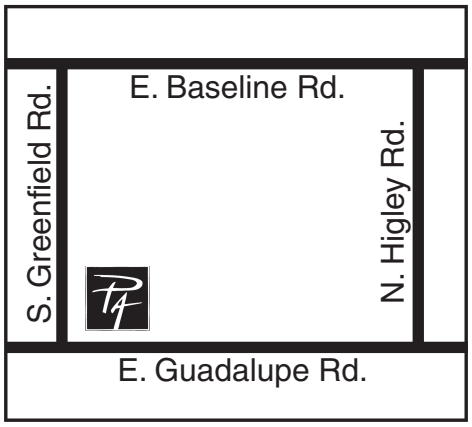
Central Phoenix Office
1112 E. McDowell Road
Phoenix, AZ 85006
Ph. (602) 258-4951 Fax (602) 340-1853



North Phoenix Office
9225 N. 3rd Street, Ste. 205
Phoenix, AZ 85020
Ph. (602) 997-7263 Fax (602) 944-4553



Glendale Office
5750 W. Thunderbird Rd. Bldg. E, Ste. 500
Glendale, AZ 85306
Ph. (602) 298-1932



Gilbert Office
2450 E. Guadalupe Rd., Ste. 103
Gilbert, AZ 85234
Ph. (602) 258-4951 Fax (602) 340-1853

POS Reorder # 1212172

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 ways that we can 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 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 the 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 use 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 associate 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 inaccurate. 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 a 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 no 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 the 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 compiled 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 of this delay.
Privacy Practice Officer:
Cecilia Jenkins
(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.