Arizona Grand Medical Center
3777 Crossings Drive Prescott, AZ 86305

Patient Information

Home Phone: ____________________ Cell Phone: ____________________

Last Name: ____________________ First Name: ____________________MI_______

Mailing Address: ____________________APT _______City/State/Zip____________________

Sex: Male Female Birthdate: ______________ Age ________ Soc. Sec. # ___________ -_________ -___________

Language: ________________ Race / Ethnicity: ________________ Email: ____________________

Employer: ____________________Work Phone: ________________ Occupation: ________________

Referring/PCP Physician

Primary Care Physician ____________________ Phone: ____________________

Referring Physician: ____________________ Phone: ____________________

Emergency Contact Information

Name: ____________________ Relationship: ______________ Telephone #:________________

Living Will: _________ I do have one __________ I do **not** have one at this time

Authorization to Release Information & Assignment of Benefits

I hereby authorize any insurance company to pay the proceeds or any benefits due me directly to Arizona Grand Medical Center, PLLC. I further acknowledge and understand that I am responsible for all services rendered to me or any member of my family. Although I have requested the doctor bill my insurance, it is still my responsibility to make sure the bill is paid in a reasonable time. If for any reason any portion of my bill is not paid by my insurance, I further agree to make arrangements for prompt payment of the bill.

I consent to receive calls from Arizona Grand Medical Center for my protected healthcare and other services at the phone number(s) above, include my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automatic dialing system

Signature: ______________________________ Date: ____________________

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

I have received a copy of the privacy Rules from the provider and authorize the list of person(s) who may receive my protected health information. I may revoke this at any time by giving written notification to the provider. I further authorize Arizona Grand Medical Center to receive medical records & medications, paper or electronic.

Name of Authorized Person: ______________________________ Relationship: ________________

May we leave a message regarding: TEST RESULTS Yes ( ) No ( ) APPOINTMENTS Yes ( ) No

Signature: ______________________________ Date: ____________________

PLEASE ANSWER THE FOLLOWING QUESTIONS:
Your help is greatly appreciated

Name:_______________ DOB_______________ Date:_______________

Occupation: (Former & Current)_______________

Do you smoke? _______________ if Yes, what?_______________ How many years? _______________

How much? _______________ when did you stop? _______________ what did you do to quit?_______________

Have you been diagnosed to have any of the following, currently or in the past?

Asthma, allergic rhinitis, sinusitis, bronchitis, COPD, emphysema, lung fibrosis, pneumonia, tuberculosis, valley fever, lung cancer, long nodule, any other cancer. Deep venous thrombosis, pulmonary embolism, pulmonary hypertension, sleep apnea, insomnia, narcolepsy, restless leg syndrome, pleural effusion, congestive heart failure, gastro esophageal reflux disease, stroke, Parkinson's disease, anemia.

Diseases that you have been diagnosed with:	**When:**
_______________	_______________
_______________	_______________
_______________	_______________

Family History (any diagnoses or cause of death):
Mother: _______________
Father: _______________
Siblings: _______________

Have you experienced any of the following? (Circle when appropriate)

Shortness of breath	How Long _______________	always or episodic, on exertion, at rest, at night
Coughing	How Long _______________	always or episodic, on exertion, at night
Sputum	How Long _______________	amount_______________ color _______________blood_______________
Chest pain	How Long _______________	Where _______________with breathing- Yes or No
Sleep problems	Snoring, Choking, Stops breathing, Leg or body movements, Leg cramps.	

Sleepy during the day time, other _______________
Vaccinations Flu- When_______________ Pneumonia- When _______________

Did you have the following tests?	**Where:**	**When:**
Blood Test		
CT scan of the chest		
Chest X-ray		
Echocardiogram		
Pulmonary function tests		
Sleep Study		
Bronchoscopy		
Past Surgeries		

Are you currently on:	Oxygen	if yes, how much? _______________	How long? _______________
	CPAP	if yes, what pressure? _______________	How long? _______________
	BiPAP	if yes, what pressure? ________ _____	How long? _______________

How do you feel using CPAP? worse about the same better much better
Have you had a previous sleep test? yes no
If yes, when?_______________ if yes, where?_______________ if yes, what type of test? _______________

Circle Y or N

1.	Y	N	Do you experience daytime sleepiness?
2.	Y	N	Do you take daytime naps?
3.	Y	N	Have you ever fallen asleep while driving or at a stop sign?
4.	Y	N	Have you been told that you snore?
5.	Y	N	Have you been told you hold your breath when you sleep?
6.	Y	N	Have you ever snored or gasped yourself awake?
7.	Y	N	Do you experience morning headaches?
8.	Y	N	Do you experience hoarseness or throat irritation?
9.	Y	N	Do you experience itchy or crawly sensation in your legs at bedtime?
10.	Y	N	Have you been told that you kick at night?
11.	Y	N	When angry or happy, have you ever lost muscle strength?
12.	Y	N	Have you been unable to move upon waking up?
13.	Y	N	Have you experienced hallucinations upon sleeping or waking?
14.	Y	N	Do you have difficulties initiating sleep?
15.	Y	N	Do you feel depressed?
16.	Y	N	Do you awaken earlier then you would like to in the morning?
17.	Y	N	Do your thoughts prevent you from falling asleep at night?
18.	Y	N	Do you drink caffeine in the evenings?
19.	Y	N	Do you use tobacco in the evenings?
20.	Y	N	Do you use illicit drugs?
21.	Y	N	Do you use alcohol in the evenings?
22.	Y	N	Do you use medication to help you sleep?
23.	Y	N	Do you use medication to help you stay asleep? (if yes include in medication list)

What is your usual bed time? _______________________ (Weekend: _______________________)
What is your usual wake time? _______________________ (Weekend :_______________________)
How many hours of sleep do you usually get? _________ (Weekend: _______________________)
Are you a shift worker: Yes No
If yes how often do you change shifts? ____
Current shift hours: From:______________________ To: ________________________
Since ________________(date)
Why do you think that you are being tested?
____
Describe your problem:
a. How long have you had it?
b. What have you done about it?
c. How has it affected your quality of life?

EPSWORTH SLEEPINESS SCALE

PLEASE USE SCALE TO RATE THE SITUATIONS

0= would NEVER doze
1= SLIGHT chance of dozing
2 = MODERATE chance of dozing
3= HIGH chance of dozing

Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting inactive in a public place (i.e. theater, meeting)	0	1	2	3
As a passenger in a car, for a hour without a break	0	1	2	3
Lying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking with someone	0	1	2	3
Sitting quietly after lunch without alcohol	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

ARIZONA GRAND MEDICAL CENTER
3777 CROSSINGS DR. PRESCOTT, AZ 86305
7900 E. FLORENTINE RD. PRESCOTT VALLEY, AZ 86314
PHONE: 928-771-3793 EXT. 6
FAX: 928-708-0505

I, ___________________________________(*PLEASE PRINT NAME*), HEREBY AUTHORIZE MY PROVIDER (DOCTOR OR NURSE PRACTITIONER) AT AGMC AND HIS OFFICE STAFF TO OBTAIN MY MEDICAL RECORDS FROM MY OTHER DOCTORS AND CORRESPONDING MEDICAL FACILITIES, INCLUDING HOSPITALS AND OUTPATIENT CLINICS. I UNDERSTAND THAT THE STAFF MAY NEED TO REQUEST RECORDS FROM SAID FACILITIES AND I GIVE MY CONSENT TO DO SO.

I AUTHORIZE THE PHYSICAN TO PERFORM ADDITIONAL PROCEDURES IN THE OFFICE WHICH IN HIS JUDGEMENT ARE NECESSARY OR APPROPRIATE TO CARRY OUT MY DIAGNOSIS/TREATMENT.

INITIALS: __________

CANCELLED/MISSED APPOINTMENTS:
A SCHEDULED APPOINTMENT MEANS THAT TIME IS RESERVED ONLY FOR YOU. IF AN APPOINTMENT IS MISSED OR CANCELLED FOR ANY REASON WITH LESS THAN 48 HOURS NOTICE, YOU MAY BE CHARGED FOR THAT VISIT. THIS FEE IS NOT COVERED BY ANY INSURANCE COMPANY.

INITIALS: ___________

PRESCRIPTION REFILL POLICY:
OUR OFFICE POLICY IS THAT ALL PRESCRIPTION REFILL REQUESTS MUST BE MADE 7-10 BUSINESS DAYS IN ADVANCE, TO AVOID RUNNING OUT OF THE MEDICATION.
IF YOU HAVE 0 REFILLS, YOU MAY CALL THE OFFICE TO REQUEST A REFILL.

INITIALS: ___________

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE.
SIGNATURE: ____ *DATE*: ____________

ARIZONA GRAND MEDICAL CENTER, PLLC

3777 CROSSINGS DRIVE
PRESCOTT, AZ 86305

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.

Protected health information, about you, is obtained as a record of your contacts or visits for healthcare services with ARIZONA GRAND MEDICAL CENTER. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

ARIZONA GRAND MEDICAL CENTER is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations and for other purposes that are permitted or required by law.

If you have any questions about this Notice please contact our Privacy Manager at 928-771-9693

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your protected health information. Please feel free to discuss any questions with our Privacy Manager .

You have the right to receive and we are required to provide you with a copy of this Notice of Privacy Practices- We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.
You have the right to authorize other use and disclosure- This means you have the right to authorize or deny any other use or disclosure of protected health information not specified in this notice. You may revoke an authorization, at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.
You have the right to designate a personal representative- This means you may designate a person with the delegated authority to consent to, or authorize the use or disclosure of your protected health information.
You have the right to inspect and copy your protected health information- This means you may inspect and obtain a copy of protected health information about you that is contained in your patient record.
You have the right to request a restriction of your protected health information- This means yon may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. In certain cases we may deny your request for a restriction.
You may have the right to have us amend your protected health information - This means you may request an amendment of your protected health information for as long as we maintain this information. In certain cases, we may deny your request for an amendment.
You have the right to request a disclosure accountability - This means that you may request a listing of your protected health information disclosures we have made to entities or persons outside of our office.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager of your complaint.

How We May Use or Disclose Protected Health Information

Following are examples of use and disclosures of your protected health care information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

For Treatment- We may use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that is involved in your care and treatment. *For* example, we would disclose your protected health information, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose protected health information to other physicians who may be involved in your care and treatment. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or

recommends treatment alternatives regarding your care. And, we may contact you to provide information about health related benefits and services offered by our office.

For Payment- Your protected Health information will be used, as needed, to obtain payment for our health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

For Healthcare Operations- We may use or disclose, as-needed, your protected health information in order to support the business activities of our practices. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, and auditing functions. It also includes Education, provider credentialing, certification, underwriting, rating, or other insurance related activities. Additionally it includes business administrative activities such as customer service, compliance with privacy requirements, internal grievance procedures, due diligence in connection with the sale or transfer of assets, and creating de-indentified information.

Other Permitted and Required Uses and Disclosures -

We may also use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information.

To others Involved in Your Healthcare- Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, general condition or death. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

As Required by Law- We may use or disclose your protected health information to the extent that the use or disclosure is required by law.

For Public Health- We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information.

For Communicable Diseases- We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

For Health Oversight- We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

In Cases of Abuse or Neglect- We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

To The Food and Drug Administration- We may disclose your protected health information to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

For Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceedings, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

To Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes.

To Coroners, Funeral Directors, and Organ Donation- We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

In Cases of Criminal Activity- Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

For Military Activity and National Security- When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services.

For Worker's Compensation- Your protected health information may be disclosed by us as authorized to comply with worker's compensation laws and other similar legally-establish1ed programs.

When an Inmate- We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Required Uses and Disclosures- Under the law, we must make disclosures about you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of the Privacy Rule.

Notice of Privacy Practices
ARIZONA GRAND MEDICAL CENTER
HIPAA-NOTICE

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Signature: ______________________________ Date: ____________________

MEDICATION LIST (or attach one):