EAST VALLEY
Pulmonary Associates

East Valley Pulmonary Associates, PLLC.
Firas Joudeh, MD
1520 S Dobson Rd Suite 218
Mesa, AZ 85202
Phone# 480-626-8737
Fax# 480-704-4698

PATIENT REGISTRATION FORM

(PLEASE PRINT and FILL OUT ALL FORMS COMPLETELY)

Patient Name: _____ Date of Birth: _____ / _____ / _____

Address: _____ City: _____ State: _____ Zip: _____

Home # _____ Cell # _____ Work # _____

Email: _____ SSN#_____

Ethnicity: __ Hispanic or Latino __ Not Hispanic or Latino __ Declined

Race: □ Native American or Alaska Native □ African or African American □ Asian or Asian American
□ Caucasian or European American □ Native Hawaiian or Other Pacific Islander □ Declined

Emergency Contact: _____ Ph # _____

Pharmacy Name: _____ Ph # _____
Cross Streets

How did you hear about our office? _____

****

Primary Insurance: _____ Effective Date: _____ / _____ / _____

Member / Policy #_____ Group # _____

Policy Holder's Name: _____ Relationship: _____

Policy Holder's Date of Birth: _____ / _____ / _____ Policy Holder's Employer: _____

****

Secondary Insurance: _____ Effective Date: _____ / _____ / _____

Member / Policy #_____ Group # _____

Policy Holder's Name: _____ Relationship: _____

Policy Holder's Date of Birth: _____ / _____ / _____ Policy Holder's Employer: _____

****

Acknowledgement: I certify that the above information is true and correct. I hereby authorize release of any and all medical information that may be requested by the above named insurance carrier(s) in order to process a claim for benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I am financially responsible for all charges accumulated from any missed appointments that were not cancelled by the patient at least 24 hours prior to my scheduled appointment. In the event of default and the account is placed with a collection agency, I agree to pay the fees of the collection agency equal to a maximum of 50% of the outstanding balance at the time the account is placed with the agency and interest accrual of 10% per year on the principal balance. Should legal action be necessary to collect the account, I agree to pay attorney fees and court costs that occur.

Patient Signature: _____ Date: _____ / _____ / _____

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Medical History Form

Name:_____ Date of Birth:_____ Todays Date:_____

Reason for todays visit:_____

PCP: _____ Ph # _____ Fax # _____
(Primary Care Doctor)

Other Physicians you would want to share the visit with:_____

Past Medical History:

Past Surgical History:

Current Medication:

Allergies:

Social History: Do you smoke? ☐ Yes ☐ No If yes: Packs/day_____ How many years?_____

Did you ever smoke? ☐ Yes ☐ No If yes: Packs/day_____ How many years? _____

Have you ever quit? ☐ Yes ☐ No If Yes, when and for how long did you quit? _____

How did you quit? _____

Pets : Cats Dogs Birds None

Work History:_____

Family History:_____

_____

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Medical History Form

Name:_____ Date of Birth:_____ Todays Date:_____

REVIEW OF SYMPTOMS

REVIEW OF SYSTEMS(check): Do you **CURRENTLY** or **FREQUENTLY** suffer from or have difficulty with any of the below

SLEEP: □Day time sleepiness □Snoring □Other_____

GENERAL: □Weight Loss □ Fever □ Other_____

EAR, NOSE, THROAT, MOUTH: □Sore Throat □Hoarseness □Other _____

CARDIOVASCULAR: □Chest Pain □Palpitation □Other_____

HEMATOLOGIC: □Easy Bleeding □Other_____

ENDOCRINE: □Increased thirst □Sensitivity to cold □Other_____

URINARY: □Blood in Urine □Weak Urine stream □Other_____

MUSCLE AND BONES: □Joint Pain □Muscle Pain □Other_____

NEUROLOGIC: □Dizziness □Numbness □Weakness □Other_____

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Release and Authorization for Use or Disclosure of Protected Health Information

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

Address: _____

_____

Telephone: _____

I authorize **East Valley Pulmonary Associates** to disclose/release the following information:

_____ All medical records related to (specify condition, treatment, etc.): _____

_____ All billing records related to (specify condition, treatment, etc.): _____

_____ Specific records/information as follows: _____

_____

Purpose of disclosure: _____

I do not want the following information disclosed (as defined by applicable state and federal laws):

_____ Alcohol/Drug Abuse _____ HIV Test Results _____ Mental Health/Developmental Disabilities

Release information TO:

Address: _____

_____

Telephone: _____ **Fax:** _____

This Authorization is good until the following date: _____
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the disclosing medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim/policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and/or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Printed Name of Patient or Personal Representative Address

_____ _____
Description of Personal Representative's Authority Telephone

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PRACTICE EXPECTATIONS

We are a specialty practice and we see our patients by referral from their Primary Care Physician (PCP) or as a follow-up to a hospital admission. As a specialist, we do not coordinate primary care activities for our patients. Please contact your Primary Care Physician (PCP) for assistance **obtaining follow-up referrals, completion of disability claim paperwork, and completion of work release or light duty requests**. We do not provide laboratory testing or imaging study results by telephone, we do not accept worker's compensation insurance, we **do not** prescribe Narcotics or Anxiolytics, and please contact your pharmacy to request prescription refills.

PAYMENT POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. Payment for services is due at the time of the visit. We accept cash, check, or credit card (Visa, Mastercard, and American Express). Patients are responsible for their health care charges and should be familiar with their insurance policy. Please be aware of your co-pay amounts, which will be due at the time of your visit. If you need further information, please ask to speak with the Billing Specialist who is available to answer questions and provide assistance.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable copayments and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to East Valley Pulmonary Associates, PLLC. I authorize Easy Valley Pulmonary Associates, PLLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Patient Signature: _____ Date: _____ / _____ / _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE AND HEALTH INFORMATION NOTICE

I acknowledge that I have been provided the East Valley Pulmonary Associates PLLC. ("EVPA") Notice of Privacy Practices:

- It tells me how EVPA with use my health information for the purposes of my treatment, payment for my treatment and EVPA's health care operations.
- The notice explains in more detail how EVPA may use and share my health information for other than treatment, payment, and health care operations.
- EVPA will also use and share my health information as required/permitted by law.

I acknowledge that I have been provided the East Valley Pulmonary Associates PLLC. (EVPA) Notice of Health Information:

- It tells me how EVPA will electronically share health information with a Health Information Organization (HIO)
- The notice explains in more detail how I may Opt-out of sharing my health information with the HIO.

_____ _____

Signature of Patient or Personal Representative Date

Please refer to our practice website for additional practice information, including normal office hours, www.evpaclinic.com