PIA
Pulmonary Institute of Arizona

Welcome to Pulmonary Institute of Arizona, LLC. We believe in providing every patient excellent quality care and are proud you have selected us for your healthcare needs. In order to prepare for your appointment, please take a moment and complete the information below. You will be requested to review this information at every visit to ensure we always have the most current information on file. We also request knowledge of your race and ethnicity in order to accurately interpret lung function tests. This is important in this area of medicine and ensures accurate test interpretations and treatment plans.

Please Print **Patient Number «PatientNumber»**

Personal Information

First Name «PatientFirstName» **Middle Name** «PatientMiddleName» **Last Name** «PatientLastName»

SS# _____ **Sex** «PatientSex» **Date of Birth** «PatientDOB»

Race **«PatientRace»** ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Black ☐ Asian ☐ Other

Ethnicity **«PatEthnicity»** **Marital Status** **«PatientMaritalStatus»**

Employment Status «EmploymentStatus» **Employer** «Employer»

Address «PatientAddrLine1» «PatientAddrLine2» **City** «PatientAddrC **State** «P **Zip** «PatientAd

Home Phone «PatientPhoneNumber» **Work Phone** «PatientWorkPhone» **Cell Phone** «PatientMobilePhone»

Emergency Contact Name _____ **Contact Phone** _____

Contact Work _____ **Relationship** _____

Referring Physician **«RefProviderName»** **Primary Care Provider** **«PrimaryCareProviderFullName»**

Authorization for Voicemail: I authorize physicians and staff members of PIA to leave a detailed message pertaining to my medical care on my home or mobile phone. I know it is my responsibility to ensure I have accurate contact information on file with PIA. **Home phone** ☐Approved ☐Decline **Mobile Phone** ☐Approved ☐Decline

Pharmacy Information

Pharmacy «PatPharmacyName» **«PatPharmacyAddrLine1»**

Prescription card if applicable _____ **Phone** **«PatPharmacyPhone»**

Primary Insurance		**Secondary Insurance**	
Company	«PlanName»	**Company**	«SecPlanName»
Subscriber Name	«SubscriberName»	**Subscriber**	«SecPlanSubscriberName»
Subscriber Date of Birth	«SubscriberDOB»	**Subscriber Date of Birth**	«SecPlanSubscriberDOB»
Relationship to Subscriber		**Relationship to Subscriber**	
Group#	«GroupNumb	**Member ID** «ClaimMemberID»	**Group#** «SecPlanGrou	**Member ID** «SecPlanClaimMe

☐ I affirm that the information above is complete and accurate to the best of my knowledge. By signing this form, I consent to the treatment by PIA providers and I acknowledge receipt of the PIA Notice of Privacy Practices, The practice's Notice of Privacy is posted in the reception area, a copy is available upon request. I know it is my responsibility to ensure I have accurate contact information on file with PIA.

Assignment of Benefits: I hereby assign to Pulmonary Institute of Arizona (PIA any insurance or other third-party benefits available for healthcare service provided to me. I understand that PIA has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to PIA, I agree to forward the Practice all health insurance and other third-party payments I receive for service rendered to me immediately upon receipt.

_____
«PatientFirstLastName» «ApptDate»

Pulmonary Institute of Arizona

PATIENT HIPAA and SECURE PATIENT PORTAL INFORMATION
CONSENT FOR DISCLOSURE OF INFORMATION FOR PURPOSES REQUESTED BY THE PATIENT

Pulmonary Institute of Arizona, LLC (PIA) is committed to securing the privacy of your health information. Federal Law permits Pulmonary Institute of Arizona, LLC, to disclose your protected Health information (PHI) to specific individuals you designate. These individuals may assist you with making appointments, calling our office about your need to speak to your doctor, or picking up medical records on your Behalf.

I **«PatientFirstLastName»** Date of Birth: **«PatientDOB»** ,hereby authorize Pulmonary Institute of Arizona, LLC to provide protected health information to the following individuals on my behalf. I understand that the following identified individuals will need to provide proof of identification in order to access the requested information or pick up needed medical and/or health information. I also understand that I may revoke any of the following identified individuals from this list at any time by notifying my health care provider in writing and/or by updating this form.

I understand that this document is valid in my file for one year and that it is my responsibility to update this form periodically or upon request by the staff of Pulmonary Institute of Arizona, LLC. Disclosure will be given to listed individuals as directed by the most current form placed on file.

Authorization to release information (Family and/or Friends):

I Authorize PIA to release and communicate my healthcare information with the following individuals:

Name	Relationship	Phone Number

We would like to communicate with you via our Patient Portal. You are able to request Medication Refills, Appointments, send a secure message to the office staff and you will have the ability to see an overview of your chart.

https://myhealthrecord.com/Portal/SSO

Email Address _____«PatientEmail»_____

Authorization for Email: Read carefully, if you do not wish communication through our portal, please leave blank. I am providing my e-mail address to PIA in order to become authorized to use the patient portal system of the practice and to benefit from the ability to see my records and communicate securely with the physician and staff members of the Practice:

If you choose to decline this option, please initial here _____

«PatientFirstLastName» «ApptDate»

Pulmonary Institute of Arizona

«PatientFullName»
«PatientDOB»

APPOINTMENT / FINANCIAL POLICY

The physicians of Pulmonary Institute of Arizona, LLC, (PIA) are committed to providing quality care at a reasonable cost to our patients. Your clear understanding of our financial and appointment policy is important to our professional relationship. Please read and sign the form and return it to the front desk. They will be able to assist in any questions you might have.

- Always supply us with current and complete insurance information. We will ask you for a copy of your insurance card at each visit, and ask that you update any changes in your demographic information.

- Pay in full for all co-payments, deductibles, and non-covered services when you check in the day of your appointment. Retain copies of all payment receipts given at time of service to assist you should a payment dispute arise.

- We accept cash, checks, Visa, Mastercard and debit cards. Inability to pay your copay may result in your appointment being rescheduled. You will be charged a $25 fee for any returned checks.

- If a procedure is ordered, any additional copays, coinsurance, and/or deductible owed will have to be paid 24 hours prior to testing. If payment in full cannot be made prior to your procedure, the patient is responsible to establish a payment arrangement with the office prior to the procedure.

- Patient will be required to provide both your Insurance company and PIA any additional information requested to complete the processing of claims filed on your behalf.

- Authorize release of information as necessary, by signing a patient registration form at each visit.

- Please arrive 15 minutes before your scheduled appointment time to allow sufficient time for the check-in process. If you are more than 10 minutes late, your provider may request you reschedule for the convenience of patients who arrive on time.

- Your provider may refer you to another provider or setting outside this clinic (such as a laboratory) for additional services. We will assist you to the best of our ability with the referral process. However, insurance companies do not notify us whether services outside our clinic have been approved. You are responsible for ensuring insurance coverage of an any outside services your provider ordered.

- Due to high demand for new pulmonary visits, if you do not show for your new patient appointment and do not call at least 24 hours in advance to reschedule, you may not be rescheduled.

- Sometimes our patient cannot attend their scheduled appointment. Please let us know if you cannot make your appointment. Cancellations must be done at least 24 hours prior to your appointment. We charge a $25 fee for all scheduled appointment no shows and for appointment cancelled without 24 hour notice.

- Please understand that repeatedly canceling appointments interferes with the provider's ability to provide the highest quality care. For this reason, we will discontinue the relationship with a patient who cancels or does not show for 3 appointments.

Pulmonary Institute of Arizona

«PatientFullName»
«PatientDOB»

INSURANCE
We have contractual agreements with many managed care plans. Each time that you make an appointment with one of our physicians, it is your responsibility to make sure that your provider is contracted with your plan. We may require verification of coverage and benefits before you are seen. If you have questions about provider participation with your insurance plan, please contact your insurance carrier prior to your visit. Our staff can also assist in answering questions regarding your insurance by contacting our office.

If you are covered by an insurance that your physician is not contracted with, or you have no insurance coverage, you will be treated on a cash/self-pay basis, and responsible for payment in full at check out. Uninsured patients may be offered a discount if paid in full on the date of service rendered. There is no discount for patients that need to make payment arrangements.

If you have a high deductible or consumer driven health plan, and we are able to determine at the time of your visit how much you will owe after contractual adjustments, we will ask you to pay that amount in full. If we are unable to determine the amount owed at time of service we will bill you accordingly.

COLLECTIONS
PIA makes every effort to work with our patients that for whatever reason may be having a hard time satisfying balances due. Patients who do not make reasonable progress toward retiring outstanding debts may, or who do not agree to a payment plan, may, at the sole discretion of the provider, be terminated from PIA. The practice will turn unsatisfied accounts over to the practice's collection agency, and report debts to credit reporting agencies. Patients terminated from the practice will be given thirty-day notice during which time their emergency medical care needs will be addressed.

_____ _____
«PatientFirstLastName» «ApptDate»

I have been given the opportunity to review the following policies:
Patient Rights and Responsibilities
HIPAA Privacy Notice
Grievance / Complaint procedure

_____ _____
«PatientFirstLastName» «ApptDate»

Waiver of Patient Authorizations—**Read Carefully**—"I do not wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion."

_____ _____
«PatientFirstLastName» «ApptDate»

Pulmonary Institute of Arizona

«PatientFullName»
«PatientDOB»

ADULT HEALTH QUESTIONNAIRE

Personal Health History

General

How long have you lived in Arizona: _____

Did you move for health reason: _____ If so, please explain: _____

_____

Where did you live before Arizona? _____ How long? _____

What is your occupation? _____ How long? _____

Habits

Do you use tobacco: Yes No Former Type of tobacco: Cigarettes Cigar Pipe Chew Smokeless

Daily Average: _____pack(s)/pipe/can Total # of years used:_____ Date quit: _____

Do you use recreational drugs: Yes No Former Type:_____ How often:_____ Date quit:_____

How many caffeinated drinks do you consume per day? _____

How many alcoholic beverages do you consume per week? _____

Immunizations/Vaccinations (List Most Recent Date)

Flu: _____ Tetanus: _____ Pneumovax 23: _____

Prevnar: _____ Zostavax: _____ Other: _____

Current Medication	Amount/Dosage	Frequency

Allergic to **Reaction** **Date**

_____

_____

Pharmacy ____«PatPharmacyName»_____«PatPharmacyPhone»_____

Durable Medical Equipment

Do you use oxygen? _____ If so, do you use 24/7 or only at night? _____

How many liters? _____ What company supplies oxygen? _____

Please circle if you use **CPAP/BIPAP/ASV/Vent/Trilogy**

If so, what are your settings? _____ What company supplies your equipment? _____

Pulmonary Institute of Arizona

«PatientFullName»
«PatientDOB»

General

Fever Sweats Chills Headaches Weight Change Faintness/Lightheadedness Excess Tiredness Fatigue

Skin Rashes- Itching Skin Dryness Other Skin Problems Problem Hair and Nails Other _____

Eyes, Ear, Nose and Throat

Eyes Ears Nose Throat Sinuses

Heart/Lungs

Coughing or Wheezing Irregular Heartbeat Sputum/Phlegm Chest Tightness/Pain Edema

Coughing Blood Shortness of Breath Other _____

Stomach/Digestion

Change of Appetite Constipation Food Intolerance Change in Bowel Habits Indigestion/Heartburn

Bloody or Black Stools Ulcers Hemorrhoids Vomiting Other _____

Kidneys/Urination

Frequent Urination Hesitancy Urination at Night Pain with Urination Blood in Urine

Other _____

Emotions

History of Child Abuse Excessive Anxiety History of Depression Thoughts of Suicide

Psychiatric Care of Counseling Problems with Family or Work Relation Difficulty Sleeping Excessive Sadness

Other _____

Muscular/Skeletal

Joint swelling Muscle pain Bone pain Joint pain Weakness Other

Neurological

Numbness Tingling Balance Dizziness

Medical History

Do you have or has a doctor ever told you that you have any of the following conditions? (Please circle any that apply)

Alpha 1 Antitrypsin Asthma COPD Asbestosis Valley Fever

Emphysema Lung nodule Pulmonary Embolism Pulmonary Fibrosis Epilepsy

Sarcoidosis Sleep Apnea Insomnia Stroke Kidney Disease or stones

Alcohol Problems Chronic Back Pain Atrial Fibrillation Allergies Drug Abuse

Anxiety/Panic Disorder Glaucoma Mental Illness Sexual Problems Hypothyroidism

Deafness Congestive Heart Failure Heart Attack/Angina Depression

Pulmonary Institute of Arizona

«PatientFullName»
«PatientDOB»

Hospitalizations/Surgeries-Please list hospitalizations or surgeries within the last 10 years:

Name of Facility City State Diagnosis Date

_____
_____
_____
_____
_____

Have you recently had any if the following:

Chest X-Ray:_____ When:_____ Where:_____

Chest CT: _____ When:_____ Where:_____

Echocardiogram: _____ When:_____ Where:_____

Have you ever been advised to have a surgical operation, which you have not undergone? If yes, please explain:

_____
_____

Emergency Room/Urgent Care Visit-Please list within the last 2 years:

Name of Facility City State Diagnosis Date

_____
_____
_____

Family Medical History

Has any direct member of your family (father, mother, sister, brother, grandparents) had problems in the following areas? Please circle.

Alcohol Problems Allergies Arthritis/Rheumatism Asthma Blindness Cancer Child Abuse Deafness Depression

Drug Abuse Emphysema Glaucoma Heart Disease High Cholesterol High Blood Pressure Kidney Stones

Mental Illness Stroke Diabetes Tuberculosis Other _____

Pulmonary Institute of Arizona

«PatientFullName»
«PatientDOB»

Immediate Family History

Family Member	Age	State of Health or Cause of Death	Check if Deceased
Grandparents			
Father			
Mother			
Sibling			
Sibling			
Sibling			
Child			
Child			

Do you have additional questions? If so, please list.

_____

_____

_____

_____

To the best of my knowledge, the above information is correct.

Signature (Patient) _____ Date «ApptDate»

Signature (Physician) _____ Date «ApptDate»

Pulmonary Institute of Arizona

«PatientFullName»
«PatientDOB»

Patient Sleep Questionnaire

Age: _____ Sex: M / F Height: _____ Weight: _____ Phone Number: _____

Home Address: _____

Occupation: _____Usual work hours/days_____

Referring Physician Name: _____

Emergency Contact: _____Relationship:_____

Phone Number (Must be different from above listed number):_____

What is your main sleep complaint?

_____

_____

What is the reason your physician has ordered a sleep study for you?

_____

_____

What is your normal bedtime? _____ AM / PM What is your normal wake time? _____ AM / PM

On average, how long do you feel it takes you to fall asleep? _____

How many times do you awake most nights? _____

On average, how many hours of sleep do you feel you achieve at night? _____

What is your predominant position for sleeping? Back / Stomach / Side / Sitting Up

Please check if you have had any of the following problems:

- ☐ Asthma, Chronic lung disease (COPD, Emphysema) ☐ Thyroid Disease ☐ Diabetes
- ☐ Heart Disease /Atrial Fibrillation ☐ Depression ☐ GERD
- ☐ Anxiety, Panic Attacks or Claustrophobia ☐ Stroke ☐ Seizure disorder
- ☐ Hypertension (high blood pressure) ☐ Chronic nasal / Sinus problems
- ☐ Other nose or throat surgery / Tonsillectomy

Please list all medications you currently take including prescription, Non-prescription and any sleeping agents. (Please attach a list if needed)

_____

_____

Do you have any allergies (such as tape)? If yes, please describe: _____

Use the following scale to choose the most appropriate number for each situation.

EPWORTH SCALE - Situation or Activity	Chance of Dozing
0 = would never doze 1 = slight chance 2 = moderate chance 3 = high chance	(0) (1) (2) (3)
Sitting and watching TV	☐ ☐ ☐ ☐
Sitting and Reading	☐ ☐ ☐ ☐
Sitting inactive in a public place (theatre/meeting)	☐ ☐ ☐ ☐
As a passenger in a car for an hour without a break	☐ ☐ ☐ ☐
Lying down to rest in the afternoon when circumstances permit	☐ ☐ ☐ ☐
Sitting and talking to someone	☐ ☐ ☐ ☐
Sitting quietly after a lunch with no alcohol	☐ ☐ ☐ ☐
In a car, while stopped for a few minutes in traffic	☐ ☐ ☐ ☐
Total:	

Pulmonary Institute of Arizona

«PatientFullName»
«PatientDOB»

Please circle **Y** for Yes or **N** for No

Y/N Have you ever had a sleep study done previously?
Y/N Have you ever been diagnosed with a sleep disorder?
Y/N Have you ever had surgery for a sleep problem or snoring?
Y/N Do you use oxygen when you sleep? If yes, how much? LPM: _____
Y/N Has anyone in your family ever been diagnosed with a sleep problem? If yes, please describe:
_____

Y/N Do you use medication to help you sleep?
Y/N Do you drink alcoholic beverages? If yes, how many drinks per day? _____
Y/N Do you regularly drink caffeinated beverages? If yes, how many cups per day? _____
Y/N Do you use Tobacco?
If yes, what type? Cigarettes / Cigars / Chewing. How many/much per day? _____
Y/N Do you have trouble relaxing and feeling ready to go to sleep?
Y/N Do you wake up too early and have trouble falling back to sleep?
Y/N Do you experience a creeping-crawling or tingling sensation in your legs?
Y/N Do you ever hear, see or feel things that may not be real as you are falling asleep?
Y/N Have you ever awakened feeling like you are awake but cannot move momentarily?
Y/N Have you felt the sensation of muscle weakness as a reaction to an emotional response?
Y/N Do you take daily naps? If yes, for how long? _____
Y/N Do you feel tired when you wake up?
Y/N Are you sleepy at any time during the day?
Y/N Have you ever had accidents or near accidents due to sleepiness?
Y/N Do you have a history of sleepwalking?
Y/N Do you talk and/or eat in your sleep?
Y/N Do you grind your teeth in your sleep?
Y/N If yes, do you use a mouth device for this?
Y/N Does your partner complain about your leg movements at night during sleep?
Y/N Do you have nightmares?
Y/N Have you ever been told that you are acting out your dreams?
Y/N As an adult, do you have a history of bed-wetting?
Y/N Have you ever awakened confused or disoriented?
Y/N Do you snore?
Y/N Has anyone told you that you stop breathing in your sleep?
Y/N Do you ever awake up with gasping breaths sensation or racing heart beat?
Y/N Do you wake in the morning with a headache?
Y/N Do you wake in the morning with dry mouth?
Y/N Do any of the following affect your ability to sleep? **Check all that apply**
☐ Pain/discomfort ☐ Sweating ☐ Headaches ☐ Leg Discomfort ☐ Heartburn
☐ Cough ☐ Shortness of Breath ☐ Frequent Urination ☐ Anxiety, stress/racing thoughts
☐ Disruptive sleep environments (i.e. partner/ noise)
Y/N Do you perform the following in bed? **Check all that apply**.
☐ Argue ☐ Check the clock ☐ TV ☐ Worry ☐ Eat ☐ Read/Write ☐ use computer