Phoenix Neurology and Sleep Medicine
Phone: (623) 535-0050   Fax: (623) 535-9520

Phoenix Neurology
& Sleep Medicine

Goodyear Office:
2940 N Litchfield Rd
Goodyear, AZ 85395

Deer Valley Office:
2925 W Rose Garden Lane
Phoenix, AZ 85027

Central Office:
300 E Osborn Rd Ste # 200
Phoenix, AZ 85012

Phone (623) 535-0050   Fax (623) 535-9520

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

(Original to be maintained in patient's permanent medical record)

I acknowledge that the office's Notice of Privacy Practices has been made available to me.

_______________________________________   _____________________
Patient or Legally Authorized Individual Signature   Date

_______________________________________   _____________________
Patient Name if signed on behalf of the Patient   Relationship to the Patient

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Patient Information Date: ___________________

Name: ______________________________________ SSN__________________________
(Last) (First) (MI)

Address____

City__________________________ State___________ Zip Code____________________

Home #_________________________Cell #___________ Work_____________________

Sex __Male Age_____ DOB_________ ___ Married ____Single ___Divorced

__Female ___Widowed ___Other

Email Address ____

Employed? ___No ____ Yes Employer ____________________________________

Emergency Contact ____________________________________Phone #________________

Referring Physician_____________________________________Phone #________________

Primary Care Doctor____________________________________Phone #________________

Primary Insurance

Insurance Name: __________________________ Insured's Name _____________________

Insured's DOB ___________________ Insured's SSN_________________________________

Relationship to Insured___________________ Insurance Phone #______________________

Policy or ID # ________________________________ Group #__________________________

Secondary Insurance

Insurance Name: __________________________ Insured's Name _____________________

Insured's DOB ___________________ Insured's SSN_________________________________

Relationship to Insured___________________ Insurance Phone #______________________

Policy or ID # ________________________________ Group #__________________________

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Contact Information:

I may be contacted in the following manner:

OK to leave message with detailed information ___ Home ____ Work ___ Cell ___NO

OK to leave call back number only ___ Home ____ Work ___ Cell ___NO

OK to send mail to ___ Home ____ Work ___NO

Those who may receive information included in my medical records:

___ Spouse Name______________________________ DOB ________________________

___Other Name______________________________ DOB________________________

___ Other Name______________________________ DOB ________________________

____ ___________________________
(Patient's Signature) (Date)

Assignment and Release

I certify that I, and/or my dependents, have insurance and assign directly to Phoenix Neurology and Sleep Medicine all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Phoenix Neurology and Sleep Medicine may use my healthcare information and may disclose such information to the above named insurance company/s and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ___________________________
(Signature of the Patient/Parent/Guardian) (Date)

____ ___________________________
(Signature of the Patient/Parent/Guardian) (Date)

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Front Office and Appointment Guidelines

- All co-payments and account balances are due at the time services are rendered, unless other arrangements have been made. We accept cash, check, Visa, MasterCard, American Express and Discover.

- Inform the front office receptionist of any change in demographics or insurance. Failure to do so may lead to an account balance.

- If you have an insurance plan that requires a paper referral or authorization number, it is your responsibility to make sure the referral has been completed by your primary care physician and is in our office for your scheduled appointment time. If we do not have a referral or authorization your appointment can be rescheduled.

- Give at least a 24 hour notice when cancelling or rescheduling an appointment, so we may use that appointment slot for another patient.

- If you are late for your appointment the doctor will be unable to see you.

- **There is a $50 fee for No Show appointments and same day cancellations.**

- **There is a $25 fee for ALL NSF Returned Checks.**

- **There is a $200 fee for No Show Sleep Test appointments or same day cancellations.**

- Please allow 24 to 48 hours for your prescription to be filled. PRESCRIPTIONS WILL NOT BE REFILLED OVER THE WEEKEND.

- Please allow 7 to 14 business days for your tests or procedures to be scheduled (e.g. MRIs, CTs, Physical Therapy, etc.). Either our office or the contracted facility will contact you to schedule the appointment.

____

(Patient Signature and Date)

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Your Name ___________________________________ Today's Date _____________________

Chief Complaint: Please explain why you have come here, including problems, date of onset, sudden or gradual onset, frequency, duration, nature and factors which bring on, worsen or improve this complaint. Please describe intermittent problems/spells as best as you can:

Past Medical History (Please mark all problem referring to the following functions.)

General Problems:

___ Energy ___ Weight Loss ___Fever ___Sweats ___Chills ___Fatigue ___Stamina ___Appetite

Neurological Problems:

___Headache/Migraine ___Blurred Vision ___Double Vision ___Hearing Loss ___Ringing in Ears

___Speech(slurred/loss)___Swallowing,Chewing ___Head Trauma ___Concussion ___Blackouts

___Seizures ___Dizziness ___Vertigo(spinning) ___Incontinence ___Weakness ___Coordination

___Gait ___Balance ___Involuntary Movements ___Insomnia ___Obstructive Sleep Apnea

___Restless Legs ___Stroke ___Confusion ___Memory Loss ___Neck Pain ___Low Back Pain

___Numbness/Tingling ___TIA Other____

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Medical Problems:

___Diabetes ___High Blood Pressure ___TB ___Heart Disease ___Heart Attack ___Asthma

___COPD ___Breathing Problems ___Thyroid ___Bleeding ___Clotting ___Anemia ___Colitis

___Irritable Bowel ___Fibromyalgia ___Lupus ___Rheumatoid Arthritis __Kidney Disease

___Lyme Disease ___Cancer ___Sleep ___Snoring ___Frequent Awakening

___Difficulty Falling Asleep   Other____

Past Surgical History (Please list all surgeries you have had.)

____

____

____

____

Current Medications and Dosages

____

____

____

____

Drug Allergies (Please list allergies to any medications and the reaction you have.)

____

____

____

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Review of Systems

General

___ Weight Loss or Gain ___ Fatigue ___ Fever or Chills ___ Trouble Sleeping

Skin

___ None ___ Rashes ___ Dryness

Ears

___ None ___Decreased hearing ___ Ringing in ears(tinnitus) ___ Earache

Eyes

___ None ___ Vision ___ Pain ___ Blurry or double vision

Respiratory

___ None ___Cough ___ Shortness of breath

Cardiovascular

___ None ___Chest pain or discomfort ___Palpitations ___ Swelling (edema)

Gastrointestinal

___None___Swallowing difficulties__Change in appetite__Nausea___Diarrhea ___Constipation

Urinary

___ None ___ Frequency ___ Urgency ___ Incontinence

Musculoskeletal

___ None ___ Muscle or joint pain ___Stiffness ___Back pain ___Redness of joints ___Swelling

Neurologic

___ None ___ Dizziness/Vertigo ___ Fainting___ Seizures ___ Weakness ___ Numbness/Tingling ___ Tremor

Endocrine

___ None ___ Head or cold intolerance ___ Sweating

Psychiatric

___ None ___Anxiety ___ Depression ___ Memory Loss ___ Stress __Hallucinations/delusions

Family History

___ Alzheimer's___ Stroke/Heart Attack ___ Epilepsy ___ Migraines/Headaches ___Neuropathy

Other____

Social History

Smoking: Y/N PPD:_____________ Alcohol: Y/N Amount:____________

Caffeine: Y/N Amount: ___________ Illicit Drugs: ______________________

Any Additional Information:

What pharmacy should we list in our system where all your prescriptions will go to? (Please list name, address and phone number. If you do not have this information please list the major cross streets.)

____
(Pharmacy Name)

____ __________________
(Pharmacy Address) (Phone #)

____
(Pharmacy Cross Streets)

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Patient Additional Information Needed

Please note we are required by the government to ask these questions for demographic purposes

Patient Name:_________________________________ DOB: _________________________

Date: ____________________________ Account #: ________________________________

Please choose a Race:

___ Asian
___ American Indian / Alaska Native
___ Black / African American
___ Native Hawaiian / Other Pacific Islander
___ White
___ Declined

Please choose an Ethnicity:

___ Hispanic / Latino
___ Non-Hispanic / Latino
___ Declined

What languages do you speak?

____

How did you hear about this office:

___ My Insurance
___ IMS Marathon
___ Friend / Family Member
___ Quest Dex / Yellow Pages
___ Online Search
___ Other, Please Specify: ____

Can DCR contact you about studies you may qualify for?

___ Yes
___ No

*THIS INFORMATION IS REQUIRED FOR STATISTICAL ANALYSIS. FROM THE AGENCIES OF EXECUTIVE OFFICE OF THE PRESIDENT, OFFICE OF MANAGEMENT AND BUDGET, OFFICE OF INFORMATION AND REGULATROY AFFAIRS, DUE TO REVISIONS TO THE STANDARDS FOR THE CLASSIFICATION OF FEDERAL DATA ON RACE AND ETHNICITY (10/30/1997). THE REVISED STANDARDS WILL HAVE 5 MINIMUM CATEGORIES FOR DATA ON RACE (AMERICAN INDIAN OR ALASKA NATIVE, ASIAN, BLACK OR AFRICAN AMERICAN, NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER, AND WHITE) AND 2 CATEGORIES FOR DATA ON ETHNICITY (HISPANIC, NOT HISPANIC). OMB IS ANNOUNCING ITS DECISION CONCERNING THE REVISION OF STATISTICAL POLICY DIRECTIVE NO. 15, RACE AND ETHNIC STANDARDS OF FEDERAL STATISTICS AND ADMINSTRATIVE REPORTING.

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Signature below is acknowledgement that you have read and understand this Privacy Notice.

Patient Name: ____ DOB ___________________________

Signature: ____ Date ___________________________

Release of Information

I _______________________________________ hereby authorization PNSM to release or discuss any and all information pertaining to myself or my medical records with the following people.

Name: _______________________ Relationship: _______________________ Phone #: _____________

Name: _______________________ Relationship: _______________________ Phone #: _____________

Name: _______________________ Relationship: _______________________ Phone #: _____________

I authorize PNSM to contact me at:

Home #: ___________________________________ Work #:___________________________________

May we leave a message on machine? ___ Yes ___ No

Cell #: _______________________________ Alt #: ____

Patient Signature: ____ Date: ________________________

Witness: ____ Date: ________________________