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

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
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 # _________________________
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)
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)
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 ________________________________________________
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)
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 REGULATORY 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 ADMINISTRATIVE REPORTING.*
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: __________________________