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

________________________________________
Patient Name if signed on behalf of the Patient

________________________________________
Date

________________________________________
Relationship to the Patient
## Patient Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
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<tbody>
<tr>
<td>Name</td>
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<td>Age</td>
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<td>DOB</td>
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<td>__Widowed</td>
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<td>__Other</td>
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<td>Email Address</td>
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<tr>
<td>Employed?</td>
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<tr>
<td>Employer</td>
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<td>Emergency Contact</td>
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<tr>
<td>Referring Physician</td>
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<tr>
<td>Primary Care Doctor</td>
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## Primary Insurance

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<td>Insured’s SSN</td>
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<td>Relationship to Insured</td>
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<td>Insurance Phone #</td>
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<td>Policy or ID #</td>
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<td>Group #</td>
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## Secondary Insurance

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</tbody>
</table>
Phoenix Neurology and Sleep Medicine  
Phone: (623) 535-0050  Fax: (623) 535-9520

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

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: ___________________________
Authorization to Release / Receive Medical Records

Patient Name ___________________________________________ DOB: ____________________
Address ____________________________________________________ SSN: ____________________

_______________________________________________________________________________
(City)                                               (State)                             (Zip Code)

I hereby authorize Phoenix Neurology & Sleep PLLC to receive and/or release medical record information
concerning the above named patient to:

Requesting Records From:                   Releasing Records To:
Name: ____________________________________       Name: ____________________________________
Phone Number: ____________________________       Phone Number: ____________________________
Fax Number: _______________________________       Fax Number: _______________________________
Address _____________________________________       Address _____________________________________

_______________________________________________________________________________
(City)                      (State)                             (Zip Code)

☐ Copy of all medical records of the last two years of treatment received
☐ Copy of medical records covering dates from _____________________ to _____________________
☐ Copy of ______________________________________________ results.

___________________________________________       _____________________________
Patient’s Signature                                                                             Date

**********************************************************************************************
FOR OFFICE USE ONLY**********************************************************************************************

☐ Printed Records on __________________.       Initials _____
☐ Given to __________ on ______________.       Initials _____
☐ Faxed on ___________________________.       Initials _____