Arizona Pulmonary Specialists, Ltd.
9700 N. 91st Street, Suite A200
Scottsdale, AZ 85258
480-614-2000/ FAX 480-614-1751

Welcome to Arizona Pulmonary Specialists, Ltd.! Thank you for utilizing our website and choosing us for your health care needs.

Please read our forms thoroughly. As a reminder, you must arrive in our office 30 minutes before your appointment time with your new physician. Time with the physician has been reserved for you and is valuable. If you are unable to keep this appointment for any reason, we require that you provide us with 48 hours notice to avoid a charge of $300. Unfortunately, we will be unable to reschedule your appointment until that charge is paid.

Our physicians prefer that you print our new patient forms and complete them in ink rather than completing them online. Please be sure you are filling out the Scottsdale forms if you have an appointment at the Scottsdale office. Our office and the Phoenix office do not use the same forms.

When checking in to the office, please present:

- ❑ Your insurance card(s), your photo ID, and your referral (if applicable).
- ❑ Your **completed forms:** demographic form, office policy agreement, new patient questionnaire (all pages please) and physicians involved in your care form. **Any forgotten or incomplete forms will require that we reschedule your appointment.**
- ❑ Your most recent chest x-ray and/or CT film unless other arrangements have been made. **It is imperative that we have your films/disc in the office at the time of your appointment to avoid delays in your care.** Please call the office if you have NOT had an x-ray within the last thirty days. We will order one prior to your appointment. For imaging done at SMIL (Scottsdale Medical Imaging) films/discs are **NOT** needed.
- ❑ **Pharmacy phone number and a complete list of your current medications** including prescription and nonprescription medications as well as their dosages and frequency. **Please note: an accurate med list is required at every office visit.**
- ❑ Your CPAP mask, machine, download card (if applicable)
- ❑ Your copayment, if applicable. We accept VISA , Mastercard, Discover, and American Express as well as checks and cash.

Every patient is different. The length of time it takes to complete your medical care is individualized based on **your** needs. Please understand that we make every effort to see you at your appointed time; however, **delays do occur**. We appreciate your patience.

We look forward to seeing you! Welcome to our practice!

ARIZONA PULMONARY SPECIALISTS, LTD.
9700 N. 91ST STREET, SUITE A200
SCOTTSDALE, ARIZONA 85258

SASSIA BRAVE, M.D.
ADITYA GUPTA, M.D.
MICHAELA LESSLER, M.D.
JORIDA LULAJ, FNP-BC
EWA LUPA-LASKUS, M.D.
BRIDGETT RONAN, M.D.
JONATHAN D. RUZI, M.D.
FIDA SAWALHA, M.D. endocrinologist
HEEMESH SETH, D.O.
LAWRENCE SLAMA, M.D.

PATIENT'S NAME ______________________ SOCIAL SECURITY # ____/____/____
last first middle initial

BIRTHPLACE ____________ BIRTH DATE ____/____/____ AGE ______ SEX ☐ M ☐ F
month day year

HOME ADDRESS ______________________
number street apt city state zip code

HOME PHONE ____________ CELL PHONE ____________ WORK PHONE ____________

EMAIL ______________________ MARITAL STATUS ____________

EMPLOYED BY ______________________ OCCUPATION ____________

EMPOYER'S ADDRESS ______________________

AT WHICH NUMBER MAY WE LEAVE A MESSAGE? ☐ HOME ☐ WORK ☐ CELL ☐ NONE

NAME OF SPOUSE ______________________ BIRTH DATE ____/____/____ AGE ______
month day year

CLOSEST RELATIVE (other than spouse) IN CASE OF EMERGENCY:

NAME ____________ RELATIONSHIP ____________ PHONE ____________

WITH WHOM MAY THE DOCTOR DISCUSS YOUR MEDICAL CONDITION?

____________ ____________ ____________ ____________
name relationship name relationship

REFERRED BY ______________________

PRIMARY CARE PHYSICIAN ______________________ PHONE ____________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY ______________________ GROUP NAME ____________

NAME OF INSURED ______________________ RELATIONSHIP ____________

SUBSCRIBER OR CERTIFICATE NUMBER ____________ GROUP NUMBER ____________

BILLING ADDRESS ______________________

CITY, STATE, & ZIP CODE ______________________

SECONDARY INSURANCE COMPANY ______________________ GROUP NAME ____________

NAME OF INSURED ______________________ RELATIONSHIP ____________

SUBSCRIBER OR CERTIFICATE NUMBER ____________ GROUP NUMBER ____________

BILLING ADDRESS ______________________

CITY, STATE, & ZIP CODE ______________________

***** I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES OF ARIZONA PULMONARY SPECIALISTS, LTD. I HEREBY AUTHORIZE ARIZONA PULMONARY SPECIALISTS, LTD., OR ITS APPOINTED AGENTS, TO FURNISH INFORMATION TO INSURANCE CARRIERS OR OTHER 3RD PARTY PAYORS CONCERNING MY ILLNESS AND TREATMENT, TO INCLUDE REVIEW ACTIVITIES RELATED TO MY PHYSICIAN'S PARTICIPATION WITH MY HEALTH PLAN. I FURTHER AUTHORIZE MY INSURANCE CARRIER TO PAY DIRECTLY TO SAID PHYSICIAN GROUP ALL MEDICAL AND SURGICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY, AS PAYMENT TOWARD THE TOTAL CHARGES FOR PROFESSIONAL SERVICES RENDERED. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY, IN A CURRENT MANNER, ANY BALANCE OF SAID PROFESSIONAL SERVICE CHARGES OVER AND ABOVE THIS INSURANCE PAYMENT. A PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS EFFECTIVE AND VALID AS THE ORIGINAL.***

SIGNATURE ______________________ DATE ____________

Office Policies

FINANCIAL POLICY:

Please bring your insurance card to each visit. If your insurance changes, please confirm that we are contracted with your new plan. If your insurance requires a copayment for office services, it is due at the time of service. NO EXCEPTIONS. We accept cash, checks and credit cards (VISA, Mastercard, Discover, American Express). Your appointment may be cancelled if you are unable to pay your copay upon arrival.

If your insurance requires an authorization or a referral, it is **your** responsibility to be aware of this and obtain the referral from your primary care physician. If a referral has not been received 48 hours prior to your appointment, your appointment will be cancelled or rescheduled.

CANCELLATION POLICY:

Patients are seen by appointment only. When you schedule an appointment with one of our specialists, that time is reserved for YOU. When you fail to show or cancel at the last minute, it is not only a financial loss to the practice, but it is a time slot we could have given to another patient, perhaps someone who was sick and needed to be seen. For this reason, if you are a new patient and cancel with less than 48 hours notice, you will be charged a $300 fee and your appointment may not be rescheduled. If you are an existing patient and fail to appear for your appointment or you cancel or reschedule with less than 24 hours notice, we will assess a $50 fee to your account.

REFILLS AND AFTER HOURS CALLS:

The physician on call is caring for our critically ill patients in the hospital and cannot always respond promptly. He/she is unable to handle many matters over the phone. If you have a life-threatening issue, please call 911. Calls of a non-urgent nature should be made during normal business hours which are 9am-12pm or 1pm-4:30pm Monday through Friday. If you are an existing patient and you are sick, please call our office as early as possible. We will make every effort to accommodate you. **Refills are handled during office hours only**. Please have your pharmacy contact us by phone or fax. Allow 2 business days for your request to be filled and longer if the medication requires prior authorization from your insurance carrier. **The doctor on call will not authorize refills at night or on the weekend.** Please call your primary care physician.

SWITCHING DOCTORS:

If you have a specific request for a particular physician at Arizona Pulmonary Specialists, Ltd., you must tell us when scheduling your first office visit. Every attempt will be made to accommodate your request at that time. In order to maintain continuity of care, avoid opinion shopping within the practice, and provide seamless care to you if you are hospitalized, subsequent requests for switching doctors will generally be denied. All physicians at Arizona Pulmonary Specialists, Ltd. are experienced in the practice of pulmonary medicine and all deliver the highest quality care to our patient population.

STANDARDS OF CONDUCT:

At Arizona Pulmonary Specialists, Ltd., we embrace a culture of service delivered in an atmosphere of respect, civility and empathy. These values are expected of everyone including physicians, staff, patients, and families. Failure by our staff to follow this policy will result in corrective action and potential loss of employment. Offensive or demeaning behavior by a patient or family member toward our staff or physicians will result in our withdrawal from a patient's medical care.

FORMS:

Your primary care physician is the best resource to complete forms including but not limited to FMLA, disability, etc. Physicians at APS reserve the right to charge a $40/page fee (paid in advance) for form completion.

Your signature below signifies your understanding and willingness to comply with these office policies as well as the Arizona Pulmonary Specialists, Ltd. Privacy Policy.

_______________________________/______________________ ______/______/______

Patient or Responsible Party Signature/ Print name please Date

ARIZONA PULMONARY SPECIALISTS, LTD.

Sassia Brave, M.D.(formerly Donaldson-Morgan)
Aditya Gupta, M.D.
Michaela Lessler, M.D.
Lorie Loreman, D.O.
Ewa Lupa-Laskus, M.D.
Bridgett Ronan, M.D.
Jonathan D. Ruzi, M.D.
Heemesh Seth. D.O.
Lawrence E. Slama, M.D.
Fida Sawalha, M.D., endocrinologist

NEW PATIENT QUESTIONNAIRE

NAME____________________ **DOB**________ **AGE**_____ **DATE**________

REASON FOR YOUR VISIT TODAY?____________________________

____

How long has it been going on?____________________________

PAST MEDICAL PROBLEMS	YES	NO	WHEN?
Heart Problems	☐	☐	_____
Stroke	☐	☐	_____
Emphysema	☐	☐	_____
Asthma	☐	☐	_____
GERD	☐	☐	_____
Thyroid Disease	☐	☐	_____
Liver Problems	☐	☐	_____
Kidney Problems	☐	☐	_____
Arthritis	☐	☐	_____
Glaucoma	☐	☐	_____
Brittle Bones	☐	☐	_____
Cancer	☐	☐	_____
High Blood Pressure	☐	☐	_____
Diabetes	☐	☐	_____
Cholesterol	☐	☐	_____
Sleep Apnea	☐	☐	_____
Allergic Rhinitis	☐	☐	_____

MAJOR SURGERIES AND HOSPITALIZATIONS (Include year of illness/surgery)

____

____

____

MEDICATIONALLERGIES________________________________

____

PHARMACY NAME AND PHONE ____________________ / (   )_________
(BOTH REQUIRED)

MEDICATIONS YOU ARE TAKING **(or attach a complete list including prescription and non prescription meds)**

Name	Strength	Frequency	Name	Strength	Frequency
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___
___	___	___	___	___	___

SOCIAL HISTORY

Have you ever smoked? yes☐ no☐
At what age did you begin? ______________
At what age did you quit? ______________
How many packs a day ______
How often do you drink alcohol? ______ How many?______
Are you married? ______ How long?______
Is someone living with you? ______ How long?______
Do you have children? ______ How many?______
Do they live in Arizona? ______________
How long have you lived in Arizona? ______________
What kind of work do/did you do? ______________
Your spouse? ______________
Do you have any pets? ______________
What kind? ______________
Have you traveled in the past year outside of the southwest? ______

FAMILY HISTORY: (please note if deceased and age at death)

	Mother	Father	Siblings	Children
Asthma	☐	☐	☐	☐
Emphysema	☐	☐	☐	☐
Heart Attacks	☐	☐	☐	☐
Heart Failure	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐
Strokes	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Sleep Apnea	☐	☐	☐	☐
Cancer	☐	☐	☐	☐

Types of cancer______________________________

Name______________________________DOB______________________

SLEEP QUESTIONS

What time do you typically go to bed ____________________
What time do you typically get out of bed ____________________
Do you snore ____________________
Have you been told that you stop breathing during sleep ____________

On average, how much of these beverages do you drink:

		During a typical day	Within 2 hours of bedtime
Coffee (caffeinated)	cups	___________	___________
Starbucks (caffeinated)		___________	___________
Tea (caffeinated)	cups	___________	___________
Soda (caffeinated)	cans	___________	___________
Beer	cans/bottles	___________	___________
Wine	glasses	___________	___________
Other alcoholic drinks	glasses	___________	___________

Are you presently using CPAP ____________ and what is the pressure ___________ ?

Epworth Sleepiness Scale

Rate the chance that you will doze off or fall asleep during the following routine daytime situations

0=would never dose off
1=slight chance of dozing off
2=moderate chance of dozing
3=high chance of dozing

Situation	Chance of dozing (0-3)
Sitting and Reading	
Watching TV	
Sitting inactive in a public place (ex: Theatre or Meeting)	
As a passenger in a car for an hour without a break	
Lying down to rest in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (when you've had no alcohol)	
In a car, while stopped in traffic	

Name____ DOB _________________________________

REVIEW OF SYSTEMS

Have you had any of the following in the last 6 months (check yes or no, circle if positive)

Constitutional:	yes ☐	no ☐	(fever chills	night sweats	unexplained weight loss loss of appetite)
Eye:	yes ☐	no ☐	(vision changes	cataracts	double vision)
ENT	yes ☐	no ☐	(hoarseness	nasal drip	seasonal allergies)
Respiratory:	yes ☐	no ☐	(cough sputum	shortness of breath	coughing blood)
Cardiac:	yes ☐	no ☐	(chest pain	shortness of breath when lying down)	
GI:	yes ☐	no ☐	(nausea	vomiting	diarrhea)
GU:	yes ☐	no ☐	(painful urination	frequent urination at night – how often ___)	
Endo:	yes ☐	no ☐	(frequent urination	frequent thirst)	
Skin:	yes ☐	no ☐	(rash)		
Heme/Lymph:	yes ☐	no ☐	(abnormal bleeding	leukemia/lymphoma	hx of blood clots)
Neuro:	yes ☐	no ☐	(vertigo	new headaches	seizures)
Musc/Skeletal :	yes ☐	no ☐	(arthritis - what type? __________		gout)
Infectious:	yes ☐	no ☐	(ever had a TB skin test? positive negative)		

<u>Xray</u>

When was your last chest xray? _______

Where was it taken? ________________

Have you ever had a chest CAT Scan?

Where? __________________________

<u>Immunizations</u>

☐ Pneumovax

if yes when _________?

☐ Flu

☐ Shingles

This entire questionnaire was reviewed with the patient. Comments as noted above.

☐ yes ☐ no **Physician Sig:** _________________**DATE**_____

Name____________________________ DOB___________________________________

ARIZONA PULMONARY SPECIALISTS, LTD.

Patient Name: ______________________________

Date of Birth: ____________________

Physicians involved in my care

Physician: ________________ Specialty: ________________ Address: ________________ ________________ Phone: ________________	***Physician:*** ________________ Specialty: ________________ Address: ________________ ________________ Phone: ________________
Physician: ________________ Specialty: ________________ Address: ________________ ________________ Phone:	***Physician:*** ________________ Specialty: ________________ Address: ________________ ________________ Phone:
Physician: ________________ Specialty: ________________ Address: ________________ ________________ Phone:	***Physician:*** ________________ Specialty: ________________ Address: ________________ ________________ Phone:
Physician: ________________ Specialty: ________________ Address: ________________ ________________ Phone:	***Physician:*** ________________ Specialty: ________________ Address: ________________ ________________ Phone:

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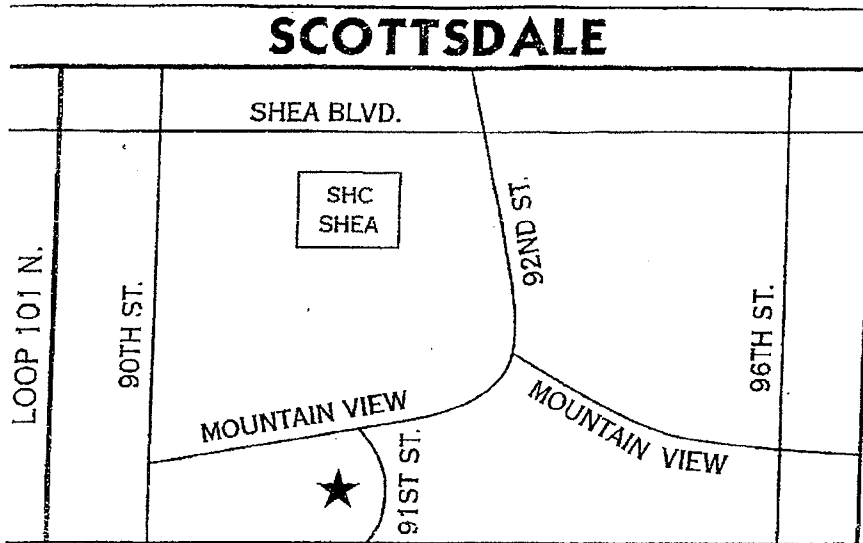
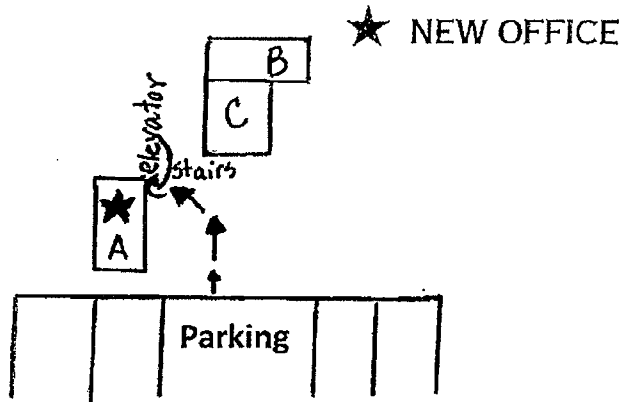


★ NEW OFFICE



Directions from the East or South part of the Valley:

101 North
Exit **#42, Pima/90th Street**
Merge onto North 90th St., **to the right**
Right on Mountain View
Right on 91st St.

Directions from the North or West:

101 South
Exit **#41 Shea Blvd, slight left** onto Shea
Right on 90th Street
Left on Mountain View
Right on 91st St.

Turn into **Mountain View Medical Plaza** (your first **right**)
Immediately go **left** once you enter into the parking lot
Building A is the last building on your **right**
Park in **"Arizona Pulmonary"** designated spaces or any open spaces
Walk to the **center of the courtyard** and proceed to the **elevator**
The elevator is located directly behind the stairs
Our second floor suite is on your left as you exit the elevator.
See you soon!

ARIZONA PULMONARY SPECIALISTS, LTD.

Notice of Privacy Practices

To our patients. This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

ARIZONA PULMONARY SPECIALISTS, LTD.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Medical Records Department at Arizona Pulmonary Specialists, Ltd., at the office address. You may call the office for more information.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Arizona Pulmonary Specialists, Ltd., at the office address. You must provide us with a reason that supports your request for amendment.
5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Privacy Officer at Arizona Pulmonary Specialists, Ltd. at the practice address. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.