# Sleep Center of Yuma

**Ashvin Shah M.D./Blanca Huerta PA-C**

2110 W. 24th St Yuma Az 85364

Pulmonary Ph: 928-344-1891/Sleep Center Ph: 928-726-7106/Fax: 928-726-6306

**PLEASE PRINT** **Date:**

**PATIENT INFORMATION**

First Name: ____________________ Last Name: ________________________SSN#______________________

Home PH: (      )_________________Cell PH: (      )______________DOB:_________ Age:____ Sex: M/F

Home Address: __________________________City ___________ State _______________ Zip _____________

Mailing Address/PO Box: __________________ City ___________ Sate _______________ Zip ____________

Marital Status: Single / Married / Divorced / Separated / Widowed / Other

Ethnicity : Hispanic / NON-Hispanic / Race: ______________________ Language: ______________________

Religion: _________________________ Mother's Maiden Name: ____________________________________

**Email Address:**______________________ Pharmacy: _______________ Referring DR.: _________________

Emergency Contact: ________________________ Ph#: (      ) ___________________ Relationship: __________

**PATIENT EMPLOYER**

*RETIRED / FULL TIME / PART TIME / DISABLED / UNEMPLOYED / TEMPORARY*

Employer: ____________________ Address: ________________________ Ph#: (      ) ___________________

Is current insurance through this Employer? Yes / No / Spouse / Parent

**GUARANTOR/PARENT INFORMATION**

Parent Name: ______________________ DOB: ____________ Social Security # _________________________

Address: __________________________ City: _____________ State: ______________ Zip ________________

PH: (      ) _______________________ Relationship to Patient: _____________________________________

## Insurance Information

Primary Ins: ________________________ Policy Holder Name: _______________________________________

Birth Date: ____________________ Social Security #: ____________ Employer: _________________________

Secondary Ins: _____________________ Policy Holder Name: _______________________________________

Birth Date: __________________ Social Security #: _________________ Employer: ______________________

**PATIENT, PARENT OR GUARDIAN SIGNATURE:** ____________________________ DATE: _________________

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2110 WEST 24TH ST. YUMA, AZ. 85364

**PHONE#** PULMONARY= 928-344-1891 / SLEEP CENTER= 928-726-7106 / FAX: 928-726-6306

***PRIOR AUTHORIZATION POLICY***

REQUEST FOR PRIOR AUTHORIZATION ON MEDICATION(S) WILL BE CONSIDERED ON A CASE BY CASE BASIS. **A MINIMUM OF 7-14 BUSINESS DAYS ARE REQUIRED**. WE MAY NOT BE ABLE TO OBTAIN AUTHORIZATION FOR SOME MEDICATIONS. IN THIS INSTANCE, ALTERNATE MEDICATION MAY BE AN OPTION OR PATIENT CAN PAY OUT OF POCKET, MAKING THE AUTHORIZATION PROCESS VOID.

**REFILLS ON MEDICATION - OFFICE POLICY**

**1= ________INITIAL OF PT** ONE WEEK NOTICE REQUIRED FOR ALL ROUTINE MEDICATION REFILLS

**PLEASE READ, PER OUR OFFICE POLICY- YOUR INITIALS ARE REQUIRED**

***2=*** **_______INITIALS OF PT** ***CONSENT FOR MEDICAL RELEASE:***

THE INFORMATION GIVEN ON THE DEMOGRAPHIC PAGE IS TRUE TO THE BEST OF MY KNOWLEDGE. I HEREBY AUTHORIZE DR SHAH/ BLANCA HUERTA PA-C, TO RELEASE INFORMATION REQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT (INCLUDING INSURANCE COMPANIES, DURABLE MEDICAL EQUIPMENT PROVIDERS, REFERRING PHYSICIANS, ETC)

**3= _______INITIALS OF PATIENT** ***CONSENT FOR MEDICAL TREATMENT***:

KNOWING THAT I AM SUFFERING FROM A CONDITION REQUIRING MEDICAL CARE, I HEREBY VOLUNTARILY CONSENT TO SUCH CARE EMCOMPASSING DIAGNOSTIC PROCEDURES AND/OR MEDICAL TREATMENT BY MY PHYSICIAN, HIS/HER ASSISTANTS OR HIS/HER COSIGNEES AS MAY BE NECESSARY IN HIS/HER JUDGEMENT. I ACKNOWLEDGE THAT NO GUARANTEES HAVE BEEN MADE AS TO THE RESULT OF TREATMENTS OR EXAMINATIONS.

**4= ______INITIALS OF PATIENT** ***AUTHORIZATION TO PAY:***

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO DR SHAH/ BLANCA HUERTA PA-C, FOR MEDICAL BENEFITS, IF ANY, AND OTHERWISE PAYABLE TO ME FOR SERVICES. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY MY INSURANCE. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL OF MY CLAIMS

PRINT NAME: ____________________________________________

DATE OF BIRTH: ____________________

SIGNATURE: ____________________________________________

DATE: ____________________

# SLEEP CENTER OF YUMA

**ASHVIN K. SHAH M.D.,P.C. / BLANCA E. HUERTA PA-C**
**2110 WEST 24TH ST., YUMA, AZ. 85364**

**OFFICE NUMBER: 928-344-1891 (OR) 928-726-7106** **FAX NUMBER: 928-726-6306**

**INSTRUCTIONS: PLEASE MARK AND ANSWER EVERY QUESTION TO THE BEST OF YOUR RECOLLECTION.**

**NAME:** ______________________ **DATE OF BIRTH:** ______________

**LIST ALL MEDICAL CONDITIONS (past and present):**

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________
7. ____________

**LIST ALL HOSPITALIZATIONS AND SURGERIES:**

1. ____________
2. ____________
3. ____________
4. ____________
5. ____________
6. ____________

**CURRENT MEDICATIONS:**

| | | | |
|---|---|---|---|
| 1. | ____ | 6. | ____ |
| 2. | ____ | 7. | ____ |
| 3. | ____ | 8. | ____ |
| 4. | ____ | 9. | ____ |
| 5. | ____ | 10. | ____ |

**ALLERGIES:** ____________

**PERSONAL & SOCIAL HISTORY:**

Occupation: ____________

Marital Status: ____________

Tobacco use: Never ____ Former ____ Year quit ______
How much _____ Current smoker _____ How much ______

Alcohol use: Never _____ Former _____ Current ______
Nearly daily ______ How much ______

Recreational Drug Use: Never ______ Current ______
Former ______ Year quit ______

Have you ever used intravenous drugs? ______

**FAMILY HISTORY:**

Present age (or age at death):

Father: ____________

Mother: ____________

Brothers/Sisters: ____________

Children: ____________

Did any relative ever have asthma, lung cancer, sleep apnea, emphysema, tuberculosis or a heart attack?

| | | |
|---|---|---|
| **High Blood Pressure:** | **YES** | **NO** |
| **Cancer:** | **YES** | **NO** |
| **Heart Attack:** | **YES** | **NO** |
| **Stroke:** | **YES** | **NO** |
| **CHF:** | **YES** | **NO** |
| **Ulcers/Reflux:** | **YES** | **NO** |

**Surgeries:**

| | | |
|---|---|---|
| **Tonsillectomy:** | **YES** | **NO** |
| **Appendectomy:** | **YES** | **NO** |
| **Gallbladder:** | **YES** | **NO** |
| **Lungs:** | **YES** | **NO** |
| **Coronary artery bypass:** | **YES** | **NO** |
| **Hysterectomy:** | **YES** | **NO** |

**Review of Systems (Check all that apply.)**

1. **Digestive:** Heartburn _____ Vomiting______ Blood in bowel movement______ Jaundice______ Constipation ______ Diarrhea______ Difficulty swallowing______ Abdominal pain______ Change in bowel habits______
2. **Constitutional:** Weight loss____ Fever___ Fatigue____
3. **Ear/Nose/Throat/Eyes:** Cataracts______ Hoarseness of voice______ Sore throat_______
4. **Cardiovascular:** Chest pain______ Palpitations____ Shortness of breath upon exertion______
5. **Respiratory:** Cough_____ Shortness of breath______ Wheezing______
6. **Genitourinary:** Problems passing urine____ Blood in urine_____ (Females: Date of last menstrual period)_____ Burning with urination_____ History of sexually transmitted diseases______
7. **Hematological:** Blood transfusions_____ Easy bruising or bleeding_____
8. **Musculoskeletal:** Joint pains_____ Swelling of joints____ Muscle aches______
9. **Neurological:** Headache____ Seizures_____ Loss of consciousness______
10. **Psychological:** Emotional stress_____ Anxiety_____ Depression_____ Suicidal thoughts/attempts_____
11. **Dermatological:** Rash____ Skin cancer_____
12. **Endocrine:** Thyroid disorder_____ Diabetes_____
13. **Sleep:** Snoring_____ Stopped breathing_____ Excessive daytime sleepiness_____

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## FINANCIAL POLICY

We would like to take this opportunity to welcome you and thank you for choosing us for health care. The following is the Financial Policy for Dr. Ashvin K. Shah and Dr. Marvin Lesser. Please read and sign the Financial Policy and complete the Patient Registration form prior to seeing the doctor. If you would like a copy of the Financial Policy, please inform the receptionist. **Please be advised if you lapse in treatment from our facility for a six year period of time, your medical records will be destroyed thereafter.**

**Regarding Insurance/Office Visits/Hospital Admission:**
Your insurance policy is a contract between you and your insurance company; we are not a party to that contract. We will bill non-contracted insurance companies as a courtesy for your office visits. If we are contracted providers with your insurance companies, co-pays and deductibles are due at the time of service. **Referrals required by insurance companies must be presented to the receptionist; if a referral is not obtained at the time of service, the appointment will be rescheduled. Obtaining the referral is the patient's responsibility.** Services obtained in the hospital will be billed to your insurance company; however, you are responsible for all non-covered services. We will accept benefits, however, deductibles and cost shares remain your responsibility. The physician has limited knowledge as to your charges. All questions or concerns regarding your charges must be directed to the billing department or the office manager. Full payment is due at time of services for all non-contracted insurance companies. Our forms of payment are: cash, checks, Visa and Mastercard.

**Usual and Customary Charges:**
Our practice is committed to providing the best care for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary charges.

**Supplemental Insurance:**
Medicare patients: We will bill all secondary payers; however, if your secondary insurance does not pay within 30 days from the Medicare payment, you will be responsible for payment and collecting from your secondary insurance. Secondary insurances will be billed one time only, if the secondary insurance does not pay within 30 days of original billing, you will be billed for the balance.

**Bad Debt/Collection:** If your account is turned over to collection agency, all future visits will be charged on a cash basis.

**If you have any questions about the above information, or any uncertainty regarding insurance, please do not hesitate to ask us. We are here to help you!**

**SIGNATURE (Patient or Responsible Party):**__________________________________**DATE:**____________

**Ashvin K. Shah, M.D., M.D., Blanca Huerta, MS, PA-C**
**2110 W. 24th Street Yuma, AZ. 85364**
**Pulmonary Office: (928) 344-1891 Sleep Center: (928) 726-7106 Fax: (928) 726-6306**

## NOTICE OF PRIVACY PRACTICES

This notice describes how health information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.
The privacy of your health information in important to us.

**OUR LEGAL DUTY**
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our Privacy Practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 15, 2003 and will remain in effect until we replace it.

We reserve the right to change our Privacy Practices. Applicable law permits changes to the terms of this Notice at any time. The new terms of this Notice will be effective for all health information that we maintain, including health information that we created or received before the changes were made. We will inform patients of any changes to our Privacy Practices through an updated copy of this Notice, which will be available upon request.

You may request a copy of our Notice at any time. For more information about our Privacy Practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

**USES AND DISCLOSURE OF HEALTH INFORMATION**
We use and disclose your health information for treatment, payment and healthcare operations. For example:
**TREATMENT:** We may use or disclose your health information to a physician or other health care provider providing treatment upon a written request.
**PAYMENT:** We may use or disclose your health information to obtain payment for services provided to you.
**HEALTH OPERATIONS:** We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, review of competency and qualifications of healthcare professionals, evaluation of practitioner performance, as well as administration of training programs, accreditation, certification, licensing or credentialing activities.
Your authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use or disclose your health information to any person for any purpose. You may revoke this authorization in writing at any time. Your revocation will not affect any use of prior disclosures permitted by your authorization while it was in effect. *Unless you give us a written authorization, we cannot use or disclose your health information for any reason, except for those described in this Notice.*
**YOUR FAMILY AND FRIENDS:** We must disclose health information to you as described in the Patients' Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
**PERSON/S INVOLVED IN YOUR CARE:** We may use or disclose your health information to locate, identify and notify a family member, your personal representative, or another person responsible for your care regarding your location, your general condition, or your death. If you are present, then prior to the use or disclosure of your health information, we may provide you with an opportunity to object to such uses or disclosures. In the event that you are incapacitated or in emergency circumstances, we will use our professional judgement in disclosing only health information that is directly relevant to the persons' involvement in your healthcare. We will also use our professional judgement and our experience with common practices to make reasonable decisions in your best interest in allowing a person to pick up signed prescriptions, medical supplies, X-Rays or other similar forms of health information.
**MARKETING HEALTH-RELATED SERVICES:** We will not use your health information for marketing communications without your written authorization.
**RESEARCH:** We may use or disclose your health information for research projects, such as studying the effectiveness of treatment you received. These research projects must go through a special progress to protect the confidentiality of your health information.
**REQUIRED BY LAW:** We may use or disclose your health information when we are required to do so by law. We may disclose your health information to appropriate authorities, if we have reason to believe that you are a possible victim of abuse, neglect, domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others.
**NATIONAL SECURITY:** We may disclose the health information of Armed Forces personnel to military authorities under certain circumstances. We may disclose health information required for lawful intelligence, counterintelligence, and other national security activities to authorized federal officials. Under certain circumstances, we may disclose the health information of inmates to correctional institutions or law enforcement officials who have lawful custody.
**APPOINTMENT REMINDERS:** We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages, postcards or letters.
**PATIENTS' RIGHTS ACCESS:** You have the right to view and/or obtain copies of your health information, with limited exceptions. We are happy to provide you with copies of your health information in the format of your request, unless we are unable to do so. You must make your request in writing to obtain access to your health care information. If you request copies, we will charge you a reasonable price for staff time to locate and copy your health information and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or explanation of your health information for a fee. Contact us using the information below for a full explanation of our fee structure.
**DISCLOSURE ACCOUNTING:** You have the right to receive a list of instances in which we have disclosed your health information for purposes other than treatment, payment or healthcare operations for the last six years, but not before April 15, 2003. If you request this accounting more than once in a 12 month period we may charge you a reasonable cost-based fee for responding to additional request.
**RESTRICTIONS:** You have the right to request that we place additional restrictions on our use or disclosures of your health information. We are not required to agree to implement these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.
**ALTERNATIVE COMMUNICATION:** You have the right to request that we communicate with you about your health information by alternative means for communication or at an alternative address. You must make this request in writing, and it must specify the alternative means of communication or the alternative address, and provide a satisfactory explanation as to how payments will be handled under these alternative means.
**AMENDMENT:** You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

**QUESTIONS AND COMPLAINTS**
You may inform us of a complaint using the contact information below (1) If you are concerned that we may have violated your privacy rights; (2) If you disagree with a decision we made about access to your health information; (3) In response to a request that you made to amend or restrict the use or disclosure of your health information; or (4) to request that we communicate with you by alternative means or at an alternative address. You may also submit a written complaint to the U.S. Department of Health and Human Services. Upon request, we will provide you with this address to file a complaint. We support your right your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

If you would like more information about our privacy practices, or have any questions or concerns, please contact us.

**CONTACT INFORMATION: VALERIE HAWKINS, OFFICE MANAGER**
**2110 W. 24TH STREET YUMA, AZ. 85364 PHONE #: (928) 344-1891**

**SIGNATURE:**____________________ **DATE:**________