Denali Asthma and Pulmonary

4001 Laurel Street, Suite 206, Anchorage AK 99508
Phone: 907.770.5864 · Fax: 907.770.5868

PERSONAL INFORMATION		
Last Name:	First Name:	Middle Initial:
Social Security #:	Date of Birth:	Gender: ☐ M ☐ F
Address:		
Home Phone:	Work Phone:	Cell Phone:
E-mail Address:		
Employer:		
Employed: ☐ Full Time	☐ Part Time	☐ Retired
Marital Status: ☐ Single	☐ Married	☐ Other

INSURANCE INFORMATION	
Primary Insurance	Secondary Insurance
Company:	Company:
Group #:	Group #:
Contract #:	Contract #:
Policy Holder:	Policy Holder:
Policy Holder SS#: DOB:	Policy Holder SS#: DOB:
Policy Holder Employer:	Policy Holder Employer:

EMERGENCY CONTACT	
Name:	Relationship to Patient:
Address:	Phone:

PREFERRED PHARMACY	
Name:	Phone:

REFERRAL INFORMATION	
Referring Physician:	Phone:
Primary Care Physician:	Phone:

By signing this form, I consent to treatment necessary for the care of the patient indicated on this form. I authorize the release of medical information necessary to process this claim and payment of insurance benefits directly to the physician for services rendered.

_____ _____/_____/_____

Signature of Patient or Responsible Party *Date*

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Name: _____ SSN: _____ Date: _____

Age: ____ Height: _____ Weight: _____ ☐ Male ☐ Female

This questionnaire is designed to assist us in understanding the nature of your sleep-related problem. Please take your time and answer each question as completely and accurately as possible.

SLEEP QUESTIONNAIRE

CHIEF COMPLAINT(S)

☐ Difficulty falling asleep ☐ Difficulty staying asleep ☐ Fatigue despite adequate sleep ☐ Snoring
☐ Significant daytime drowsiness ☐ Witnessed apnea ☐ Gasping / choking upon awakening
☐ Sleep walking / talking ☐ Night terrors ☐ Acting out dreams ☐ Legs kick / move while sleeping
☐ Morning headaches ☐ Insomnia ☐ Other: _____

HISTORY OF PRESENT ILLNESS

1. How long have you had this problem? ☐ < 1 month ☐ 1-6 months ☐ 6 months-2 years ☐ >2 years
2. Rate the severity of your problem. ☐ Mild ☐ Moderate ☐ Severe ☐ Problem only for others
3. Is your sleep-related problem getting worse? ☐ Yes ☐ No
4. What factors aggravate your symptoms? _____
5. Does your problem have a negative impact on your ……. work performance ☐ Yes ☐ No
   …….sex life ☐ Yes ☐ No
   ……. quality of life ☐ Yes ☐ No
   ……. social activities ☐ Yes ☐ No
6. Do you use any medications or other substances to help you sleep? ☐ Yes ☐ No
   If yes, please list drug/substance(s), dose, frequency, and length of usage.
   _____
7. Do any members of your family have significant sleep-related problems? ☐ Yes ☐ No
   If yes, please explain:
   _____
8. Have you discussed your sleep-related problems with another doctor? ☐ Yes ☐ No
   Doctor's Name: _____ Diagnosis: _____
   Current treatment: _____ Prior treatment: _____

PLEASE RATE HOW OFTEN YOU OR OTHERS NOTE THAT YOU:

	Never	Occasionally	Frequently
Snore	_____	_____	_____
Snore loudly enough for others to complain	_____	_____	_____
Awaken from sleep feeling short of breath, gasping, or choking	_____	_____	_____
Hold your breath or stop breathing while asleep	_____	_____	_____
Experience other breathing problems at night	_____	_____	_____
Wake up with a headache that improves in less than 2 hours	_____	_____	_____
Have dry mouth upon awakening	_____	_____	_____
Sweat excessively at night	_____	_____	_____
Experience heart pounding or irregular heart beats during night	_____	_____	_____
Feel sleepy or tired during the day	_____	_____	_____
Awaken feeling unrested or unrefreshed	_____	_____	_____
Become drowsy while driving	_____	_____	_____
Have motor vehicle accidents due to sleepiness	_____	_____	_____
Have trouble at school or work because of sleepiness	_____	_____	_____
Become irritable or crabby	_____	_____	_____
Have difficulty concentrating; experience memory impairment	_____	_____	_____
Fall asleep involuntarily, suddenly or in an awkward situation	_____	_____	_____
Experience sudden weakness, knees buckling, or jaw drop when laughing, scared, angry or crying	_____	_____	_____
Feel unable to move (paralyzed) when waking or falling asleep	_____	_____	_____
Experience vivid dreamlike scenes, smells or sounds upon waking or falling asleep similar to hallucinations	_____	_____	_____
Perform complex tasks of which you are totally unaware such as driving or navigating without conscious awareness	_____	_____	_____
Have nightmares or night terrors	_____	_____	_____
Act out dreams by yelling and swinging arms and legs	_____	_____	_____
Walk or talk while asleep	_____	_____	_____
Do anything else considered “unusual” while asleep	_____	_____	_____
Move, twitch or jerk your legs while asleep	_____	_____	_____
Feel leg restlessness, agitation or discomfort at or before bedtime	_____	_____	_____
If yes: Do you feel an overwhelming urge to move your legs?		☐ Yes	☐ No
Does it happen only in the evening?		☐ Yes	☐ No
Does it only happen when you are relaxed?		☐ Yes	☐ No
Does it get better if you move around or walk?		☐ Yes	☐ No
Does it disturb your sleep or sleep onset?		☐ Yes	☐ No

How often do you experience this feeling? _____

SLEEP HYGIENE

1. Do you often have anxiety around bedtime? ☐ Yes ☐ No
2. Do you have thoughts racing through your mind while trying to fall asleep? ☐ Yes ☐ No
3. Do you sleep better away from home than in your own bed? ☐ Yes ☐ No
4. Are you anxious or upset if you have difficulty falling asleep? ☐ Yes ☐ No
5. Do you usually take coffee, tea, or chocolate within 2 hours of your bedtime? ☐ Yes ☐ No
6. Do you exercise within 2 hours of your bedtime? ☐ Yes ☐ No
7. Do you watch TV or read in bed before falling asleep? ☐ Yes ☐ No
8. Do you ever nap or rest during the awake portion of your day? ☐ Yes ☐ No

   If yes: How often? _____ times per day; _____ times per week
   How long is your nap / rest? ☐ < one hour ☐ ≥ one hour
   After the nap / rest, do you still feel tired? ☐ Yes ☐ No

9. Check conditions that routinely apply to you: ☐ Sleep alone ☐ Sleep with someone else in bed ☐ Sleep with pet in room/bed ☐ Provide assistance during night to child, invalid, bed partner, animal
10. Check factors that generally disturb your sleep: ☐ Heat ☐ Cold ☐ Light ☐ Noise ☐ Bed Partner Other: _____

SLEEP HABITS

1. When do you feel your very best? ☐ Morning ☐ Afternoon ☐ Evening
2. Approximately, how many hours do you actually sleep per night? _____
3. What time do you usually go to bed? Workdays: _____ Non-Workdays: _____
4. What time do you usually rise from bed? Workdays: _____ Non-Workdays: _____
5. How long does it usually take for you to fall asleep? _____
6. How many hours of sleep do you need to feel your very best? _____
7. In an perfect world, what would be the ideal hour for you to go to bed? _____
8. In an perfect world, what would be the ideal hour for you to awaken? _____
9. What usually prevents you from quickly falling asleep? _____
10. How many times do you typically wake up during the night? _____
11. What generally causes you to wake up during the night? _____
12. If you wake up during the night, how long do you typically stay awake? _____
13. If you wake up during the night, when do you typically wake up?
    ☐ Soon after falling asleep ☐ In the middle of the night ☐ Near the end of the sleeping period
14. What do you usually do when you awaken during the night? _____

MEDICAL HISTORY

Please check conditions for which you have been diagnosed:

- ☐ Angina
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Arteriosclerosis
- ☐ Heart murmur
- ☐ Rheumatic heart disease
- ☐ Arrhythmia
- ☐ Hypertension
- ☐ Stroke
- ☐ Peripheral artery disease
- ☐ Other cardiovascular disorders _____

- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Sinusitis
- ☐ Other respiratory disorders _____

- ☐ Acid reflux
- ☐ Diverticulitis
- ☐ Hiatal hernia
- ☐ Swallowing disorder
- ☐ Stomach ulcers
- ☐ Other gastrointestinal disorders _____

- ☐ Arthritis
- ☐ Back pain
- ☐ Osteoporosis
- ☐ Chronic fatigue syndrome
- ☐ Fibromyalgia
- ☐ Autoimmune disorder
- ☐ Neuromuscular disorder

- ☐ Diabetes
- ☐ Sickle cell anemia
- ☐ Thyroid disease
- ☐ Cancer

- ☐ Migraines
- ☐ Seizures / Epilepsy
- ☐ Brain infection
- ☐ Brain injury
- ☐ Spinal infection
- ☐ Spinal injury
- ☐ Nerve injury
- ☐ Other neurologic disorders _____

- ☐ Liver disease
- ☐ Kidney disease
- ☐ Blood disorder

- ☐ Depression
- ☐ Anxiety / Panic attacks
- ☐ Alcoholism
- ☐ Drug abuse
- ☐ Other psychiatric disorders _____

CURRENT MEDICATIONS: Please list all medications that you are currently taking and their dosages:

_____

_____

DRUG ALLERGIES: Are you allergic to any drugs? ☐ Yes ☐ No If yes, please list:

_____

PAST SURGERIES: Please list all operations and the approximate date of the procedure. _____

_____

FAMILY HISTORY: Has anyone in your blood-related family been afflicted with the following conditions:

☐ Hypertension ☐ Diabetes ☐ Heart disease ☐ Stroke ☐ Cancer
☐ Sleep apnea ☐ Narcolepsy ☐ Restless legs syndrome ☐ Sleep walking / talking ☐ Parasomnias

OCCUPATIONAL HISTORY: Occupation: _____ Are you a shift worker? ☐ Yes ☐ No
If yes, please describe work schedule: _____

SOCIAL HISTORY

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Children living at home: ☐ No ☐ Yes Ages of children: _____
Others living at home: ☐ No ☐ Yes ☐ Spouse ☐ Parents / Grandparents ☐ Friend
Alcohol consumption: ☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Alcoholic
Tobacco use ☐ No ☐ Yes If yes, Type: _____ Frequency: _____
Recreational drug use ☐ No ☐ Yes If yes, Type: _____ Frequency: _____

REVIEW OF SYSTEMS

Please check any of the following symptoms which you currently or recently have experienced.

General
- ☐ Fatigue
- ☐ Malaise / lethargy
- ☐ Generalized weakness
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Fever / chills

Eyes
- ☐ Vision changes
- ☐ Double vision
- ☐ Discharge
- ☐ Pain
- ☐ Sensitivity to light

Ears, Nose, Throat and Mouth
- ☐ Earache
- ☐ Ringing in the ears
- ☐ Allergies
- ☐ Frequent colds
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Sinusitis
- ☐ Toothache
- ☐ Oral ulcers
- ☐ Dry mouth
- ☐ Facial pain
- ☐ Jaw pain
- ☐ Hoarse voice
- ☐ Sore throat
- ☐ Difficulty swallowing
- ☐ Swollen glands

Cardiovascular System
- ☐ Chest pain
- ☐ Pain in arm, shoulder, jaw, neck or back
- ☐ Rapid heart rate
- ☐ Irregular heartbeat
- ☐ Dizziness
- ☐ Pain in leg when walking
- ☐ Ankle / leg swelling

Lungs
- ☐ Chronic cough
- ☐ Shortness of breath with mild exertion
- ☐ Difficulty breathing
- ☐ Wheezing
- ☐ Bloody sputum

Gastrointestinal System
- ☐ Nausea / vomiting
- ☐ Indigestion
- ☐ Acid reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Cramps
- ☐ Bloating
- ☐Vomiting blood
- ☐ Blood in stool
- ☐ Abdominal pain
- ☐ Abdominal swelling
- ☐ Rectal pain
- ☐ Rectal bleeding

Genitourinary System
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Urinary incontinence
- ☐ Blood in urine
- ☐ Pelvic / groin pain
- ☐ Genital ulcers

Male:
- ☐ Erectile dysfunction
- ☐ Testicular pain / swelling

Female:
- ☐ Irregular periods
- ☐ Hot flashes
- ☐ Vaginal discharge

Musculoskeletal System
- ☐ Joint pain / swelling
- ☐ Back pain
- ☐ Muscle pain / weakness
- ☐ Leg cramps

Nervous System
- ☐ Headaches / migraines
- ☐ Dizziness / fainting
- ☐ Seizures
- ☐ Tremors
- ☐ Disorientation
- ☐ Lack of coordination
- ☐ Numbness / paralysis
- ☐ Memory loss / impairment

Psychiatric Symptoms
- ☐ Depression
- ☐ Anxiety / panic attacks
- ☐ Hallucinations
- ☐ Delirium
- ☐ Dementia
- ☐ Suicidal ideation

Endocrine System
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Sexual dysfunction
- ☐ Hair loss
- ☐ Excessive sweating

Skin
- ☐ Rashes
- ☐ Bruises
- ☐ Hives
- ☐ Lesions

Patient Signature _____ Date _____

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EPWORTH SLEEPINESS SCALE

Name: _____ Date: _____

Age: _____ Gender: □ Male □ Female

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

This refers to your usual way of life in recent times. Even if you haven't done some of these things recently try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 - Would **never** doze
1 - **Slight chance** of dozing
2 - **Moderate chance** of dozing
3 - **High chance** of dozing

It is important that you answer each question as best you can.

SITUATION	**CHANCE OF DOZING (0-3)**
Sitting and reading	_____
Watching TV	_____
Sitting, inactive in a public place (e.g., a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____
Total score:	_____

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BED PARTNER QUESTIONNAIRE

Observer's Name: _____ Relationship to Patient: _____ Date: _____

Frequency of observations: ☐ Once or twice ☐ Often ☐ Almost every night

Check any of the following behaviors observed while watching person sleep. Circle behaviors that you consider severe problems for this person.

☐ Light snoring
☐ Loud snoring
☐ Loud snorts
☐ Pause in breathing (How long? ____seconds)
☐ Choking
☐ Gasping for air
☐ Twitching, moving or kicking of legs
☐ Twitching or flinging of arms
☐ Grinding teeth
☐ Apparently sleeping even if person behaves otherwise
☐ Other _____

☐ Sleep talking
☐ Sitting up in bed not awake
☐ Getting out of bed not awake
☐ Head rocking or banging
☐ Awakening with pain
☐ Becoming very rigid or shaking
☐ Biting tongue
☐ Crying out

If person snores, what makes snoring worse?

☐ Sleeping on back ☐ Sleeping on side ☐ Alcohol ☐ Fatigue

Does snoring sometimes require you or your partner to sleep separately? ☐ Yes ☐ No

Does this person drink alcohol or use street drugs? ☐ Yes ☐ No

Denali Asthma and Pulmonary

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Address: _____

☐ **I hereby authorize and request release of my medical records:**

From: (Doctor's Name or Hospital)

_____

_____

To:

Denali Asthma and Pulmonary LLC
4001 Laurel Street, Suite 206, Anchorage AK 99508 · Phone: 907.770.5864 · Fax: 907.770.5868

☐ **I hereby authorize and request release of my medical records:**

From:

Denali Asthma and Pulmonary LLC
4001 Laurel Street, Suite 206, Anchorage AK 99508 · Phone: 907.770.5864 · Fax: 907.770.5868

To: (Doctor's Name or Hospital)

_____

_____

Information to be released: All medical records, charts, files, prognoses, reports, x-rays, laboratory reports, clinical records, and such other information relative to my medical condition or my treatment at any time provided to me and to the extent said information is available and within your possession. You are further requested not to disclose any information concerning my past or present medical condition to any other person without my express written permission.

Patient's Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

RELEASE OF MY INFORMATION TO FAMILY MEMBERS OR CLOSE FRIENDS

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):
   _____
   _____

2. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:
   _____

3. Please list people we should NOT give any information to:
   _____

4. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.
   _____

5. Please print the telephone number* where you want to receive calls about you appointments, laboratory and x-ray results or other health care information: _____

6. May we leave confidential messages on your telephone* answering machine or voicemail? ___Y___N

**Note: The cell phone is not a secure and private line.*

Patient's Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your PHI. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health, health care services provided to you, or payment for health care services rendered.

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office involved in your care for the purpose of providing health care services to you, paying your health care bills, supporting the operation of our medical practice, and for any other use required by law.

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your health care and related services. For example, we may request your PHI from, or disclose your PHI to, other physicians and health care providers involved in your treatment and care.

Payment: We may use and disclose your PHI to bill and obtain payment from health insurers or other entities for services rendered to you. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health insurance plan to obtain approval for the hospital admission.

H**ealth Care Operations:** We may use or disclose your PHI to operate our medical practice, improve your care, and contact you when necessary. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing and credentialing activities, and conducting or arranging for other business activities. For example, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment.

Other Uses and Disclosures: We are also allowed or required to share your PHI in certain other circumstances pertaining to: public health and safety issues (for example, communicable diseases; product recalls; adverse reactions to medications; suspected abuse, neglect or domestic violence; and situations that may endanger an individual's health and safety); health research; health oversight agency activities; law enforcement and compliance with governmental requests; lawsuits and legal proceedings; criminal activity; work with coroners and funeral directors; organ donation; military activity, national security and presidential protective services; and workers' compensation claims.

In any other situation not described above, we will not use or disclose your medical information without your express written consent and authorization. You may revoke your authorization at any time, in writing. However, any revocation will not apply to disclosures already made or taken in reliance on that authorization.

Patients' Rights

With respect to your protected health information (PHI), you have certain rights:

- You have the right to inspect and obtain an electronic or paper copy of your medical record and other health information with the exception of: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI that is subject to law that prohibits access to PHI.
- You have the right to request that your PHI be amended if you believe that it is incorrect or incomplete. If we deny your request, you have the right to file a statement of disagreement with us. Upon receipt of your statement, we will prepare and provide you with a rebuttal to your statement within 60 days.
- You have the right to request that we not use or share certain PHI for your treatment, payment, or our health care operations. For example, you may request that any part of your PHI not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restriction requested and to whom you want the restriction to apply. Also, if you pay for a health care service or item out-of-pocket, you can request that we not share your PHI with your health insurer for purposes of payment or our operations. We are not required to agree to a restriction that you may request if your physician believes that it would adversely affect your care and is not in your best interests.
- You have the right to request an accounting of all disclosures of your PHI, with the exception of those for treatment, payment, and our health care operations, that we have made during the six years prior to the date of your request.
- In the event of a breach that may have compromised the privacy or security of your PHI, you have the right to receive notice of such breach.
- You have the right to request that we contact you with confidential communications in a specific way, such as by home or office phone, or by mail to a different address.
- You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

For certain health information, you have the right and choice to tell us whether to: share information with your family, friends, or others involved in your care; share information in a disaster relief situation; include your information in a hospital directory.

Disclosures of your PHI for purposes of marketing our services and/or selling your PHI will never be made without your express written permission. In the case of fundraising, we may contact you for fundraising efforts but you have the right to opt out of receiving any future fundraising communications.

If you have given an individual medical power of attorney or if you have a legal guardian, the designated person will be able to exercise your rights on your behalf. We will make certain that the designated person has the authority to act on your behalf before any action is taken.

We are required by law to maintain the privacy and security of your PHI, follow the legal duties and privacy practices described in this notice, and provide you with a copy of this notice. This notice became effective on April 14, 2003 and remains in effect until replaced. We reserve the right to change the terms of this notice and will provide you with the new notice upon request. Any changes will apply to all information that we have about you.

If you believe that your privacy rights have been violated, you may file a complaint either with our Privacy Officer, Tearsa Nelson at the above stated address and phone number or with the U.S. Department of Health and Human Services Office of Civil Rights at 200 Independence Avenue, S.W., Washington, D.C. 20201 (1-877-696-6775). We will not retaliate against you for filing a complaint.

By signing this form, I acknowledge that I have read and understand the above Notice of Privacy Practices.

_____ _____ /_____ /_____

Signature of Patient or Responsible Party Date

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MEDICAL OFFICE POLICIES

We are delighted that you have chosen to entrust us with your care and we welcome the opportunity to serve you. We are committed to working closely with you and your primary care physician to deliver the most effective treatment available. As part of this commitment, it is important that you have a clear understanding of our administrative and financial policies.

OFFICE HOURS

Normal business hours are Monday through Friday 9:00 A.M. to 5:00 P.M. Should you wish to contact us after hours, please leave a message on voicemail and we will return your call within 12 -24 hours.

EMERGENCY SITUATIONS

In the event of an emergency during regular office hours, our staff will notify the appropriate health care provider and he or she will return your call promptly. If the office is closed, you will be directed to our on-call physician covering emergencies. In severe emergencies, call an ambulance or go to the nearest hospital emergency room.

APPOINTMENT SCHEDULING, CHANGES, AND CANCELLATION POLICY

Appointments are scheduled between 9:00 A.M. to 5:00 P.M. Monday through Friday. If you need to cancel or reschedule your appointment, please notify our office during normal business hours at least 24 hours prior to your appointment. It is very important that you arrive for each visit on time in order for you to have adequate time with your provider. If you are more than 10 minutes late or if your new patient packet is not completed, you may be asked to reschedule. Occasionally, the doctor's schedule and hospital emergencies necessitate a change in your appointment. When this occurs, we will do our best to contact you to avoid an extended wait or unnecessary trip on your part.

Please be aware that if you do not give us notice of cancellation at least 1 business day prior to your appointment, you will be charged a fee for missed appointments. This fee is $125 for new patient consultations that include pulmonary function testing, and $35 for office follow-up visits. Such fees are not covered by health insurance, and will be your responsibility. Kindly call our office as far in advance as possible should you need to reschedule your appointment.

PRESCRIPTIONS

Prescription refills should be requested during regular office hours. Please have the name and number of your pharmacy and the name and the dose of the medication handy when you call for a refill. You may find it easier to have you pharmacy fax us a refill request. Please allow up to 48 to 72 hours for prescription refills.

MEDICAL RECORDS

Denali Asthma and Pulmonary is committed to protecting the privacy of your medical information. Please review our Notice of Privacy Practices which describes our legal duties, the different ways that we are permitted to use and disclose your protected health information, and your rights to access and control the information. All records that we create or receive concerning your health or condition and the services rendered are confidential and cannot be disclosed without your prior written authorization, except as otherwise permitted by law.

To authorize the release of your medical information to a specific person(s) or entity(ies), or to request a personal copy of your own medical records, you must submit your request in writing to our Office Manager. By law, we are required to retain your medical records for 7 years.

If you request that our staff complete forms on your behalf, such as short-term disability forms or creditor forms, please allow our staff 48 hours to respond to your request. We charge $35 per form.

FINANCIAL POLICY

We appreciate payment at the time of service and will accept personal checks, cash, and credit cards. As a courtesy to you, we will process your claim with your insurance company. Please note that insurance is a contract between you and your insurance company. While we may be the service provider, we are not party to that contract. Not all services are a covered benefit in all contracts. In some instances, you may be responsible for amounts not covered by insurance. We will make every effort to assess whether our services are covered by your insurer before treatment and will notify you of our findings. If you have any questions or are uncertain as to your insurance coverage, please contact us for assistance.

Payment Options

- Insured Patients: We require that you present a current copy of your insurance card to the receptionist at each office visit. You must pay all deductibles, copayments and coinsurance in full at the time of service. Although we may estimate the portion that your insurance carrier will pay, it is the insurance company that makes the final determination of eligibility and payment. Once your claim is processed by your insurance carrier, any amounts not covered by your insurance will be billed to you and it is your obligation to pay the charges.
- Private Pay / Uninsured Patients: If you do not have insurance coverage or your insurance carrier declines to cover a specific service, or if you are paid directly by your insurance company, you are expected to pay in full for services rendered at the time of service. In some instances payment arrangements may be made prior to the date of service. If prearranged payments are approved, we will require a valid credit card on file.

Refunds: If there is an overpayment for services rendered, we will refund the amount to you once all claims are settled on the account and no payment is due on any other claim.

Returned Checks: There will be a returned check fee of $20.00 for checks returned by the bank. If a returned check is received on your account, you will be required to pay all fees associated with this check in cash prior to scheduling a new appointment. Future visits will need to be paid in cash.

Account Balances: If there is a balance on your account, we will send you a monthly statement. Balances are expected to be paid in full upon receipt of the statement. Payments not received within 30 days of receipt of the statement are considered past due. Accounts with balances outstanding for 90 days will be referred to a collection agency. If your account is sent to a collection agency, you may be subject to agency fees and penalties.

Workers' Compensation / Personal Injury: We do not accept workers' compensation or personal injury cases nor do we bill attorneys for medical services. Any services performed in relation to a personal injury case will be considered self-pay and payment will be required at the time of service.

Disputes: Any disputes of your account should be submitted in writing within 30 days of receipt of the monthly statement. You will be notified of the outcome within 14 days of receipt of your dispute.

COMPLAINTS AND GRIEVANCES

To file a complaint, please complete our Complaint Form and submit it to the Office Manager. Within 14 days of submission of your complaint, you will receive written notice of the results of our investigation and actions taken to resolve your issues. To report concerns about safety or quality of care, please call 314.308.4879.

By signing this form, I acknowledge that I have read and understand the office policies of Denali Asthma and Pulmonary's medical practice..

_____ _____ /_____ /_____

Signature of Patient or Responsible Party *Date*

Denali Asthma and Pulmonary

PATIENT'S RIGHTS AND RESPONSIBILITIES

PATIENT'S RIGHTS

- The patient has the right to be treated with dignity and considerate, respectful care.
- The patient has the right to impartial access to care regardless of race, gender, religion, national origin, cultural, socioeconomic, or educational background, physical handicap, or ability to pay.
- The patient has the right to emergency care without discrimination due to economic status or payment source.
- The patient has the right to know what patient support services are available, including whether an interpreter is available if he/she does not speak English.
- The patient has the right to personal privacy and confidentiality of all records and communications concerning his/her medical history and treatment to the extent of the law.
- The patient has the right to receive relevant and timely information in a manner that is easily understandable concerning his/her diagnosis, treatment, risks and benefits of treatment, prognosis, plan for follow-up care, unanticipated outcomes of care, reasonable alternatives to proposed care, and consequences of non-treatment.
- The patient has the right to discuss and request additional information relating to specific procedures and/or treatments, including associated risks and benefits and alternative procedures and/or treatment.
- The patient has the right to inspect his/her medical record, have information explained or interpreted as necessary, request an amendment to, or receive an accounting of, disclosures regarding his/her personal health information, and for a reasonable fee, receive a copy of the medical record.
- The patient has the right to know the identity of the physicians, nurses, and other healthcare providers who are providing medical services and responsible for his/her care.
- The patient has the right to request information on the existence of business relationships between the health care provider and other health care facility, educational institution, or payers that may influence treatment.
- The patient has the right to know if medical treatment is for purposes of experimental research and to give his consent or refusal to participate in the experimental research.
- The patient has the right to accept or refuse treatment, except as otherwise provided by law, and to be informed of the medical consequences of refusing treatment.
- The patient has the right to receive, prior to treatment, a reasonable estimate of charges for the treatment.
- The patient has the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have charges explained.
- The patient has the right to receive care in a safe setting, free of all forms of abuse or harassment.
- The patient has the right to file a grievance or complaint regarding violation of his/her rights or any concerns regarding the quality of care received. To file a grievance or complaint, the patient is requested to complete and submit the Complaint Form to the Office Manager. Within 14 days of submission of the Complaint Form, the patient will receive written notice of the steps taken on his/her behalf to investigate the grievance, the results of the investigation, and actions taken to resolve the grievance or complaint.

PATIENT'S RESPONSIBILITIES

- The patient is responsible for providing, to the best of his/her knowledge, accurate and complete information concerning his/her medical history, past illnesses, hospitalizations, medications, and other matters relating to his/her health.
- The patient is responsible for reporting unexpected changes in his/her condition to the health care provider.
- The patient is responsible for reporting whether he/she comprehends the contemplated course of action and what is expected of him/her.
- The patient is responsible for following the recommended plan of treatment.
- The patient is responsible for keeping his/her appointments and, when he/she is unable to do so for any reason, for notifying the health care facility.
- The patient is responsible for his/her actions if treatment is refused or the health care provider's instructions are not followed.
- The patient is responsible for assuring that the financial obligations of his/her health care are fulfilled as promptly as possible.
- The patient is responsible for adhering to the facility's rules and regulations regarding patient conduct, being considerate of the rights of other patients and facility personnel, and respectful of the personal property of the other patients and facility personnel as well as the property of the health care facility.