Advanced Pulmonary Sleep Disorders & Internal Medicine (APSDIM)

Phone: 435-688-7770 / Fax: 435-688-8122

Please bring your 1. Drivers License / Picture ID, 2. Insurance Cards & 3. This Form to the office

At least 10 DAYS PRIOR TO YOUR APPOINTMENT

Patients Name: _____ DOB: _____ Phone: _____

Address: _____ Alt Phone: _____

Email Address: _____

○ Self Pay

Responsible Party: _____Resp. Party DOB: _____ Phone: _____

○ Primary INS: _____ Secondary INS: _____

Policy: _____ Policy: _____

Phone: _____ Phone: _____

Address: _____ Address: _____

Medications:

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Medical History Related to your Appointment and Consent for Release of Medical Records:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Contact Information for the Doctor's office / Facility that has your Medical Records that relate to what you're being seen for at our clinic?:

Dr: _____ Phone No._____
Date: _____Type of Record: _____

Request for Release of Medical Records

Please allow APSDIM (offices of Dr Mustufa Saifee, Dr Zahabia Gandhi, Victoria Larsen, and Heather Bandle to obtain/release my medical records for continuity of my medical care and/or purposes described above in the HIPPA notification.

There will be NO CHARGE if the purpose of releasing /getting my medical records is for the continuity of care, directly to and from doctor's offices. I understand that there will be a charge for releasing my Medical records to either me someone designated by me for any other circumstances. (Cost Price = $10 Locating/Handling Fee + per page price or applicable cost of media {paper/CD/floppy/external drive etc})

I also understand APSDIM cannot guarantee the recipient of these Medical Records to follow privacy policies governing us as described below.

_____ _____/ /_____

Patient/Guardian Signature **Date**

HIPAA notification: (Protected Health Information (PHI) as defined under the Health Information Portability and Accountability Act)

- APSDIM will maintain the privacy of your heath information and provide this notice that describes the ways we may use and share your health information. We reserve the right to change our notice and practices, and a revised notice will be made available upon request.
- By law in certain events, we are required to disclose your PHI even without your authorization.
- You have a right to review this notice prior to signing any consent, and request restrictions on how we use and share your health information.
- Revoke the consent in writing, except in the extent that we have already taken action in reliance thereon. We reserve the right to refuse future appointments/treatment if you refuse to sign or revoke consent.
- File a complaint with us to investigate any perceived breach of our privacy policies.
  Please direct all suggestions/complaints to our administrators at advanced.admin@apsdim.com.

Consent for disclosure of PHI (Protected Health Information)

I grant the staff of this office permission to call my phone at any number given by me while communicating to the office and leave a message on my voice mail or with any other person available at that number in reference to my PHI, such as but not limited to: appointment reminders, account statements, laboratory/test results etc. I also agree that this offices' staff may mail or email my PHI to my home or other designated location. I agree that for purposes of carrying out usual business activities my PHI may be shared with other individuals or businesses via phone/ fax/ email/ mail or any other format appropriate.
I hereby grant the following people (a.k.a Contact List) to have access to my PHI and I agree to keep this list current at all times: _____

Financial and Privacy Policies

You are responsible for all charges for services rendered to you whether as self-pay OR via Insurance coverage. It is your responsibility to determine what your covered benefits are. We will bill your insurance company on your behalf, if/when applicable and accept contractual assignments from them. Denials of payments from your insurance for any reason will be billed to you directly. Any out-of-pocket expenses (whether co-pays, % portion of coverage or deductibles, balance of past dues, self-pay amounts) are due at the time of service. Remember that your insurance policy is a contract between you and your insurance carrier. We submit claims on your behalf only as a courtesy for you.

Insurance authorization/ assignment

I authorize my insurance benefits to be paid directly to APSDIM. I am agreeing to accept complete responsibility to confirm that APSDIM is contracted with my insurance company and/or any prior authorization required has been obtained prior to receiving services. I understand that I am financially responsible for any non-covered benefit. I also understand that I am responsible for all collections and/or court costs in the event of default of payment of any amount due.
Your signature below indicates your acceptance of the office's Financial and Privacy Policies, Insurance authorization/ assignment, HIPAA notification, Consent for disclosure of PHI and Request for Release of Medical Records. This will remain a legally binding document for the entire duration of business-client relationship with APSDIM.

_____ _____/ /_____

Patient/Guardian Signature **Date**