Advanced Pulmonary Sleep Disorders & Internal Medicine (APSDIM)

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

640 East 700 South, Suite 105

St. George, UT 84770

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: _____

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, Chris Lamb -APRN, and Heather Bandle -APRN 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.   By signing below, I further acknowledge receipt of the 'Patients Rights & Responsibilities' and 'complaint' disclosures. (pg 3 & 4)

_____   _____/ /_____

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 Agreement

You are & shall remain 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. Your responsible to provide correct / updated insurance information. APSDIM will bill your insurance company on your behalf, if/when applicable & accept contractual assignments from them. Your insurance policy is a contract between you & your insurance carrier. APSDIM submits claims on your behalf only as a courtesy. 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. Denials of payments from your insurance for any reason will be billed to you directly.

If your account is referred to a third part debt collection agency, you are agreeing that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) You will also be responsible for a **collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code**. The terms of this paragraph shall apply to all amounts(s) incurred by you or by any individual for whom you have legal responsibility whether such amount(s) are incurred today or after today.

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**

[Type text]

Patient/Client Rights and Responsibilities

Have one's property and person treated with respect, consideration, and recognition of client/patient dignity and individuality.

Be able to identify clinic personnel or authorized visitors through proper identification.

Choose a healthcare provider, including choosing an attending physician.

Receive appropriate care without discrimination in accordance with physician's orders.

Be informed of any financial benefits when referred to an outside Sleep Lab Center.

Be fully informed of one's responsibilities.

Refuse care or treatment after the consequences of refusing care or treatment are fully presented.

We are listening

Advanced Pulmonary, Sleep Disorders & Internal Medicine, PLLC (APSDIM) encourages patient and family feedback about their experiences with our office. By obtaining feedback from patients and families, our clinic can identify opportunities to improve its processes, thereby enhancing patient and family satisfaction.

As a patient or family member of a patient, we would like to provide you with the following mechanisms for communicating a concern or complaint and ensure that appropriate action is taken in regard to this information.

1. You or your family member may express a concern or complaint regarding any aspect of care or treatment to any member of the clinic's staff. This may be communicated verbally or in writing.

2. In each of our patient rooms there are patient satisfaction surveys which can be given to a staff member or turned in to the comment box by the front desk.

3. Each patient room has a Comment Sheets ((+) High Five or (-) Down Low) which can also be given to a staff member or turned in to the comment box by the front desk.

4. You can go Online to visit www.healthgrades.com and take a survey which can be done anonymously.

5. Patients are welcome to also call into the office, email or visit the patient portal to communicate any issues.

6. Patients can file a formal complaint with the state by calling DOPL at 801-530-6628.

7. Patients can file a formal complaint with ACHC our accrediting body by calling 855-937-2242. ACHC will document and investigate all complaints received.

[Type text]