Advanced Pulmonary Sleep Disorders & Internal Medicine (APSDIM)

* 640 E 700 S STE 105 St. George, UT 84770
* 110 W 1325 N STE 175 Cedar City UT 84720 * 1301 Bertha Howe Ave STE 11 Mesquite NV 89027
Phone: 435-688-7770 Fax: 435-688-8122 advanced.admin@apsdim.com

APDIM strives to respect the individuality of each patient & provide counsel regarding their choices for healthcare, moving along the health continuum where maximum quality of life can be achieved.

Return your 1. Completed Welcome Packet 2. Insurance Cards 3. Picture ID to the office
At Least 10 DAYS PRIOR to your appointment

Patient's Name: _____ DOB: _____ Preferred Phone: _____
Address: _____ Alt Phone: _____
Email Address: _____ Prefered Language: English ____ / Other: _____

○ Self Pay ○ Responsible Party: _____ Resp. Party DOB: _____ Phone: _____
○ Primary INS: _____ ○ Secondary INS: _____
Policy: _____ Policy: _____
Phone: _____ Phone: _____

Ethnicity: (check ONLY one) ○ Hispanic or Latino ○ Non- Hispanic or Latino

Race: (check all that apply)
○ Asian ○ Black or African American ○ White
○ American Indian or Alaska Native ○ Native Hawaiian/Pacific Islander ○ Choose not to disclose

Current Medications: After your initial visit, do you authorize APDIM to get electronic updates of your medications from your pharmacy? ___ YES / ___ NO ○ SEE ATTACHED LIST

_____ _____ _____
_____ _____ _____
_____ _____ _____

List known diagnosis/medical conditions:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Advanced Directive: Do you have ANY **Advanced Care Planning** documents such as a Living Will, Physician's Order of Life Sustaining Treatment or something similar? ___ YES* / ___ NO *** If you answered YES provide the office a copy.**

Please provide details about the following tests that you may have had done:

Test	Year	Place (facility or Doctor)
Eye Exam		
Colonoscopy (or Stool Test)		
Mammogram (women)		

Fall Risk & PHQ2 Questions	YES	NO
Have you had 2 or more falls anytime in the past year?		
Do you have difficulty with walking or with balance?		

During the past 2 weeks, have you been bothered by emotional problems like feeling anxious, depressed, irritable, sad, downhearted or blue?		
During the past 2 weeks, have you felt little interest or pleasure in doing things?		

Please provide details about your Immunization History:

Vaccine	Year	Place (facility or Doctor)
Flu (Influenza)		
Pneumonia/Pneumococcal (Pneumovax)		
Pneumonia/Pneumococcal (Prevnar 13)		
Shingles (Herpes Zoster)		
Tetanus, Diphtheria, Pertussis (Tdap)		
Covid-19		
Other(please provide name)		

Please provide details about your Lifestyle Choices:

During the past year have you used the following?	YES	NO
Alcohol		
Prescription Pain medications more than what is prescribed for you or using someone else's Rx		
Illegal Drugs		
Have you **ever** used ANY tobacco products (including chewing/vaping/e-ciggarettes etc)?		
Generally speaking, do you use caffeinated and sugary drinks such as coffee/ tea or soda pop?		
Generally speaking do you engage in the recommended exercises? (see below)		

Recommended Exercises: BOTH 1&2

1. Weekly Aerobic
   - 150 min moderately intense (noticeably increases heart rate but able to speak during activity)
   - OR > 75 min high intensity (heart rate & breathing rate rise rapidly. Unable to say more than a few words without pausing for a breath).
2. Minimum twice a Week: Strengthening activities such as stretches/yoga/pilates/tai-chi/use of weights etc

Please provide details about your Family History:

◯ Check here if you are adopted and/or DO NOT know your family history.
◯ No Known Family History of Medical Issues in 3 generations such as parents, siblings, children etc
◯ The following are known Disease/Illness that run in my family (Please fill in table below)

Relationship	Age of Dx	Disease/Illness	If applicable - Age of Death

Consent for disclosure of PHI (Protected Health Information)

I grant permission to call my phone at any number given by me while communicating to the office. I further grant permission to 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 & balances, laboratory/test results, etc. I also agree that my PHI may be mail or email 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 Emergency Contact / Contact List) to have access to my PHI and I agree to keep this list current at all times:
Are the below named individuals authorized to make medical decisions on your behalf? ___ **YES /** ___ **NO**

_____/_____/_____

Name & Relationship Date Phone

_____/_____

Patient/Guardian Signature Date

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HIPAA notification:

(Protected Health Information (PHI)/ Health Information Portability & 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 will request and maintain records that pertain to your continuity of care. 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 (see Rights & Responsiblities disclosure).
- 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.
- You have a right to 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 if you revoke consent.
- **You have a right to f**ile 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.**

Patient: _____ DOB:_____

Request for Release of Medical Records

I authorize the release of my medical records to & from APSDIM, Office(s) of Mustufa Saifee-MD, Zahabia Gandhi-MD Chris Lamb -APRN, Codie Bingham -APRN & Elizabeth DeMille-PA for continuity of my medical care &/or purposes described in the above HIPPA notification.

Facility/ Provider	Specialty	Phone	Date Range

There will be NO CHARGE for releasing medical records 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 or someone designated by me for any other circumstances. (APSDIM Cost Price = $10 Handling Fee + $ .10 per page 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 above.

Your signature below authorizes the release of records.

_____ _____ / / _____

Patient/Guardian Signature **Date**

Patients Name:_____ DOB:_____ Phone: _____

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.

All accounts not paid within 30 days may assess a late fee of $15.00 per month/per date of service. The undersigned agrees to pay a service charge of $20.00 for each check or instrument tendered but returned unpaid. In the event any balance is not paid as agreed, the undersigned agrees to pay a **collection fee of up to 40%** of the unpaid balance, as allowed by Utah Code Annotated, sec. 12-1-11. If your account is referred to a third part debt collection agency and a lawsuit is brought to collect the unpaid balance, the undersigned further **agrees to pay all other costs of collection, court costs and reasonable attorney fees, in addition to, the collection fee.** The terms of this agreement shall apply to all amount(s) incurred by me or by any individual whom I have legal responsibility wheather such amount(s) are incurred today or after today.

You have provided us with contact information (phone, email, additional contact etc). By signing below, you understand and agree you are providing us and its affiliates, agents and service providers with your express consent to use written, electronic or verbal means to contact you, This consent includes, but is not limited to, contact by manual calling methods, prerecorded or artificial voice messages, text messages, emails and/or automatic telephone dialing systems about the services, goods or loans provided to you today or in the future. You may revoke consent for us to contact you by any of these methods or otherwise restrict your permissions as provided in this form by calling us at 435-688-7770 between the hours of 8:00 am -5:00 pm Monday through Friday, or visiting our business office at any time you are at our facility.

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. Rates, terms and conditions are subject to change without notice.

Your signature below indicates your acceptance of the office's Financial and Privacy Policies & Insurance authorization/ assignment in its entirety.

This will remain a legally binding document for the entire duration of your relationship with APSDIM, and if applicable, will survive all charges that occurred before severance of said relationship.

_____ _____/ /_____

Patient/Guardian Signature **Date**

Patients Name: _____ DOB: _____ Phone: _____

Patient Rights and Responsibilities:

1. To be informed of these rights, as evidenced by the patient's written acknowledgement, or by documentation by staff in the medical record, that the patient was offered a written copy of these rights and given a written or verbal explanation of these rights, in terms that the patient can understand. The facility shall have a means to notify patients of any rules and regulations it has adopted governing patient conduct in the facility;
2. To be informed of services available in the facility, of the names and professional status of the personnel providing and/or responsible for the patient's care, and of fees and related charges, including the payment, fee, deposit, and refund policy of the facility and any charges for services not covered by sources of third-party payment or not covered by the facility's basic rate;
3. To be informed if the facility has authorized other health care and educational institutions to participate in the patient's treatment. The patient also shall have a right to know the identity and function of these institutions, and to refuse to allow their participation in the patient's treatment;
4. To receive from the patient's physician(s) or clinical practitioner(s), in terms that the patient understands, an explanation of his or her complete medical/health condition or diagnosis, recommended treatment, treatment options, including the option of no treatment, risk(s) of treatment, and expected result(s). If this information would be detrimental to the patient's health, or if the patient is not capable of understanding the information, the explanation shall be provided to the patient's next of kin or guardian. This release of information to the next of kin or guardian, along with the reason for not informing the patient directly, shall be documented in the patient's medical record;
5. To participate in the planning of the patient's care and treatment, and to refuse medication and treatment. Such refusal shall be documented in the patient's medical record;
6. To be included in experimental research only when the patient gives informed, written consent to such participation, or when a guardian gives such consent for an incompetent patient in accordance with law, rule and regulation. The patient may refuse to participate in experimental research, including the investigation of new drugs and medical devices;
7. To voice grievances or recommend changes in policies and services to facility personnel, the governing authority, and/or outside representatives of the patient's choice either individually or as a group, and free from restraint, interference, coercion, discrimination, or reprisal;
8. To confidential treatment of information about the patient. Information in the patient's medical record shall not be released to anyone outside the facility without the patient's approval, unless another health care facility to which the patient was transferred requires the information, or unless the release of the information is required and permitted by law, a third-party payment contract, or a peer review, or unless the information is needed by the State Department of Health for statutorily authorized purposes. The facility may release data about the patient for studies containing aggregated statistics when the patient's identity is masked;
9. To be treated with courtesy, consideration, respect, and recognition of the patient's dignity, individuality, and right to privacy, including, but not limited to, auditory and visual privacy. The patient's privacy shall also be respected when facility personnel are discussing the patient;
10. To not be required to perform work for the facility unless the work is part of the patient's treatment and is performed voluntarily by the patient. Such work shall be in accordance with local, State, and Federal laws and rules;
11. To exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, or any attendance at religious services, shall be imposed upon any patient;
12. To not be discriminated against because of age, race, religion, gender identity & sexual orientation, nationality, or ability to pay, or deprived of any constitutional, civil, and/or legal rights solely because of receiving services from the facility;
13. To expect and receive appropriate assessment, management and treatment of pain as an integral component of that person's care.

We are listening

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:

   Advanced Pulmonary Sleep Disorders & Internal Medicine
   Attn: Office Manager
   640 East 700 South STE 105
   St George, UT 84770
   P * 435-688-7770 F * 435-688-8122
   Email: advanced.admin@apsdim.com

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 encouraged to 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** or online at dopl.utah.gov.

7. Patients can file a formal complaint with ACHC our accrediting body by calling **855-937-2242** or online at www.achc.org/complaint-policy-process.html. ACHC will document and investigate all complaints received.

I further acknowledge receipt of the 'Patients Rights & Responsibilities' and reporting disclosure.

_____ _____/__/_____

Patient/Guardian Signature **Date**

Thank you for choosing APSDIM!