CHANDLER NEUROLOGY & SLEEP DISORDERS

Patient Demographic Information Sheet

SS#: _____-_____-_____ Patient Name: _____
Last Name, First Name Middle Initial

Date of Birth: _____/_____/_____ Sex: (**Male / Female**) Marital Status: (**S / M / W / D**)
Month Day Year

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Secondary Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone#: (_____)_____-_____ Cell Phone#: (_____)_____-_____

E-mail Address: _____ Employer: _____

Race: _____ Ethnicity: _____ Language: _____

Primary Care Physician: _____Phone#: (_____)_____-_____

Referred By (if other than PCP): _____Phone#: (_____)_____-_____

Pharmacy Information

Name: _____ Pharmacy Type: (**Mail Order** / **Regular**)

Cross Streets & City: _____ Phone#: _____

Insurance Information

Primary Insurance: _____
ID#: _____
Group#: _____
Card Holder Name: _____
Card Holder SS#: _____
I gave a copy of my Insurance card: (**Y / N**)

Secondary Insurance: _____
ID#: _____
Group#: _____
Card Holder Name: _____
Card Holder SS#: _____
I gave a copy of my Insurance card: (**Y / N**)

Who, on behalf of you, may receive information regarding your Protected Health Information?

Name: _____ DOB: _____ Relation: _____
Name: _____ DOB: _____ Relation: _____
Name: _____ DOB: _____ Relation: _____
Name: _____ DOB: _____ Relation: _____

Personal Representatives I have received a copy of the Privacy Rules from this provider and authorized the above list of persons who may receive my Protected Health Information. I may revoke this at any time by giving written notification to this provider: **INITIAL** _____

I give my consent to obtain any and all records pertaining to my prescription history: **INITIAL** _____

Today's Date: _____ **Signature:** _____
Circle One: *(Patient / Parent / Guardian)*

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MEDICAL APPOINTMENT & TESTING CANCELLATION/NO SHOW POLICY

Thank you for trusting your medical care to Chandler Neurology and Sleep Disorders. When you schedule an appointment with Chandler Neurology and Sleep Disorders we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation/No Show Policy below:

- Effective August 1, 2021 any established patient who fails to show or cancels/reschedules any test appointment and has not contacted our office with at least 24 hour notice will be considered a No Show and charged a $50.00 fee.
- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hour notice will be considered a No Show and charged a $50.00 fee.
- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hour notice, a second time, will be considered a No Show and charged a $50.00 fee.
- If a third No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be dismissed from Chandler Neurology and Sleep Disorders.
- Any new patient who fails to show for their initial visit will not be rescheduled a third time.
- *The fee is charged to the patient, not the insurance company*, and is due at the time of the patient's next office visit.
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Staff, who may be able to waive the No Show fee.

You may contact Chandler Neurology and Sleep Disorders 24 hours a day, 7 days a week at the numbers below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

Chandler Neurology and Sleep Disorders (480) 722-0239

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____	_____	_____
Patient Printed Name	**Signature (Parent/Legal Gaurdian)**	**Date**

CHANDLER NEUROLOGY & SLEEP DISORDERS

HIPPA PRIVACY NOTICE

I have received the HIPPA Privacy Notice regarding the uses and disclosures of my Protected Health Information and I understand my rights and responsibilities with respect to my medical records. **(Page 3)**

I hereby authorize Chandler Neurology & Sleep Disorders, PC to release any medical or incidental information to my referring physician or any other physicians who have been or may become involved with my care.

I also authorize the release of information that may be necessary in the processing of any insurance claims.

I also authorize the release of any medical record including pharmacy records to Chandler Neurology and Sleep Disorders Associates, PC upon request.

If I have provided a list of personal representatives (family member, spouse, attorney, etc), I hereby authorize Chandler Neurology and Sleep Disorders, PC and its employee's permission to discuss, send and/or receive medical information to/with the individuals listed. **(Page 1)**

Faxes

When expedient, I authorize the transmittal of my records by fax. I understand that transmission by fax, by its very nature is not confidential.

Messages

May we leave a voice message regarding test results & appointments on your home number? **(Y / N)**
May we leave a voice message regarding test result & appointments on your cell phone? **(Y / N)**

Disability Paperwork

Paperwork can be done in this office for disabilities related to your neurological condition; ***an appointment is required, paperwork may take up to 10 business days to be completed and you may be charged up to $25.00 for the paperwork***. I understand that it is my responsibility to ensure all needed paperwork is received by the office in a timely manner if there may be a deadline to submit my paperwork.

Insurance

I understand that I am responsible for ensuring this office has my insurance information up-to-date at every office visit. Tests done in this office may or may not require prior authorization through my insurance. If a test does not require prior authorizations or if it is approved by my insurance, this is not a guarantee that my insurance will pay for this test. Please contact your insurance if you have any questions about specific test done in this office: **INITIAL** _____

Patient Name: _____ **DOB:** _____/_____/_____

Signature: _____ **Today's Date:** _____

Circle One: *(Patient / Parent / Guardian)*

CHANDLER NEUROLOGY & SLEEP DISORDERS

Notice of Privacy Policy for Protected Health Information (PHI)

The office of Chandler Neurology & Sleep Disorders Associates, PC is dedicated to protect you "nonpublic personal health information". This notice is to tell you how and why we collect that information, and who has access to that information.

HOW WE COLLECT YOUR INFORMATION:

Your personal demographic information such as name, address, birth date, social security number and medical insurance information is obtained from you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This ensures that the information we collect is correct.

If you came in to our practice through a hospital encounter, we may obtain that information from the hospital. However, on your first visit to this office, we will ask you to fill out our information sheet to ensure that the information we received from the hospital was correct.

We may also ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION:

We collect this information so that we can treat your medical condition and obtain payment for you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION:

To ensure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION:

Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical records, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information.
Entities such as Governmental Oversight agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and the Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:

We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but the persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Healthcare Information.

YOUR RIGHTS:

You have the right to inspect your Protected Healthcare Information. You also have the right to amend any errors you may find in your records.

If you leave this practice, your Protected Healthcare Information will continue to receive the protection outlines in this notice.

COMPLAINTS / COMMENTS:

If you have any complaints concerning our privacy practices, you may contact the Secretary of the Department of Health and Human Services at 200 Independence Avenue, S. W. Room 509F, HHH Building, Washington D.C. 20201. You also may contact the Privacy Office of this practice at (480) 722-0239.

THIS PRACTICE reserves the right to amend out privacy policy as dictated by the law, without sending you a copy of the amendment. Any changes to this policy will be posted in our office.

This notice is effective as of June 1, 2008.

CHANDLER NEUROLOGY & SLEEP DISORDERS

Medical History

Patient Name: _____ **Date of Birth**: _____

Medications If you have hand carried a list, please give list to the front to make a copy

Medication name	**Dosage**	**Frequency** (How often do you take meds)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Medical History Please be as detailed as you can with any medical history

	YES	**NO**
Stroke _____	☐	☐
Heart problems or cardiac stent _____	☐	☐
Pacemaker or implantable defibrillator _____	☐	☐
High or low blood pressure _____	☐	☐
Anemia or any blood disorders _____	☐	☐
Head or neck injury _____	☐	☐
Emphysema, shortness of breath _____	☐	☐
Thyroid, parathyroid, or calcium deficiency _____	☐	☐
Kidney disease _____	☐	☐
Liver disease _____	☐	☐
Cancer _____	☐	☐
Osteoporosis/osteopenia _____	☐	☐
Neuropathy _____	☐	☐
Epilepsy, convulsions (seizures) _____	☐	☐
Tumor/abnormal growth _____	☐	☐
Arthritis, Rheumatoid arthritis, lupus _____	☐	☐
Neurological disorders _____	☐	☐
Other _____		

Are you **allergic** to any medication? **YES / NO** Please list allergies and reaction you experienced

1._____

2._____

3._____

4._____

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Medical History

List all previous **surgeries**

Date	Facility / Hospital	Procedure

List all previous **hospitalizations**

Date	Hospital	Reason

Family History Does your family have any medical conditions?

Father _____

Mother _____

Paternal Grandfather _____

Paternal Grandmother _____

Paternal Aunt _____

Paternal Uncle _____

Maternal Grandfather _____

Maternal Grandmother _____

Maternal Aunt _____

Maternal Uncle _____

Children _____

Siblings' _____

Social History Please check if you have had any of the following

1. ☐ *Nicotine/smoke* How many packs a day? _____ Since when? _____
   Former Smoker? _____ When did you quit? _____
2. ☐ *Alcohol* How many glasses per week? _____
3. ☐ *Drugs (not for medical reasons)* Name of drug _____
4. ☐ *Caffeine* Soda / Tea / Coffee / Energy Drinks How many cups/cans a day? _____