Arizona Neurology and Sleep Center
www.azns.org

Jose De Ocampo, MD
Luay Shayya, MD
Rachel Mickevich, ANP-BC
10210 N. 92nd Street, Suite 302
Scottsdale, AZ 85258
Office 480-718-9241 Fax 480-718-9248

Patient Information

Name of Patient_____
Last First Middle

Date of Birth:_____ Gender M F Other

Social Security Number:_____

Email Address:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____

Race:
- ◯ American Indian Or Alaskan Native
- ◯ Asian
- ◯ Black or African American
- ◯ Native Hawaiian or Other Pacific Islander
- ◯ White
- ◯ Hispanic/Latino

Employment Status

Employer:_____

Occupation:_____

Work Phone:_____

Manager/Supervisor:_____

Emergency Contact:_____ Relationship:_____

Phone Number:_____

Insurance

PRIMARY Insurance Medicare ◯ HMO ◯ PSO/PPO ◯ Cash ◯

Other:_____

Insurance Company:_____

Policy/ID Number:_____ Group Number:_____

Primary Insurance Subscriber:_____ Relationship:_____

Date of Birth:_____ Social Security #:_____

Employer:_____ Contact:_____

SECONDARY Insurance Medicare ○ HMO ○ PSO/PPO ○ Cash ○

Other:_____

Insurance Company:_____

Policy/ID Number:_____ Group Number:_____

Referral

Referring Physician:_____ Specialty:_____

Phone Number:_____ Fax Number:_____

Medication

Are you allergic to any medication? Yes or No

If YES, what are the medications:_____

_____

What is the reaction?:_____

Please list all current prescription medications:_____

Start Date	Name	Strength	Dose	Frequency
Start Date	Name	Strength	Dose	Frequency
Start Date	Name	Strength	Dose	Frequency
Start Date	Name	Strength	Dose	Frequency
Start Date	Name	Strength	Dose	Frequency

Patient Name:_____ Date: _____

I authorize Arizona Neurology and Sleep Center (AZNS) to contact me by telephone regarding my medical information. If I am unavailable, this authorization gives AZNS permission to leave information on my answering machine or with a member of my household.

Name	Relationship	Contact Number

HIPAA Information and Consent Form

I._____ Date:_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Office Policies

PRESCRIPTION REFILL POLICY:

Prescription refill requests must be made 7 to 10 business days before running out of medication, also please allow up to 72 hours for the refill to be processed. Refills will only be approved if follow-up visit has been kept every six months. Prescriptions will only be handled during office hours.

_____ Date:_____

Patient's Signature

Pharmacy:_____

Address: _____

Phone/Fax:_____

Arizona Neurology and Sleep Center
www.azns.org

Jose De Ocampo, MD
Luay Shayya, MD
Rachel Mickevich, ANP-BC
10210 N. 92nd Street, Suite 302
Scottsdale, AZ 85258
Office 480-718-9241 Fax 480-718-9248

FINANCIAL RESPONSIBILITY

We charge what is usual and customary for our area. Our office policy is that full private payment or insurance co-payment/coinsurance and/or deductible, as well as, account balances are due at the time of service unless prior arrangements have been made. The adult accompanying the minor patient will be required to pay in accordance with our policies. Please understand that we will only bill insurance companies that we are contracted with. Furthermore, it is your responsibility to follow up with the insurance company to insure the claim is paid within 60 days of the date of service. We must emphasize, that as health care providers, our relationship is with you, our patient, and NOT with your insurance company. You are responsible for knowing what your insurance benefits are, including what your insurance will and will not pay for; and how to access your benefits, including obtaining referrals, etc. If you are unsure, please contact your insurance carrier. **This office assumes no responsibility for your lack of knowledge regarding your insurance benefits. You are responsible for any remaining unpaid charges as determined by your insurance company regardless of cause.** This agreement is necessary in order to accept your insurance without having to bill you upfront. An account past due 60 days or more and payment plans that not kept current may be subject to collection and associated fees. Please note claim information processed by the insurance company is mailed to the policyholder. If you are not the policy holder for your insurance, the policy holder (parent, spouse and/ or guardian) may receive information from the insurance company pertaining to dates of service and diagnosis. Arizona Neurology & Sleep Center (AZNS) can not be held liable for information being received from the insurance company.

Please note: Insurance cannot be billed without the patient present.

By completing the information below, you assign your insurance benefits to be paid directly to AZNS. You also authorize AZNS to release any information which may be needed for processing all of claims; certification/ case management/ quality. improvement; and/ or other purposes related to the benefits of your health plan. **Furthermore, understand that it is your responsibility to ensure that proper referrals or authorizations are obtained for each visit**. Finally, we require notification of insurance changes at least one week prior to your appointment to avoid appointment delay and/ or private pay expenses

Some medications may require Prior Authorization. Please call your insurance company and find out what provider your PHARMACY BENEFITS are covered through. Please note: This may be located on your insurance cards (I.e. Medco, Prescription Solutions, Caremark, and Express Scripts). If not, we do need this information filled out in its entirety.

Pharmacy Benefit Provider:_____

I UNDERSTAND AND AGREE TO ALL OF THE ABOVE

_____ Date:_____

Signature of Parent/ Legal

CANCELLATION POLICY & MISSED APPOINTMENTS:
A scheduled appointment is time reserved only for you. If an appointment is missed or cancelled for any reason with less than 24 hours notice, the patient will be billed according to schedule services. Doctor's appointment will be charged $50.00 per missed visit. A procedure will be charged $150.00 per missed procedure. This fee is not generally paid by insurance and will be patient's responsibility.

_____ Date:_____
Patient's signature

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use ✓ to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1, Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding 0 + ____ + ____ + ____
= Total Score: ____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ **Somewhat difficult** ☐ **Very difficult** ☐ **Extremely difficult** ☐

Review of Systems:

Please circle any of the following symptoms you've had in the past 6 months.

General:
Fever. Chills. Sweats. Weight loss. Weight gain.

Skin:
Rashes. Lumps.

Eyes, Ears, Nose and Throat:
Blurred vision. Double vision. Trouble swallowing. Runny nose. Hearing loss. Dysphagia.

Pulmonary:
Shortness of breath. Coughing up blood. Cough.

Cardiac:
Chest pain. Palpitations. Shortness of breath with exertion.

GI:
Blood in the stool. Black or tarry bowel movements. Nausea. Vomiting. Diarrhea. Abdominal pain.

Musculoskeletal:
Join pain. Muscle pain. Morning stiffness. Joint swelling.

GU:
Pain with urination. Trouble controlling urine/accidents. Blood in the urine.

Endocrine:
Temperature intolerance. Excessive thirst. Increased amount of urination.

Psychiatric:
Depression. Suicidal ideas. Homicidal ideas. Hallucinations.

Hematologic:
Easy brusing. Bleeding. History of abnormal blood clotting.

Neurological:
Numbness. Tingling. Weakness. Tremors. Memory loss. Imbalance.

Sleep:
Snoring. Jerking of the limbs at night. Nightmare. Acting out dreams. Sleep apnea.