Modern Medicine

Khadija Rashid, M.D. **Saqib Rashid, M.D.**
4042 S Demaree St, Visalia, CA 93277
(559) 754 – 2967

Patient Information Form

PLEASE PRINT

NAME _____ DATE _____

ADDRESS _____ CITY_____ ZIP CODE _____

HOME PHONE:_____ WORK PHONE _____ SSN _____

DATE OF BIRTH _____ SEX: ☐**M** ☐**F** MARITAL STATUS: ☐**M** ☐**F** ☐**S** ☐**D**

REFERRING PHYSICIAN/SOURCE _____

EMPLOYER _____ ADDRESS_____ PHONE _____

SPOUSE'S NAME _____ SPOUSE'S SSN _____

SPOUSE'S EMPLOYER _____ PHONE _____

IN CASE OF EMERGENCY:

NAME OF CLOSEST RELATIVE NOT LIVING WITH YOU _____

PHONE _____ RELATIONSHIP _____

RESPONSIBLE PARTY IF UNDER 18:

NAME _____ RELATIONSHIP _____

ADDRESS _____ CITY_____ STATE _____

INSURANCE INFORMATION:

PRIMARY INSURANCE OR INDUSTRIAL CARRIER _____

SUBSCRIBER'S NAME _____ SSN _____ DOB _____

GROUP # _____ POLICY # _____

SECONDAY INS. NAME _____ SSN _____ DOB _____

GROUP # _____ POLICY # _____ RELATIONSHIP _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand I am financially responsible for any balances. I also authorize Dr Rashid or the insurance company to release any information required to process my claims.

_____ _____

Patient/Parent/Guardian Signature *Date*

NAME AND LOCATION OF YOUR PHARMACY: _____

FORMULARY BENEFITS DATA CONSENT FORM

Formulary Benefits data are maintained for health insurance providers by organizations known as Pharmacy Benefits Managers (PBM). PBM's are third-party administrators of prescription drug programs where primary responsibilities are processing and paying prescription drug claims. They also develop and maintain formularies, which are lists of dispensable drugs covered by a particular drug benefit plan.

We may need access to your data as maintained by the PBM's to know what medications have been prescribed to you in the past and to know which drugs are covered by your insurance plan.

By signing below, I give permission for Dr. Saqib Rashid, Dr. Khadija Rashid, and their affiliated staff/ practitioners to access my pharmacy benefits data electronically through RxHub. This consent will enable the aforementioned to:

- Determine the pharmacy benefits and drug copays for a patient's health plan.
- Check whether a prescribed medication is covered (in formulary) under a patient's plan.
- Display therapeutic alternatives with preference rank (if available) within a drug class for non-formulary medications.
- Determine if a patient's health plan allows electronic prescribing to mail order pharmacies, and if so, e-prescribe to these pharmacies.
- Download a historic list of all medications prescribed for a patient by any provider.

In summary, we ask your permission to obtain formulary information and information about other prescriptions prescribed by other providers using RxHub.

Patient Name (PRINTED)	Date of Birth
Patient/Guardian Signature	Date

☐ **Internal, Pulmonary, Critical Care & Sleep Disorders**

☐ **Neurology Associates of Tulare**

About Our Notice of Privacy Practices

We are committed to providing your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- Our obligation under the law with respect to your personal health information.
- How we may use and disclose the heath information that we keep about you.
- Your rights relating to your personal health information.
- Our rights relating to your personal health information.
- How to file a complaint if you believe your privacy rights have been violated.
- The conditions that apply to uses and disclosures not described in the Notice.
- The person to contact for further information about our privacy practices.

We are required by law to give you a copy of this notice and to obtain your written acknowledgment that you have received a copy of this notice.

Patient Acknowledgement of Receipt

I, _____, hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

_____ _____

_____ _____

_____

Office Use Only

Describe the reasons why a signed Acknowledgment of Receipt was not obtained:

_____ Patient is unwilling or refuses to sign.

_____ Other: _____

_____

Modern Medicine
Khadija Rashid, M.D.
Saqib Rashid, M.D.

PATIENT HEALTH INFORMATION (PHI) RESOURCE TOOL

Please PRINT below information:

I, _____, hereby authorize the release of my Protected Health information for verbal discussion only of my care and treatment to the person(s) specified below (45CFR, 164.502(F), and 184.502(G):

Authorized family member or person to receive information for the above-named patient's care:

Name of Contact (Other than Patient)	Relationship to Patient	Phone Number

Other authorized to receive my verbal information (Please list names and relationship):

Print Name	Relationship to Patient	Phone Number

Print Name	Relationship to Patient	Phone Number

Note: This form does not give the above referenced persons permission to make health care decisions for the patient or entitle them to paper copies or electronic access of your medical record. We will not release via the telephone or any other means of communication any information to any friends or family members not listed above unless the patient has an opportunity to object and does not (documented) or if it is reasonable to infer that the patient does not object, such as, when a patient brings a spouse into the room when treatment is being discussed. Exception: Of the release is needed in emergency situations.

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* **May we leave a message on an answering machine or voice mail?** (Example: May we leave message reminders, scheduling changes or notices that lab results are in on your answering machine. Would this process be acceptable? Pleases circle "Yes" or "No". ☐ Yes ☐ No

* **May we leave a message for patient to return call?** (Example: May we leave a message regarding appointment reminders scheduling changes or notices that lab results are in with an individual who answers the phone. Would this process be acceptable? Pleases circle "Yes" or "No". ☐ Yes ☐ No

NOTE: By signing and dating this PHI Communication Resource Tool, I revoke all previously signed Communication Resource Tool forms.

Patient Signature	Date

Personal Representative (PRINT) _____

Note: Except to the extent that action has already been taken in reliance on this PHI Communication Resource Tool, at any time I can revoke this PMI Communication Resource Tool by submitting a new PHI Communication Resource Tool Form or by written notice to the Privacy Site Coordinator or privacy site designer.

NAME _____ Date of Birth _____

Modern Medicine

Khadija Rashid, M.D.
Saqib Rashid, M.D.

PAST MEDICAL HISTORY FORM

Date_____

Patient Name _____ Date of Birth _____

Referring Physician _____

Parent/Guardian Name _____ Phone _____

Past Medical History

Have you ever been treated for any of the following illnesses? Check all that apply.

☐ High blood pressure	☐ Diabetes	☐ Epilepsy
☐ Heart disease/Heart Attack	☐ Cancer	☐ Stroke
☐ Emphysema/Bronchitis	☐ Arthritis	☐ Hepatitis
☐ Depression	☐ Ulcers	☐ Immunodeficiency disease
☐ High cholesterol	☐ tuberculosis	☐ Pneumonia

Please comment on any illness checked above or write in other conditions if not mentioned above.

_____

_____

Have you ever had surgery before? ☐ Yes ☐ No
If yes, when (Month, Year) and what for.

_____

_____

Have you ever been hospitalized for other reasons not including surgeries? ☐ Yes ☐ No
If yes, when (Month, Year) and what for.

_____

_____

Allergies to Medications _____

Other Allergies _____

Are your immunizations (tetanus, flu, pneumonia) up to date? ☐ Yes ☐ No

NAME _____ Date of Birth _____

Medications

List current medications including over-the-counter medications such as diet or allergy pills or herbal supplements:
(*If more space is needed, please provide the rest of medications on the back of this page.)*

Medication	**Dose**	**Frequency**

NAME _____ Date of Birth _____

Khadija Rashid, M.D.
Saqib Rashid, M.D.

DO YOU HAVE AN ADVANCE DIRECTIVE? ☐ Yes ☐ No

FAMILY HISTORY
Complete this information regarding your family.

Father ☐ Alive ☐ Deceased
Health Status _____
If deceased, Cause _____ *Age* _____

Mother ☐ Alive ☐ Deceased
Health Status _____
If deceased, Cause _____ *Age*_____

Other Family Members

Brothers (*how many*) _____ Healthy _____ Sisters (*how many*) _____ Healthy _____

Do any close family members have any of the following medical conditions? Check all that apply.

	Medical Condition	**Relationship to you**
☐	Arthritis	_____
☐	Asthma/Hay fever	_____
☐	Cancer	_____
☐	Drug Addiction	_____
☐	Diabetes	_____
☐	Cerebral Embolism	_____
☐	High blood pressure	_____
☐	Tuberculosis	_____
☐	Other:	_____

SOCIAL HISTORY

Marital Status
☐ Married
☐ Single
☐ Divorced
☐ Widowed

Children
_____

I live
☐ Alone
☐ With someone

Height _____ ***Type of work*** _____

Alcohol Use
(# of drinks per week)
☐ 0
☐ Occasional
☐ 1-6
☐ 7-12

Tobacco Use
(# of packs per day)
_____
If former smoker, how long ago did you quit?
_____

Caffeine Use
(# of cups per day)
☐ 1
☐ 2
☐ 3 or more

NAME _____ Date of Birth _____

Review of Symptoms

	Yes	No
Allergy/Immune		
Colds	☐	☐
Itchy eyes	☐	☐
Nasal/seasonal allergies	☐	☐
Recurrent infections	☐	☐
Runny nose	☐	☐
Cardiology		
Chest pain	☐	☐
Chest pain while asleep	☐	☐
Dizziness	☐	☐
Irregular heart beat	☐	☐
Leg swelling	☐	☐
Palpitations	☐	☐
Shortness of breath	☐	☐
Constitutional		
Chills	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Night sweats	☐	☐
Weight gain on (12 months)	☐	☐
Weight gain off (12 months)	☐	☐
Dermatology		
Hives	☐	☐
Itching	☐	☐
Lumps	☐	☐
Mole	☐	☐
Rash	☐	☐
Skin cancer	☐	☐
Endocrinology		
Excessive sweating	☐	☐
Excessive thirst	☐	☐
Fatigue	☐	☐
Heat intolerance	☐	☐
Urinating frequently	☐	☐
Diabetes	☐	☐
ENT/respiratory		
Chest pain	☐	☐
Chronic cough	☐	☐
Difficulty swallowing	☐	☐
Drooling	☐	☐
Shortness of breath	☐	☐
Sinus problems	☐	☐
Gastroenterology		
Abdominal pain	☐	☐
Blood in stool	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐

	Yes	No
(Gastroenterology continued)		
Nausea	☐	☐
Vomiting	☐	☐
Heartburn	☐	☐
Hematology		
Anemia	☐	☐
Easy bruising	☐	☐
Swollen glands	☐	☐
Fatigue	☐	☐
Loss of appetite	☐	☐
Musculoskeletal		
Back pain	☐	☐
Carpal Tunnel	☐	☐
Fracture	☐	☐
Joint pain	☐	☐
Joint stiffness	☐	☐
Joint swelling	☐	☐
Leg cramps	☐	☐
Muscle pain or weakness	☐	☐
Osteoporosis treatment	☐	☐
Sciatica	☐	☐
Neurology		
Balance difficulty	☐	☐
Dizziness	☐	☐
Fainting spells	☐	☐
Falls	☐	☐
Gait abnormality	☐	☐
Headache	☐	☐
Insomnia	☐	☐
Loss of sense in specific area	☐	☐
Strength loss in specific area	☐	☐
Memory problems	☐	☐
Pain	☐	☐
Tingling numbness	☐	☐
Seizures	☐	☐
Tremors	☐	☐
Trouble with balance	☐	☐
Trouble with coordination	☐	☐
Psychology		
Anxiety	☐	☐
Depression	☐	☐
Hallucinations	☐	☐
Irritability	☐	☐
Memory loss or confusion	☐	☐
Mental or Physical abuse	☐	☐
Sleep disturbances	☐	☐

NAME _____ Date of Birth _____

BERLIN QUESTIONNAIRE

Name _____ Date of Birth _____

Height (in.) _____ Weight (lbs.) _____ Age _____ Male / Female

Please check (**X**) the correct box.

Cagegory 1

1. Do you snore?
- ☐ Yes
- ☐ No
- ☐ Don't know

If you snore:

2. Your snoring is:
- ☐ Slightly louder than breathing
- ☐ As loud as talking
- ☐ Louder than talking
- ☐ Very loud – can be heard in adjacent rooms

3. How often do you snore?
- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

4. Has your snoring ever bothered other people?
- ☐ Yes
- ☐ No
- ☐ Don't know

5. Has anyone noticed that you quit breathing during you sleep?
- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

Category 2

6. How often do you feel tired or fatigued after you sleep?
- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

7. During your waking time, do you feel tired, fatigued or not up to par?
- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

8. Have you ever nodded off or fallen asleep while driving?
- ☐ Yes
- ☐ No

If Yes:

9. How often does this occur?
- ☐ Nearly every day
- ☐ 3-4 times a week
- ☐ 1-2 times a week
- ☐ 1-2 times a month
- ☐ Never or nearly never

CATEGORY 3

10. Do you have high blood pressure?
- ☐ Yes
- ☐ No
- ☐ Don't know

NAME _____ Date of Birth _____

NOTICE OF PRIVACY PRACTICES FOR PERSONAL HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes the practices of Khadija Rashid, M.D. and Saqib Rashid, M.D. for safe guarding individual identifiable personal health information.

We are required by law to maintain the privacy of our members' and dependents' personal health information and to provide notification of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all personal health information maintained by us. Copies of revised Notices will be mailed to plan sponsors and distributed to the members then covered under the policy. You have the right to request a paper copy of the Notice, even if you have originally requested a copy of the Notice electronically by e-mail.

Uses and Disclosures of Your Personal Health Information

Authorization. Except as explained below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing a use or disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to: 4042 S. Demaree St., Visalia, CA 93277. A form to revoke an authorization can be obtained from the Health Information Protection Analyst.

Disclosures for Treatment. We may disclose your personal health information, as necessary, for your treatment. For instance, a doctor or health care facility involved in your care may request your personal health information in our possession to assist in your care.

Uses and Disclosures for Payment. We will use and disclose your personal health information, as necessary, for payment purposes. For instance, we may use your personal health information to process or pay claims, for subrogation, to perform a hospital admission review to determine whether services are for medically necessary care or to perform prospective reviews. We may also forward information to another insurer in order for it to process or pay claims on your behalf.

Users and Disclosures for Health Care Operations. We will use and disclose your personal health information as necessary**for** health care operations. For instance, we may use or disclose your personal health information for quality assessment and quality improvement, credentialing health care providers, premium rating conducting or arranging for medical review or compliances. We may also disclose your personal health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We may contact your insurance concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures. We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-relatedprograms, products, or services that may be available to you.

Business Associate. Certain aspects and components of our service are performed by outside people or organizations pursuant to agreements or contracts. It may be necessary for us to disclose your personal health information to these outside people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your personal health information.

Plan Sponsor. We may disclose your personal health information to the plan sponsor, provided that the plan sponsor certifies that the information will be maintained in a confidential manor.

Family, Friends & Personal Representatives. With your approval, we may disclose to family members, personal friends, or another person you identify your personal health information relevant to their involvement with your care or paying for your care.If you are unavailable, incapacitated or in an emergency situation and we determine that a limited disclosure is in your best interest, we may disclose your health information without your approval. We may also disclose your personal health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures. We are permitted or required by law to use or discuss your personal health information, without your authorization in the followingcircumstances:

- For any purposes required by law;
- For public health activities (ex: reporting of diseases, injury, birth, death, or suspicion of child abuse or neglect);
- To a governmental authority, if we believe an individual is a victim of abuse, neglect, or domestic violence;
- For health oversight activities (ex: pursuant to a court order, subpoena, or discovery request);
- For law enforcement purposes (ex: reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking, or transplantation of organ, eye, or tissue donation;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual in a correctional institution or a law enforcement official having custody;
- For compliances with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We will only use or disclose AIDS/HIV related information, genetic testing information and information regarding your mental condition or any substance abuse problems as permitted by state and federal law or regulation.

Your rights:

Restrictions on Use & Disclosure of your personal health information. You have the right to request restrictions on how we use or disclose your personal health info for treatment, payment, or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a form ofrestriction, write to: 4042 S. Demaree St., Visalia, CA 93277. If your request for a restriction is granted, you will receive a written acknowledgement from us.

ReceivingConfidential Communications of your Personal Health Information. You have the right to request communications regarding your personal health information from us by alternative means (ex: fax) or at alternative locations. We will accommodate reasonable requests. To request a confidential communication, you must send a written request to: 4042 S. Demaree St., Visalia, CA 93277.

Access to your Personal Health Information. You have the right to inspect and/or obtain a copy of your personal health information that we maintain in your designated record set, with a couple of exceptions. To request access to your information you must send a written request to: 4042 S. Demaree St., Visalia, CA 93277. A fee will be charged for copying and postage.

Amendment of Your Personal Health Information. You have the right to request an amendment to your personal health information to correct inaccuracies. To request an amendment, you must send a written request to: 4042 S. Demaree St., Visalia, CA 93277. We are not required to grant the request in certain circumstances.

Accounting of Disclosure of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us of your personal health information. To request an account, you must send a written request to: 4042 S. Demaree St., Visalia, CA 93277. The first accounting in any 12-month period will be free; however, a fee will be charged for any subsequent request for an accounting during that same time period.

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to us at: 4042 S. Demaree St., Visalia, CA 93277, or to the Secretary of the U.S. Department of Health & Human Services. There will be no retaliation for filing a complaint.

Saqid Rashid, MD, FCCP DABSM
Khadija Rashid, MD
4042 S. Demaree St.
Visalia, CA 93277
(559) 754-2967

NAME _____ Date of Birth _____

Modern Medicine
Pulmonary | Sleep | Addiction

☐ **Saqib Rashid, MD, DABSM**
Pulmonary and Sleep Medicine

☐ **Khadija Rashid, MD**
Neurology and Sleep Medicine

4042 S. Demaree Street
On the corner of Demaree and Packwood in the Carmel Plaza
Visalia, CA 93277
Phone: **(559) 754-2967**

- Please bring this packet filled out, your insurance cards, and a complete list of medication you are currently taking to your appointment

Copayment (if required by your insurance) are expected at the time of your visit. Unless prior arrangements have been made, it will be necessary to reschedule your appointment. We accept cash, check, or credit/debit cards for your convenience. Any credit card refund after 60 days will incur a 2.75% processing fee.

To avoid a $50.00 fee ($20.00 for a nerve condition study), please give a courtesy call at least 24 hours before your appointment, if you need to cancel or reschedule.

If you have any questions or concerns, please feel free to contact our office at (559) 754-2967.

Appointment Date:_____

Time: _____

Sincerely,

Medical Staff for Dr. Khadija Rashid, MD and Saqib Rashid, MD