Sarah Sandell M.D., F.A.C.P. and Susan Sleep M.D.
3742 Katella Ave., Suite 302
Los Alamitos, CA 90720
Phone: (562) 936-0292 Fax: (562) 936-1943

Dear _____,

This letter is to confirm your appointment on _____ at _____.

Enclosed is a detailed medical history form to fill out before your scheduled appointment. We ask that you take the time to fill this out in detail, as this information will assist us in providing the high-quality care that you expect from our office. Even if you have been seen by Dr. Sandell or Dr. Sleep in the past, we still ask that you to fill this out in detail.

We are “out-of-network” providers with ALL insurance companies. If you have a PPO (preferred provider organization) or POS (point of service) plan, your insurance company can provide you with the information about your individual policy’s “out-of-network” benefits and their reimbursement rates. We do collect for services rendered at the end of each visit, however we extend the courtesy of billing your insurance company. If your insurance company reimburses our office, we will refund that money to you. Laboratory fees, imaging fees, and hospital charges are not affected, as they have contracts with most insurance companies. If you have HMO insurance, none of the charges are covered. Please remember to bring your insurance card so that we can copy for our records.

If you have Medicare, you will be considered a “cash patient” for office visits by Dr. Sandell, who has opted out of Medicare. Laboratory fees, imaging fees, and hospital charges are not affected, as most are contracted with Medicare.

Dr. Sleep is taking Medicare for both Dermatological Services and Internal Medicine Services on a limited basis.

If you have any questions, please feel free to contact our office at (562) 936-0292. We look forward to seeing you. If you are unable to keep your scheduled appointment, please contact our office as soon as possible to reschedule.

Best regards,

Sarah Sandell, MD, FACP

Susan Sleep, MD

Sarah Sandell, M.D., F.A.C.P. and Susan Sleep, M.D.
A Medical Corporation
3742 Katella Ave., Suite 302
Los Alamitos, CA 90720
562-936-0292 FAX 562-936-1943

Dear Patient,

You have been scheduled for a new patient office visit. At that time I will be doing a yearly check up which includes taking a thorough medical history and performing a physical exam. Please make sure you take the time to completely fill out the history form with special attention to the section on medications including dosages. If you have any medical records from other offices which are helpful please bring them in or have them sent to our office.

At this appointment we may do blood tests, some of which may require you to be fasting (nothing to eat for 8 hours before the test). If you have a morning appointment and can come fasting that is helpful otherwise you might need to return another day for blood tests.

In order to provide the best Integrative Medical care, after any tests including blood tests are performed, I will then ask you to return for a follow up appointment to review the results. At that time I will also ask you to bring in any vitamins and supplements you are taking so I can make specific recommendations re: this as well as your diet and other lifestyle issues. I believe you can have a positive impact on your health through proper nutrition, lifestyle and appropriate supplements. Enough time needs to be set aside to address these issues.

Please contact any doctors who have pertinent medical informaion and ask them to fax/mail this before your visit.

If you have any questions please give our office a call otherwise I'll look forward to seeing you.

Sincerely,

Sarah Sandell NP

Sarah Sandell, F.A.C.P., M.D.
Graduate Fellow, Integrative Medicine, University of Arizona
Assistant Clinical Professor of Medicine UC.L.A., School of Medicine

FirstLineTherapy®

What is a BIA? (And why do you need one?)

Bioelectrical Impedance Analysis or Bioimpedance Analysis (BIA) is a method of assessing your "body composition"—the measurement of body fat in relation to lean body mass. It is an integral part of a health and nutrition assessment.

Improving your BIA measurement by lowering your percentage of unhealthy body fat can help reduce your risk to a variety of serious health conditions.

Why is Body Composition Important to My Health?

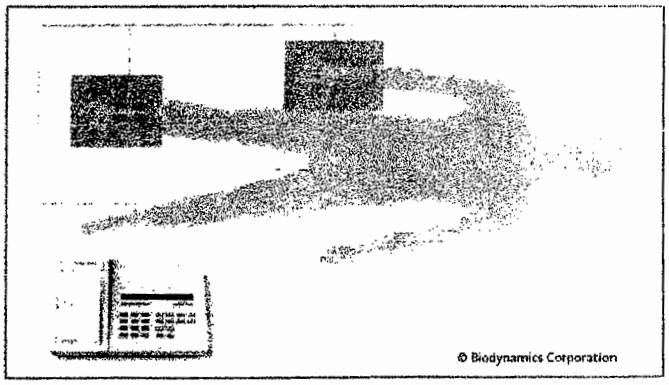
Research has shown that body composition is directly related to health. A normal balance of body fat is associated with good health and longevity. Excess fat in relation to lean body mass, a condition known as altered body composition, can greatly increase your risks to cardiovascular disease, diabetes, and more. BIA fosters early detection of an improper balance in your body composition, which allows for earlier intervention and prevention. BIA also provides a measurement of fluid and body mass that can be a critical assessment tool for your current state of health.

BIA also serves to measure your progress as you work to improve your health. Improving your BIA measurement, or maintaining a healthy BIA measurement, can help keep your body functioning properly for healthy aging and reduced risk to illness. With your BIA results, we can recommend a personalized dietary plan, nutritional supplements, and exercise to help you support optimal health and well-being for a lifetime.

How Does a BIA Work?

BIA is much more sophisticated than your bathroom scale, but just as painless—and almost as quick. BIA is a simple procedure that can be performed right in our office in a matter of minutes with the help of a sophisticated, computerized analysis.

This analyzer "calculates" your tissue and fluid compartments—using an imperceptible electrical current passed through pads placed on one hand and foot as you lie comfortably clothed on an exam table. In just minutes, we'll have very accurate measurements to help create an effective, personalized program to improve your health status.



Body Composition Testing

Bioimpedance analysis (BIA) is a reliable method of measuring body composition, including percentage of body fat and lean body mass. Measurements are taken with a bioimpedance analyzer, which uses electrodes similar to EKG electrodes. The machine passes a harmless, ultra-low level electrical current through the body. Lean tissue, which is over 70% water, is a good conductor of electrical current. Fatty tissue—low in water, is not. Thus, the resistance to the flow of electrical current measured by the analyzer can be used to calculate body composition.

Participants will need to remove their right shoe and sock or stocking. The electrodes are placed on the right hand and foot while the individual is lying down on an exam table. This whole procedure takes only a few minutes and a computer prints out the results. Optimal body fat ranges from 12%-25% for women, and 5%-20% for men.

Over 100 independent studies, conducted by researchers over the past 20 years, have demonstrated that bioimpedance analysis can provide an accurate and clinically useful assessment of body composition. However, for the most accurate results, the following guidelines should be followed:

1. **Do not eat for 4 hours prior to testing.**
2. **Do not exercise for 12 hours prior to testing.**
3. **Do not consume alcohol for 24 hours prior to testing.**
4. **Drink at least 1 quart of water one hour before your test (you may void as needed).**
5. **Do not drink caffeine the day of your test.**

IF YOU ARE INTERESTED IN HAVING THIS TEST DONE PLEASE FOLLOW THESE GUIDELINES BEFORE YOUR APPOINTMENT. ARRIVE 15 MINUTES BEFORE YOUR SCHEDULED APPPOINTMENT TIME AND NOTIFY THE STAFF WHEN YOU ARRIVE YOU WANT TO HAVE THE TEST DONE.

THE COST OF THE TEST IS $75 AND MAY NOT BE COVERED BY YOUR INSURANCE

Sarah Sandell M.D., F.A.C.P. and Susan Sleep M.D.
A Medical Corporation
Diplomates American Board of Internal Medicine
3742 Katella Ave., Suite 302
Los Alamitos, CA 90720
(562) 936-0292 Fax: (562) 936-1943

As required by the Health Insurance Portability and Accountability Act of 1996, you have a right to request that communications concerning your personal health information be made through confidential channels. We will not ask why you are making your request and will make reasonable efforts to accommodate all reasonable requests. Some method of contact must be provided, and as appropriate, information as to how payment will be handled.

I give my permission for the physicians and employees in this medical group to communicate information related to my personal health, as indicated below. This request supersedes any prior request for communication of information I may have made.

PHONE

You ☐ may ☐ may not contact me regarding my appointments by telephone.

You ☐ may ☐ may not contact me regarding my test results by telephone.

You ☐ may ☐ may not contact me regarding my condition and treatment by telephone.

You may use the following telephone numbers:

☐ Work _____ ☐ Home _____ ☐ Cell _____

You ☐ may ☐ may not leave messages on my answering machine/voice mail.

☐ You may leave messages with the following people (print names):

_____ _____

_____ _____

MAIL

Send mail regarding my appointments, test results, and condition/treatment to the following address:

_____

_____

☐ Email: You may send results or info to:_____

Signature: _____ Date: _____
(Parent or legal guardian if patient is a minor)

Patient's Name:_____ DOB: _____
(Print)

Parent/
Guardian's Name: _____ Relationship: _____
(Print)

Sarah Sandell M.D., F.A.C.P.
Susan Sleep M.D.
3742 Katella Ave. Suite 302
Los Alamitos, CA 90720
(562) 936-0292 FAX (562) 936-1943

PATIENT INFORMATION SHEET

PATIENT INFORMATION

Last Name: _____
First Name: _____ M.I. _____
Street Address: _____
City: _____ State: _____
Zip Code: _____ Sex (M/F): _____
Driver License #: _____
Employer: _____
Occupation: _____
Contact in case of
EMERGENCY: _____
Relationship: _____

Home Phone : _____
Work Phone: _____
Cell Phone: _____
E-mail: _____
Date of Birth: _____
Social Security #: _____
Marital Status: _____
Who may we thank for referring you to this office?: ___
_____
_____
Phone: _____

GUARANTOR / PARENT / INSURED INFORMATION (SEND BILL TO):

Name: _____
Employer: _____
Address: _____

Social Security #: _____
Phone: _____
Relationship to Patient: _____

PRIMARY INSURANCE CARRIED BY PATIENT

Insurance Co. Name: _____
Billing Address: _____
_____
Group or Policy #: _____
Cert. or Member #: _____
Local Union #: _____
Name of Insured: _____
Insured's DOB: _____

SECONDARY INSURANCE INFORMATION

Insurance Co. Name: _____
Billing Address: _____
_____
Group or Policy #: _____
Cert. or Member #: _____
Local Union #: _____
Name of Insured: _____
Insured's DOB: _____

I hereby assign the benefits due to me through insurance to Sarah Sandell MD FACP and Susan Sleep MD a Medical Corporation for services rendered. I authorize and instruct my insurance carrier to make payments of authorized benefits directly to Sarah Sandell MD FACP and Susan Sleep MD a Medical Corporation. I understand I am responsible for the charges not paid by the insurance and/or not covered by this assignment. I authorize release of all records required to process this claim. I understand that the doctors are not contracted with any PPO insurances. I give my permission to leave messages re: appointments on answer machine/voicemail.

We may charge a fee for any appointment that is not cancelled or rescheduled within 24 hours. This fee is not covered by insurance.

Signature _____ Date _____

Parent or Guardian
Signature of minor _____

Sarah Sandell M.D., F.A.C.P.
Susan Sleep M.D.
3742 Katella Ave. Suite 302
Los Alamitos, CA 90720
(562) 936-0292 FAX (562) 936-1943

NOTICE OF PRIVACY PRACTICES

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At Sarah Sandell MD FACP, Susan Sleep MD, we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to you insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associate, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send newsletters or other information. We may also want to call and remind you about your appointment. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your prior written authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond the above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer copies of your health information to another practice. We will mail your files for you.

You have the right to see and receive a copy of your health information, with few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records, we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but we will be happy to include your statement in your file. If we agree to an amendment or change, we will not remove nor alter earlier documents, but we will add the new information.

You have the right to receive a copy of this notice.

If we change any of the details in this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Heath and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201.

However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our Privacy Officer at (562) 936-0292.

This notice goes into effect as of April 14, 2003.

ACKNOWLEDGEMENT

I have received a copy of the Sarah Sandell MD FACP, Susan Sleep MD of Privacy Practices.

Signed _____ Print Name _____

If signing as a parent or guardian, please note the name of the patient _____

Date _____

PLEASE FILL OUT THE FOLLOWING FORM WITH DETAILS AS REQUESTED.

NAME _____ DATE OF BIRTH _____ TODAY'S DATE_____

(Use the back of the 3rd page if more room is needed to answer any of the questions)

Please describe any medical problems you wish to discuss at this visit:

Past medical history (please list and describe any current **or** past medical problems not noted above)

Past surgical history (please list any surgeries, and include dates)

Current Medications (In addition to prescription medication please include **ALL** vitamins, supplements, etc. **AND** note the amount, how often and when you take it)

Allergic reaction/side effects (Please list any medication/food/supplement and describe the reaction. Ex. Rash)

Social History/Other information Ethnicity _____

Marital status _____ Occupation _____ Who lives with you _____

Do you smoke cigarettes? If so how much _____ If quit, when _____

Have you used any recreational/illicit drugs? _____

How much alcohol do you drink? _____

How much caffeine containing beverages do you drink? _____

How much water do you drink? _____

Describe your current exercise activities _____

Describe your current diet **in detail**

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Do you have any pets at home? (If so please list) _____

PATIENT INFORMATION PAGE 2 FOR NAME:_____ D.O.B._____

Please check if you are having a problem with any of the following now:
Fever _____ Chills _____ Fatigue _____ Night sweats _____ Hot flush _____Weight loss _____ Weight gain _____
Changes in hair _____ Weakness _____ Rash _____ Dry skin _____
Changes in nails _____ Itching _____ New skin growths or changes of concern _____

Visual disturbance _____ Double vision _____ Glaucoma _____ Cataracts _____ Eye pain _____ Hearing loss _____
Ringing in your ears _____ Ear pain _____ Nasal congestion _____ Nose bleeds _____ Sinus problems _____
Problems with your teeth/gums _____ Hoarseness _____ Sore throat _____ Snoring _____
Neck pain _____ Swollen "glands"_____ Difficulty swallowing _____ Thyroid problems _____
Other problems with you eyes, ears, nose, throat, neck _____

Breast pain _____ Breast lumps _____ Nipple discharge _____ Other breast problems _____

Cough _____ Excessive or bloody sputum _____ Wheezing _____ Asthma _____ Bronchitis _____ Pneumonia _____
Other problems with your lungs/breathing _____

Palpitation _____ Arrhythmia _____ Edema _____ Shortness of breath (at rest or with exertion) _____
Valvular heart disease _____ Other heart problems _____

Leg pain/cramps _____ Phlebitis _____ Back pain _____ Neck pain _____ Hip pain _____ Groin pain _____
Knee pain _____ Arm or shoulder pain _____ Arthritis _____ Gout _____ Other musculoskeletal problems _____

Heartburn/indigestion _____ Change in appetite _____ Nausea or vomiting _____ Change in bowel habits _____
Constipation _____ Diarrhea _____ Blood in your stool _____ Black stools _____ Hepatitis _____
Irritable bowel _____ Colitis _____ Gallstones _____ Liver disease _____ Hemorrhoids _____ Abdominal pain _____
Food intolerance _____ History of Ulcer disease _____ Other intestinal problems _____

Anemia _____ Excessive bleeding/bruising _____ History of blood clots _____ Other blood disorder _____
History of blood product transfusion (if so what/when/how much) _____

History of diabetes _____ Excessive thirst or urination _____ Intolerance to heat or cold _____
Anxiety _____ Depression _____ Difficulty sleeping _____ Other mood disturbance _____
Fainting _____ Dizziness _____ Seizure _____ Stroke _____ Tremors _____ Localized weakness or numbness _____
Problems with memory _____ Headache _____ Other neurologic problems _____

Urinary frequency/urgency _____ Incontinence _____ Urinary tract infection _____ Blood in urine _____
Kidney stones _____ Other problems urinating or change in urination _____
History of a sexual transmitted disease. If so, describe _____
Problems with sexual desire or function _____
Number of sexual partners in the past few years _____ Men _____ Women _____ Both _____
Females: Vaginal discharge _____ Pain with intercourse _____ Other problems _____
If still menstruating: My period occurs every _____ days and lasts for _____ days. Are your periods regular?
Yes/No _____ Heavy Yes/No _____ Bleed in between actual period Yes/No _____ Severe cramps Yes/No _____
Check if no longer having menstrual periods _____ # of previous pregnancies _____ Miscarriage/Abortion _____
Males: Pain in testicles/penis _____ Penile discharge _____ Prostate problems _____ Other problems _____
Difficulty obtaining or maintaining an erection_____

Other problems not listed above:

_____ _____ _____

PATIENT INFORMATION PAGE 3 FOR NAME _____ D.O.B. _____

FAMILY HISTORY:

(Please note any significant illness such as cancer, diabetes, high blood pressure, heart disease, etc. and include age of onset of illness and if deceased, age at death)

Father _____

Mother _____

Grandparents _____

Brothers/Sisters _____

Children _____

Aunts/Uncles _____

Other _____

Please note the date of your last test and comment if abnormal:

PPD (skin test for tuberculosis)_____ Sigmoidoscopy _____ Colonoscopy_____

Pap smear _____ Rectal exam _____ Prostate exam _____

Mammogram _____ Breast exam by a health care provider _____ PSA _____

Bone density scan _____ Cholesterol measurement _____ (results if known)

Treadmill or other heart test _____

Eye exam by ophthamologist_____ Dental exam_____ Chest X-ray_____

Other test, which has been performed in the past:

_____

_____

_____

Please note the date of last immunization, if unsure write approximate date

Tetanus _____ Pneumonia _____ Hepatitis A _____ Hepatitis B _____ Shingles_____

Chicken Pox _____ Measles/Mumps/Rubella _____ Flu _____ HPV_____ Meningitis _____

Do you have a power of attorney for health care or advanced directives (ex. Living will)_____

Do you practice any relaxation techniques (ex. Meditation) _____

Do you have any spiritual beliefs, if so please describe _____

_____

_____

Other Information:

If you ride a bike do you wear a helmet? _____ Do you wear your seat belt?_____

Is there any other information you would like to share which would help in your medical care?

_____

_____

_____

_____

_____

_____

_____

_____

Name of the person filling out this form_____

NAME _____ DATE _____/_____/_____

NAME OF MEDICATION/ VITAMINS/SUPPLIMENTS	DOSE (mg)	TIME taken	REASON TAKING	DR (who prescribed it)