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)

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PATIENT INFORMATION SHEET

PATIENT INFORMATION

Last Name: _____ Home Phone : _____

First Name: _____ M.I. _____ Work Phone: _____

Street Address: _____ Cell Phone: _____

City: _____ State: _____ E-mail: _____

Zip Code: _____ Sex (M/F): _____ Date of Birth: _____

Driver License #: _____ Social Security #: _____

Employer: _____ Marital Status: _____

Occupation: _____ Who may we thank for referring you to this office?: ___

Contact in case of _____

EMERGENCY: _____ _____

Relationship: _____ Phone: _____

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

Name: _____ Social Security #: _____

Employer: _____ Phone: _____

Address: _____ 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 _____

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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 _____

MEDICAL HISTORY

Name:_____ D.O.B._____Today's Date:_____

Reason for today's visit _____

Height _____ Weight _____

Medical Conditions: (please indicate with an "X" all that apply)

Skin
- ▫ Basal cell skin cancer
- ▫ Squamous cell skin cancer
- ▫ Melanoma
- ▫ Psoriasis
- ▫ Eczema
- ▫ Acne
- ▫ Scarring/keloids
- ▫ Other _____

Cardiovascular
- ▫ Heart attack
- ▫ Irregular heart beat
- ▫ Chest pain/tightness
- ▫ Heart murmur
- ▫ Shortness of breath
- ▫ High/Low blood pressure
- ▫ Pacemaker
- ▫ Stent or artificial valve

Hematologic/Metabolic
- ▫ HIV/AIDS
- ▫ Hepatitis C
- ▫ Anemia
- ▫ Bleeding disorders
- ▫ Autoimmune disease
- ▫ Thyroid disease
- ▫ Diabetes
- ▫ Kidney disease

Eye, Ear, Nose
- ▫ Blurry vision
- ▫ Dry eyes
- ▫ Glaucoma
- ▫ Ear disease
- ▫ Nasal allergies
- ▫ Nasal obstruction
- ▫ Nose bleeding
- ▫ Sinus Disease

Gastrointestinal
- ▫ Gastritis
- ▫ Ulcers
- ▫ Colitis
- ▫ Diverticulitis

Musculoskeletal
- ▫ Arthritis
- ▫ Fibromyalgia
- ▫ Arthritis
- ▫ Artificial joints

Pulmonary
- ▫ Asthma
- ▫ COPD
- ▫ Pneumonia
- ▫ Tuberculosis

Neurologic/Psychiatric
- ▫ Seizures
- ▫ Headaches
- ▫ Depression
- ▫ Schizophrenia/Bipolar

Do you use:

			Frequency
Alcohol	▫ Yes	▫ No	_____
Tobacco	▫ Yes	▫ No	_____
Aspirin	▫ Yes	▫ No	_____
Illicit drugs	▫ Yes	▫ No	_____

Are you ▫ Pregnant ▫ Trying to conceive ▫ Breastfeeding

Family History (Indicate any conditions of immediate family members - mother, father, siblings, children)
- ▫ Heart disease
- ▫ Cancer (type) _____
- ▫ Melanoma
- ▫ Hypertension
- ▫ Autoimmune disease
- ▫ Non-melanoma skin cancer
- ▫ Stroke
- ▫ Eczema
- ▫ Asthma
- ▫ Diabetes
- ▫ Psoriasis
- ▫ Seasonal allergies/hay fever

Surgical/Procedure History (list all surgeries including cosmetic and laser procedures)

Date	Type	Physician	Complications

Have you or anyone in your family had problems associated with surgery?
▫ Bleeding ▫ General anesthesia ▫ Lidocaine allergy ▫ Poor scarring ▫ Other _____

Hospitalizations (Other than surgery)

Date	Reason/Illness	Physician	Complications

Medications (Include vitamins, diet pills, birth control, herbal supplements, etc.)

Name	Strength/Dose

Allergies

Medication	Reaction

Are you allergic to: Latex ▫ Yes ▫ No
Adhesives ▫ Yes ▫ No