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

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A Medical Corporation
Diplomates American Board of Internal Medicine
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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	SECONDARY INSURANCE INFORMATION
Insurance Co. Name: ____________	Insurance Co. Name: ____________
Billing Address: ____________	Billing Address: ____________
Group or Policy #: ____________	Group or Policy #: ____________
Cert. or Member #: ____________	Cert. or Member #: ____________
Local Union #: ____________	Local Union #: ____________
Name of Insured: ____________	Name of Insured: ____________
Insured's DOB: ____________	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 ______________________________

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)