Patient Information

Last Name: _____
First Name: _____ M.I. _____
Street Address: _____
City: _____ State: _____
Zip Code: _____ Sex ☐ M ☐ F
Driver License #: _____
Employer: _____
Occupation: _____
Emergency Contact: _____
Phone: _____ Relationship: _____
Preferred Appointment Reminder:
☐ Text ☐ Auto. Voice message ☐ Email

Primary Contact: (___) _____ ☐ Hm ☐ Cell ☐ Wk
Secondary Contact: (___) _____ ☐ Hm ☐ Cell ☐ Wk
E-mail: _____
Date of Birth: _____
Social Security #: _____
Marital Status: _____
Who may we thank for referring you to this office?: _____
Preferred Pharmacy: _____
Pharmacy Phone #: _____
Mail Order Pharmacy: _____

Guarantor/ Parent/ Insured Information (Send Bill To):

Last Name: _____
Employer: _____
Street Address: _____

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

Primary Insurance Carried By Patient

Insurance Co. Name: _____
Billing Address: _____
_____
Group or Policy#: _____
Member ID: _____
Local Union #: _____
Name of Insured: _____
Insured's D.O.B: _____

Secondary Insurance Information

Insurance Co. Name: _____
Billing Address: _____
_____
Group or Policy#: _____
Member ID: _____
Local Union #: _____
Name of Insured: _____
Insured's D.O.B: _____

Thank you for choosing our small boutique concierge practice. We strive to maintain a consistent and reliable medical practice. I am a board certified internist and have expanded my expertise into cosmetic, medical dermatology and offer superficial radiation therapy which is a treatment alternative to a moh's surgical procedure. My medical practice includes Kate Stults, Dermatology Nurse Practitioner specializing medical and cosmetic dermatology, Diana Rios, Nurse Practitioner, specializing in the newest weight management medications and women's health including hormone therapy. And lastly, Jack Kennis, MD a previously retired ER physician with an amazing background in internal medicine and emergency medicine. He will be available to see patients when I am unavailable.

_____
Patient Signature *Printed Name* *Date*

_____
Parent or Guardian Signature of a Minor

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 Susan Sleep MD and Associates, 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.
- 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 Health 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 Susan Sleep MD And Associates of Privacy Practices.

Signed *Print Name*

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

Patient Name *Date*

Patient Privacy Policy Consent

This consent will apply to all healthcare providers employed by and acting for the benefit of this office who conduct, plan, and direct treatment and follow-up, and may be involved in treatment, directly or indirectly. While providing services to you, this office will create, receive, and store health information that identifies you.

It is often necessary to use and disclose this health information to treat you, to obtain payment for services, and to conduct day-to-day health care operations. The Notice of Privacy Practices describes the uses and disclosures in detail. The use and disclosures of your health information may include care and services,

follow-up care from another health professional, disclosure of your information for billing purposes or processing claims for obtaining payment, or submission of claims to a third-party or insurer. You have the right to restrict the use of disclosure made for purposes of treatment or health care operations, but this office is not obligated to agree to these restrictions. If this office does agree, however, the restrictions are binding. You may revoke this consent in writing at any time, except to the extent that this office has acted relying on this consent.

I have read this document and understand it. I consent to the use and disclosure of my personal health information for purposes of treatment, payment and health care operations. I have received a copy of the Notice of Privacy Practices from this office.

_____

Patient signature or legally authorized individual ***Print name if signed on behalf of the patient*** ***Relationship - parent, legal guardian name***

Please initial and provide any additional information as required to enable us to appropriately use and disclose your protected health information for the following:

I agree to be contacted for appointments, biopsy/lab results, or follow-up information regarding my care by:

1. Phone: ☐ Yes ☐ No ☐ N/A Preferred Number: _____
   Okay to leave message/voice mail: ☐ Yes ☐ No
2. Text: ☐ Yes ☐ No ☐ N/A Mobile Number: _____
3. Email: ☐ Yes ☐ No ☐ N/A Email Number: _____
4. Mail: ☐ Yes ☐ No ☐ N/A Mailing Number: _____

Discuss personal health information with the following:

I agree to allow the practice to use and disclose information regarding my care to my family as needed.

Name:	*Relationship*	*Phone*
Name:	*Relationship*	*Phone*
Name:	*Relationship*	*Phone*

These consents will remain in effect until revoked by me in writing.

Patient Signature	*Printed Name*	*Date*

Please Fill Out The Following Form With Details As Requested.

Name *Date of Birth* *Today's Date*

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 PLEASE FILL OUT A SEPARATE FORM IN DETAIL LISTING PRESCRIPTION MEDICATION AND SUPPLEMENTS. It is important to fill this out with ALL the information.

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 Two 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 your 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 neurological 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 ☐ No # of previous pregnancies _____ Miscarriage/Abortion _____

Males: ☐ Pain in testicles/penis ☐ Penile discharge ☐ Prostate problems Other problems: _____
Other problems not listed above _____

Name _____ Date ____/____/____

Patient Information Page Three Name: _____ D.O.B. _____

Family History: _____

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

Father: _____

Mother: _____

Grandparents: _____

Brothers/Sisters: _____

Aunts/Uncles: _____

Other: _____

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

PPD (skin test for tuberculosis): ☐ Normal ☐ Abnormal _____ Sigmoidoscopy: ☐ Normal ☐ Abnormal _____

Colonoscopy: ☐ Normal ☐ Abnormal _____ Pap smear: ☐ Normal ☐ Abnormal _____

Rectal exam: ☐ Normal ☐ Abnormal _____ Prostate exam: ☐ Normal ☐ Abnormal _____

Mammogram: ☐ Normal ☐ Abnormal _____ Breast exam by health care provider: ☐ Normal ☐ Abnormal _____

PSA: ☐ Normal ☐ Abnormal _____ Bone Density scan: ☐ Normal ☐ Abnormal _____

Cholesterol measurement (results if know): ☐ Normal ☐ Abnormal _____

Treadmill or other heart test: ☐ Normal ☐ Abnormal _____ Chest X-ray: ☐ Normal ☐ Abnormal _____

Eye exam by an Ophthalmologist: ☐ Normal ☐ Abnormal _____ Dental exam: ☐ Normal ☐ Abnormal _____

Other tests, which have been performed in the past:
Please note the date of the last immunizations. If unsure, write approximate date:

Tetanus: _____ Pneumonia: _____ Hepatitis A: _____ Hepatitis B: _____

Shingles: _____ Chicken Pox: _____ Measles/Mumps/Rubella: _____ Flu: _____

HPV: _____ Meningitis: _____ COVID: _____ RSV: _____

Do you have a power of attorney for health care or advance 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? ☐ Yes ☐ No ☐ Sometimes

Do you wear a seatbelt? ☐ Yes ☐ No ☐ Sometimes

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

_____

Consent for Use of Photographs

I consent for medical photographs to be taken of me or my child (or for person whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching at Susan Sleep MD & Associates, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the staff at Susan Sleep, MD & Associates at 562-936-0292.

☐ I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information on such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes at Susan Sleep MD & Associates and to be used in my medical record.

Patient Signature *Date*

☐ I agree to the use of my images for teaching purposes AND to be used for my medical record but NOT FOR medical publication.

Patient Signature *Date*

☐ I agree to the use of my image for medical records ONLY.

Patient Signature *Date*

Financial Policy

Payment is expected as services are rendered, In addition to applicable annual concierge fee. We accept cash, Visa, MasterCard, Discover, American Express, and personal checks. Please read and initial whichever policy that applies to you below:

- Cash and out-of-network PPO patients: If you are a cash patient or your physician is not a contracted provider for your insurance company, we will collect payment in full at the end of your visit. Initial visits are charged a standard consultation fee plus additional fees for any procedures performed at the time of your visit. Feel free to discuss these charges with your doctor prior to the procedure. We will submit a electronic claim to your insurance company as a courtesy for direct reimbursement. Internal Medicine patients are responsible for the annual concierge fee, this fee is not covered by insurance. *Initials* _____

- Medicare patients: We will bill Medicare for you and Medicare will forward the claim to your supplemental insurance for processing. If there is any balance on your account, you will receive an invoice from us. Internal Medicine patients are responsible for the annual concierge, this fee is not covered by Medicare. *Initials* _____

All patient refunds will be kept as a credit on the patient's account toward their next visit unless a refund request is initiated by the patient. Refunds are up to the discretion of the office manager, and the following criteria must be met prior to issuing a patient refund: there are no outstanding insurance claims on the patient's account, and there are no outstanding balances on the patient's account.

All returned checks will be subject to a $25.00 fee per occurrence.

I understand that I will be expected to pay for all applicable fees for the day of service. I understand that I am responsible for any balances not covered by insurance. I will assume responsibility of notifying this office of any changes in insurance coverage. I authorize the office of Susan Sleep MD & Associates to release to any company providing me with medical insurance any information, including the diagnosis and the records of all treatments and/or examinations provided to me by my physician for the purpose of billing (if applicable).

I have read, understand, and agree to the above policies.

Patient Signature *Printed Name* *Date*

Medicare Recipients only: I request the payment to be made directly to Susan Sleep & Associates, AMC

Medicare Patient Signature or legally authorized

Name _____ Date ____/____/____

Medication/ Vitamins/Supplements	DOSE (mg)	TIME taken	REASON TAKING	Dr (who prescribed it)