

Patient Information

Last Name: _____ Primary Contact: (____) _____ Hm Cell Wk
 First Name: _____ M.I. _____ Secondary Contact: (____) _____ Hm Cell Wk
 Street Address: _____ E-mail: _____
 City: _____ State: _____ Date of Birth: _____
 Zip Code: _____ Sex M F Social Security #: _____
 Driver License #: _____ Marital Status: _____
 Employer: _____ Who may we thank for referring you to this office?: _____
 Occupation: _____
 Emergency Contact: _____ Preferred Pharmacy: _____
 Phone: _____ Relationship: _____ Pharmacy Phone #: _____
 Preferred Appointment Reminder: _____ Mail Order Pharmacy: _____
 Text Auto. Voice message Email

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

Last Name: _____ Social Security #: _____
 Employer: _____ Phone: _____
 Street Address: _____ 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

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

