The Angeles Clinic
AND RESEARCH INSTITUTE

Visit Checklist

Please bring with you:

- ☐ Driver's License/Photo ID
- ☐ Insurance Cards (including pharmacy card, if applicable)
- ☐ Authorizations, if applicable

Also, if available, please bring:

- ☐ Pathology slides and written reports
- ☐ Reports of any current blood work or skin tests
- ☐ Original scans and written reports for each
- ☐ X-rays and written reports
- ☐ Surgical reports
- ☐ Discharge summaries from recent hospitalizations
- ☐ Detailed reports from any other treatments
- ☐ Any other physician office addresses and telephone numbers

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NEW PATIENT MEDICAL QUESTIONNAIRE

Patient Identity

Name | Date of Birth | Age | M F Sex

Alias | Home Phone # | Cell Phone # | Work Phone #

☐ **I authorize the Angeles Clinic to leave messages on my** ☐ **Home Phone** ☐ **Cell Phone** ☐ **Work Phone**

Street Address | Suite / Apartment #

City | State | Zip Code | Driver''s License # (Please provide a copy)

Social Security # | Mother's Maiden Name | Marital Status | E-mail address

Language | Race | Ethnicity

Patient's Employer

Employer Name | Employer Phone #

Street Address | Suite #

City | State | Zip Code | Patient Occupation

Next of Kin

Name

Street Address

City | State | Zip Code

Home Phone # | Work Phone #

Relation to Patient

Person to Notify

Name

Street Address

City | State | Zip Code

Home Phone # | Work Phone #

Relation to Patient

I authorize The Angeles Clinic and Research Institute to release medical information to the following persons:

Name _____ Relationship

Name _____ Relationship

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NEW PATIENT MEDICAL QUESTIONNAIRE

Guarantor

Name

Street Address

City | State | Zip Code

Home Phone # | Date of Birth

Relationship to Patient

Guarantor's Employer

Name

Street Address

City | State | Zip Code

Home Phone # | Work Phone #

Relationship to Patient

Referring Physician

Name | Phone #

Street Address | Fax Phone #

City | State | Zip Code | Email

Other Physicians

Name

Street Address

City | State | Zip Code

Work Phone # | Fax Phone #

Name

Street Address

City | State | Zip Code

Work Phone # | Fax Phone #

Reports (Periodic reports may be sent to your physicians. To which of the above would you like these reports sent?)

Name | Fax Phone # | Email

Name | Fax Phone # | Email

Name | Fax Phone # | Email

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Present Illness

Please describe in your own words, the date of onset of your illness, symptoms, treatment, names and addresses of physicians with whom you have consulted.

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Illness and Injury History

Childhood Illnesses (Please list in chronological order)

Dates	Illnesses	Treatments

Adult Illnessess (Please list in chronological order)

Dates	Illnesses	Treatments

Injuries (Please list in chronological order)

Dates	Illnesses	Treatments

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Surgical History – Operations and Procedures (Please list in chronological order)

Month/Year	Type of Surgery	Hospital	Doctor

Transfusions (Please list in chronological order)

Month/Year	Type of Surgery	Hospital	Doctor

Hospitalizations – Other than those previously mentioned (Please list in chronological order)

Month/Year	Type of Surgery	Hospital	Doctor

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Gynecological History

Birth control pills or Hormone use type	Duration

Age at onset of menstration	Interval between periods	Duration of periods	Number of pregnancies

Number of births	Number of miscarriages/abortions	Age at birth of first child	Age at menopause

Please list all other gynecological problems you have experienced

Allergies (Please list medications with which you have had an allergic reaction)

Medication	Reaction to medication	Treatment for reaction

Social History

Smoking history / dates (onset, duration)	Alcohol use history / dates	Recreational drug use?

Amount of smoking	Amount of alcohol	What drugs / how often?

Frequency of alcohol use

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Medication History

Please list any medications you are now taking

Medication	Dosage	Schedule

Family History

When applicable, please list in chronological order

Relation	Current age	If alive, state of health	If **deceased**, caused of death	Age at death
Father				
Mother				
Spouse				
Brothers				
Sisters				
Children				

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Family History

Please check and list as necessary any disease that any of your blood relatives, husband or wife, or children may have had.

		Cancer (Please list type)	Relation (s)
Y	N	Tuberculosis	
Y	N	Diabetes	
Y	N	Leukemia	
Y	N	Anemia	
Y	N	Bleeding tendencies	
Y	N	Heart disease	
Y	N	High blood pressure	
Y	N	Kidney disease	
Y	N	Asthma, Hay fever, or other allergy	
Y	N	Chronic arthritus (rheumatism)	
Y	N	Nervous or mental disorder	
Y	N	Goiter	
Y	N	Emphysema	
Y	N	Any other illnesses (please list)	

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NEW PATIENT MEDICAL QUESTIONNAIRE

Present Medical Condition

Are you currently experiencing any of the following? Please check the appropriate response.

Yes	No	Unknown		Yes	No	Unknown	
Y	N	?	1. Bleeding tendency or easy bleeding	Y	N	?	31. Change in weight: loss___gain___
Y	N	?	2. Dizziness or fainting spells	Y	N	?	32. Decreased appetite
Y	N	?	3. Eye injuries	Y	N	?	33. Difficult swallowing
Y	N	?	4. Cataracts	Y	N	Y	34. Nausea or vomiting
Y	N	?	5. Blurring vision	Y	N	?	35. Frequent bowel movements
Y	N	?	6. Eye pain	Y	N	?	36. Constipation
Y	N	?	7. Cataracts	Y	N	?	37. Recent change in bowel movements
Y	N	?	8. Glaucoma	Y	N	?	38. Black bowel movements
Y	N	?	9. Ear Aches	Y	N	?	39. Blood in stools
Y	N	?	10. Ringing or buzzing ear	Y	N	?	40. Jaundice
Y	N	?	11. Decrease or loss of hearing	Y	N	?	41. Kidney trouble
Y	N	?	12. Sensation of spinning	Y	N	?	42. Frequent or painful urination
Y	N	?	13. Sinus trouble	Y	N	?	43. Kidney stones or blood in urine
Y	N	?	14. Nose bleeding	Y	N	?	44. Slow starting of urine flow
Y	N	?	15. Sore tongue	Y	N	?	45. Passing urine at night
Y	N	?	16. Bleeding gums	Y	N	?	46. Joint pains
Y	N	?	17. Unusual trouble with teeth	Y	N	?	47. Back or bone pains
Y	N	?	18. Skin disease	Y	N	?	48. Clumsiness or awkwardness of hands/feet
Y	N	?	19. Skin tumors or moles removed/burned	Y	N	?	49. Numbness or tingling of hands/feet
Y	N	?	20. Laryngitus	Y	N	?	50. Muscle pain or weakness
Y	N	?	21. Hoarseness or change in voice	Y	N	?	51. Forgetfulness
Y	N	?	22. Pain in breast	Y	N	?	52. Any reaction to serum, drugs or medicine
Y	N	?	23. Nipple discharge	Y	N	?	53. Swollen or enlarged lymph glands
Y	N	?	24. Pain or pressure in chest	Y	N	?	54. Unusual fatigue
Y	N	?	25. Undue shortness in breath (day or night)	Y	N	?	55. Excessive worry or depression
Y	N	?	26. Ankle swelling	Y	N	?	56. Vaginal bleeding following intercourse
Y	N	?	27. Pain in legs while walking	Y	N	?	57. Painful menstration
Y	N	?	28. Fast or irregular heart beating (palpitations)	Y	N	?	58. Irregular or excessive menstration
Y	N	?	29. Chronic cough/coughed up blood	Y	N	?	59. Vaginal Discharge
Y	N	?	30. Soaking sweats: daytime___ nighttime___	Y	N	?	60. Other: _____

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Doctors Addresses **(**For follow-up letters)

Referring Physician

Telephone

Referring Physician

Telephone

Referring Physician

Telephone

Referring Physician

Telephone

Referring Physician

Telephone

The Angeles Clinic
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Insurance Billing Information

Patient Name _____ Date _____

Primary Insurance Carrier _____ Name of Insurance Plan _____

Subscriber _____ Certification Number _____ Group _____

Street Address or P.O. Box (where claim is filed) _____ City _____ State _____ Zip _____

Secondary Insurance Carrier _____ Name of Insurance Plan _____

Subscriber _____ Certification Number _____ Group _____

Street Address or P.O. Box (where claim is filed) _____ City _____ State _____ Zip _____

I hereby authorize The Angeles Clinic and Research Institute, Inc. to furnish my insurance company (including Medicare) with all information which the Insurance company may request concerning my present illness or injury.

I hereby assign to The Angeles Clinic and Research Institute, Inc. all money which I am entitled for medical expense relative to the service reported. I understand I am financially responsible to said facility for charges not covered by this agreement. A photostat or facsimile copy of this assignment is as valid as the original.

Patient Signature _____ Date _____

The Angeles Clinic
AND RESEARCH INSTITUTE

Authorization to Release Medical Information

I hereby authorize _____

to furnish any and all medical information to any and all persons in my medical care at The Angeles Clinic and Research Institute, Inc., located at:

2001 Santa Monica Boulevard, Suite 560W, Santa Monica, CA 90404
11818 Wilshire Boulevard, Suite 200, Los Angeles, CA 90025

All information may be released, except those specifically listed below.

This authorization shall become effective immediately.

I understand that the information may only be used to facilitate my medical care, and the requester may not further use or disclose the medical information unless authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law. I further understand that I have the right to receive a copy of this authorization upon my request.

Copy requested and received ☐ Yes ☐ No Initials _____

_____ _____
Patient Name Date of birth

_____ _____
Signature Today's Date

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient (to the extreme minor could not have consented to care)

☐ Guardian or conservator of an incompetent patient

☐ Beneficiary or personal representative of deceased patient

☐ Spouse or person financially responsible (where information is solely for the purpose of processing application for dependent health coverage)

Please call our Santa Monica office at **310-582-7900** or our Wilshire office at **310-231-2121,** if you have any questions.

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Patient Profile, Information & Pharmacy Disclosure

To better meet our patients' needs, we can now dispense many of the prescriptions as prescribed by our physician(s). We will bill your pharmacy insurance and charge the applicable co-pay. Please understand that you are not obligated to have prescriptions filled here and you have the option of receiving your medications from the pharmacy of your choice. We would be happy to facilitate this for you. So that we have your complete information, please fill out the following:

Patient Name _____ Social Security # _____

Date of Birth _____ Telephone _____

Street Address _____ City _____ State _____ Zip _____

Drug Allergies _____

List of Current Medications (include strengths if known)

_____ _____

_____ _____

_____ _____

_____ _____

Please provide your Pharmacy Plan card to the recptionist so we have a copy on file (same insurance that is presented to a retail pharmacy). Please circle yes or no to the following questions:

Would you like to have your prescriptions filled at our office? Yes No

Does your prescription insurance require mail order for maintenance meds? Yes No

Your co-pay is due upon receipt. Would you like us to use the credit card on file? Yes No

Signature: _____

Please ask our receptionist if you have any questions. Thank you.

TheAngelesClinic
AND RESEARCH INSTITUTE

Notice of Privacy Practices

NOTICE TO INDIVIDUALS OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At TheAngelesClinic, we believe that individuals have a right to adequate notice of our policies, procedures and practices with respect to uses and disclosures of protected health information. The Angeles Clinic is required by law to maintain the privacy of your health information and to provide you with a notice of our legal duties and privacy practices. We are required to and will abide by the terms of the Notice of Privacy Practices in effect at the time it is provided to you. You have the right to request a paper copy of this Notice of Privacy Practices even if we have provided a copy to you electronically by e-mail.

The Angeles Clinic will not use or disclose your individually identifiable or protected health information other than to carry out health care treatment, payment, and/or operations for you, or as required by law. An example of treatment is a visit to our office for the purpose of diagnosis or care of a health issue where in doctors, nurses, laboratory technicians, medical students and others will share the information with an insurer or a third party that may be responsible for collecting payment from a health plan. Healthcare operations means sharing protected health information for the purpose of quality review.

The Angeles Clinic will use and disclose protected health information to business associates in the course of providing treatment, securing payment for such treatment, and/or to facilitate health care operations of our practice, to facilitate the requirements of our business associates' contracts, and to comply with requests from other covered entities to carry out treatment, payment or health care operations.

Except for the purposes described above, The Angeles Clinic will only use or disclose protected health information with your express written authorization and you may revoke the authorization at any time in writing. The revocation will apply only to future uses and disclosures.

Any information The Angles Clinic provides to a third party other than to our business associates or other health care providers with a treatment relationship to you will be de-identified or stripped of any and all personal data which could be used to identify a specific individual.

The Angeles Clinic may contact you to provide appointment reminders or to provide you with information about alternative treatments or other health-care services we provide. We may also contact you to raise funds. When receiving communications from us, you may request that we communicate with you at an alternate location or by alternate means and we will make every effort to accommodate your request.

You may request that certain uses and disclosures of your protected health information be restricted. To do so, you must provide the request in writing using the Request for Restriction on Use or Disclosure form available from our office. The Angeles Clinic will determine if the information constitutes required information to carry out treatment, payment, or health care operations. If, in our sole opinion, your request does not involve information that is required by us to carry out treatment, payment or health care operations, we will accept your request for restrictions and will notify you if your request will be honored within 30 days or as required by law.

The Angeles Clinic AND RESEARCH INSTITUTE

Notice of Privacy Practices
Continued

(continued on next page)

With respect to your protected health information, you have the right to request and receive the following from The Angeles Clinic:

Inspection and copying – You may request a report containing your health information that has been collected by The Angeles Clinic for you to inspect or copy. Such requests will be honored within 30 days or as required by law, and you will be notified in writing of The Angeles Clinic's receipt of the request and the date upon which the information will be available to you.

Amendment or correction – You may request that we amend or correct your health information that has been collected by The Angeles Clinic. Upon agreement by your health care provider, requests to amend health information will be honored within 30 days or as required by law, and you will be notified in writing of The Angeles Clinic's action taken.

Accounting of the disclosures – You may request that we supply you with a listing of the disclosures of your protected health information which have been made by The Angeles Clinic except those made for treatment, payment or health care operations, those required by the Final Privacy Rule or made pursuant to other law, and those made pursuant to your explicit authorization. Such requests will be honored within 30 days or as required by law, and you will be notified in writing of the date on which the accounting will be available to you. At a minimum, the accounting of disclosures will include the following information:

- Date of each disclosure
- Name and address of the organization of person who received the protected health information
- A brief description of the information disclosed
- The Angeles Clinic has also required in our business associate contracts that they offer a means to provide such a listing for you

If you believe that your privacy rights have been violated, you may send questions or complaints about this notice or The Angeles Clinic's privacy practices to us and/or to the Secretary of the Department of Health and Human Services (HHS). Such communication with The Angeles Clinic should be directed to: Chief Privacy Officer, The Angeles Clinic, (Practice Address). The address of the Secretary of Health and Human Services is 200 Independence Ave. SW, Washington, DC 20201. The Angeles Clinic will not retaliate against you for filing a complaint with the Secretary of HHS.

The Angeles Clinic reserves the right to revise this Notice of Privacy Practices at any time without prior notification. You may request a copy of the revised notice and we will provide it to you.

For additional information, please write us at The Angeles Clinic, Attention HIPAA Privacy Contact or call **310-582-7900** and ask to speak with our HIPAA Privacy Contact.

This Notice of Privacy Practices is effective as of May 15, 2005.

_____
Signature

_____
Print Name

_____
Date

The Angeles Clinic
AND RESEARCH INSTITUTE

Referrals

How did you hear about The Angeles Clinic and Research Institute?

☐ My physician referred me

☐ A friend or relative referred me

☐ I am self-referred after learning about The Angeles Clinic and Research Institute from (check all that apply):

- ☐ Internet
- ☐ The Angeles Clinic Website
- ☐ Symposium / Lecture
- ☐ Pamphlet / Flyer
- ☐ Publication / Journal Article
- ☐ Media Event (Talk Show, Radio Broadcast, etc.)
- ☐ Advertisement
- ☐ Other: _____

Correspondence

The Angeles Clinic and Research Institute and The Angeles Clinic Foundation would like to share information on programs, events, services, and newsletters related to our goal of making a difference in the lives of people touched by cancer. To receive the latest updates, please indicate your preferences below:

☐ I wish to receive e-mail updates and other information from The Angeles Clinic and Research Institute

☐ I wish to receive The Angeles Clinic Foundation Newsletter and other Foundation updates

Please indicate your preferred e-mail address for updates and other information:

_____
E-mail address

The Angeles Clinic
AND RESEARCH INSTITUTE

Credit/Debit Card on File

Although most health care providers require payment at the time of service, at The Angeles Clinic and Research Institute, Inc., we do not wish to do this but rather will continue to bill your insurance on your behalf. We do however need to collect your portion of payment at the time of service. Accordingly, we will require a credit card imprint to be kept on file. The card will be charged for balances not covered by applicable health plans. These include, among others deductibles, co-pays, co-insurance and charges known by the patient in advance not to be covered. Please note that if these charges are not completely covered by the credit card, you will be required to pay by alternate means at the time of service.

I _____, hereby authorize The Angeles Clinic and Research Institute, Inc., to bill any co-payment, deductible or balance due to my credit/debit card.

Account number | Patient Name | Date of Birth

Name as it appears on the card

Type of card (circle): Visa MasterCard American Express Debit

Credit Card Account Number

CVV2 or CVC2 | Expiration Date

Signature | Date

This authorization will remain valid unless cancelled through a written notice. We will mail receipt to current billing address on file. In order to reduce credit card fraud, the CVV2 or CVC2 is submitted with the transaction. It is on the back of the card with the 3-4 digit code. All information will be kept confidential.

Forms and Other Service Fees

The following is a list of forms, documents, and services with the corresponding fee which will be due upon request.

- Disability, Social Security, FMLA forms $25.00
- DMV forms, Airline forms $25.00
- Medical Records (up to 25 pages) $25.00 (plus 10¢ per page after 25 pages)
- Letters of Necessity, Returned checks $25.00
- Fed Ex service fee $25.00 (plus cost of package/envelope fee)
- Missed appointments (if not cancelled >24 hours prior) $25.00
- CD for scans (first one free) $25.00
- Scan Over Read (per scan) $250.00