ELI HENDEL M.D.
Pulmonary and Sleep Specialist

PATIENT INFORMATION

Welcome to our office. We are committed to providing the best, most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent. Please **PRINT ALL** information..

Patient Name	Today's Date	Date of Birth	Sex	Age
Parent If Patient is a Minor				
Patient's Social Security Number	California Driver's License Number			
Home Address	City	State	Zip	
Mailing Address, if different	City	State	Zip	
Home Telephone	Work Telephone			
Occupation	Employer's Name			
Employer's Address	City	State	Zip	
Spouse Name	Employer	Work Telephone		
Other Physician's Name	Whom may we thank for Referring you to our Practice?			

NOTIFY IN THE EVENT OF AN EMERGENCY

Name	Relationship		
Address	City	State	Zip
Home Telephone	Work Telephone		

FINANCIAL INFORMATION: PERSON RESPONSIBLE FOR ALL FEES

Name	Relationship to Patient	Telephone	
Address	City	State	Zip
Insurance Company	Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Soc. Sec. Num	
Insurance ID Number			
Secondary Insurance	Claim Address		
Subscriber's Name	Subscriber's Date of Birth	Subscriber's Soc. Sec. Num.	
Insurance ID Number			
Were you injured on the Job? ❑ Yes ❑ No	Have you informed your employer? ❑ Yes ❑ No		
Were you injured in a motor vehicle accident or personal injury? ❑ Yes ❑ No		Date of original injury	
Work Comp Carrier	Claim Policy Number		
Address	City	State	Zip

PLEASE READ OUR FINANCIAL POLICY STATEMENT AND AGREEMENT ON REVERSE

OFFICE FINANCIAL POLICY

PATIENT NAME _____ **DATE OF BIRTH:** _____

BASIC POLICY: Payment for service is due at the time service is provided in our olfice.

FOR PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. Copayments and deductibles are due at the time of service.

MEDICARE PATIENTS: We will bill Medicare for you. All copayments or deductibles are due and payable at the time service is provided.

MEDICAID PATIENTS: All Medicaid patients must provide a current valid identification card before being seen.

SURGERY FEES: All copays, deductibles and payments for noncovered surgical procedures are due prior to your Surgery. Prior authorization may be required by your carrier.

NONCOVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time of services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES: This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

WORKERS COMPENSATION: If your injury is work related, we will need the case number and carrier name prior to your visit in order to bill the worker's compensation Insurance company.

YEARLY HEALTH CHECKS: Periodic preventative health checks may or may not be covered under your health insurance policy. It is your responsibility to verily with your Insurance carrier that these services are covered under your plan prior to scheduling the exam as you will be responsible for all non covered services.

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. You may be charged $50.00 for missed appointments or dismissed from the practice.

MEDICARE PATIENTS: SIGNATURE ON FILE: I request payment or authorized Medicare benefits be made either to me or on my behalf to Ell Hendel, M.D. for any services furnished me by the listed provider/supplier. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health Insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the Information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for the deductible and/or coinsurance. Coinsurance and the deductible are based upon the charge determination of the Medicare Intermediary.

Patient's Name (Please Print): _____ Date:_____

Patient's Medicare Number: _____

Patient's Signature: _____

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurance please read and sign below.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Eli Hendel, M.D .. This assignment will remain in effect until revoked by me in wriling. A photocopy or this assignment is to be considered as valid as an original. I undertsand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information necessary to secure the payment.

Signature: _____ Date: _____

I have read, understood, and agreed to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees.

Signature: _____ Date: _____

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1500 South Central Ave, Suite #117 I Glendale, CA 91204
Tel: (818) 500-9545 I Fax: (818) 500-7414

COMMUNICATING WITH YOU

ELI HENDEL, M.D. (EEHMD) requires you to complete and return this form so that EEHMD will know your preferred methods of receiving communications regarding your confidential health related information (e.g., test results, medication/prescriptions and responses to messages left by you). **EEHMD may communicate with you by mail, secure e-mail, and telephone, including messages on your answering machine/voicemail.**

Please check all the boxes below through which you authorize EEHMD to communicate with you.

❏ You may contact me by telephone at the following number: _____

❏ You may leave a message at the following number: _____

❏ You may contact me by E-mail _____

❏ You may contact me by mail

In the spaces below, please provide the name, telephone number, and relationship to patient of any other individual to whom EEHMD may communicate your confidential health information.

1.	_____	_____	_____
	Name	Telephone Number	Relationship
2.	_____	_____	_____
	Name	Telephone Number	Relationship
3.	_____	_____	_____
	Name	Telephone Number	Relationship

This request supersedes any prior requests that I may have made regarding the subject matter of communications by EEHMD of my confidential health information.

_____ _____
Signature of Patient/Responsible Party Date

_____ _____
Name of Patient/Responsible Party (please print) Relationship to Patient

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ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICES

By completing this form below, you acknowledge having received a copy of the Notice of Privacy Practices Eli E. Hendel, M.D. on the date and at the time specified below.

Print Name: _____

Signature: _____

Relationship to Patient: _____

Date Received: _____ Time Received: _____ am / pm

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Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health infromation.

Under federal law, however, you may not inspect or copt the following records; psychotherapy notes; information compiled in a reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding, and professional healthinformation that is subject to law that prohibits access t protected health information.

You have the right to request a restriction of your protected health information.

Th-is means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure ofyour proteated health information, your protected health information will not be restricted. You then have the right to use another Healtheare Professional.

You have the right to request to receive confidential communication from us by alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, f your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us, You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before april 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance officer in person or by phne at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name _____

Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE CAREFULLY REVIEW THIS NOTICE! EFFECTIVE DATE: SEPTEMBER 23, 2013

ELI HENDEL, M.D. (EEHMD) furnish medical and related services to patients through a partnership (EEHMD) of professional corporations. EEHMD sometimes operated under the name Eli Hendel, M.D. EEHMD understands that information about your health is very personal. EEHMD strives to protect the privacy and security of individually (patient) identifiable health information **(PHI)** that it receives, creates, or maintains in accordance with applicable law. EEHMD educates its workforce to respect patient privacy and to comply with the laws applicable to the confidentiality and security of PHI.

This Notice summarizes your rights with regard to your PHI. This Notice also summarizes the obligations of EEHMD with regard to your PHI. EEHMD is required to abide by the terms of this ***Notice of Privacy Practices*** for so long as they remain in effect. EEHMD reserves the right to change the terms of this ***Notice of Privacy Practices*** as and to the extent necessary and to make such new practices effective as to any and all PHI then in its possession. You may ask for a copy of the current ***Notice of Privacy Practices*** at the office. You may also send a written request by mail to **Eli Hendel, M.D., 1500 South Central Ave, Suite #117, Glendale, CA 91204.**

The terms of this Notice of Privacy Practices apply to the following individuals and entities:

- EEHMD affiliated physicians
- EEHMD employees, including paramedical and non-professional stan: who reasonably require access to PHI in connection with the perfonnance of their job functions
- Independent entities and individuals, also known as "business associates," who reasonably require access to PHI in connection with the performance of their functions and activities in support of EEHMD operations (*e.g.,* billing and transcription)
- A member of an authorized volunteer group who may require access to PHI in connection with your receipt of health care services

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USES AND DISCLOSURES OF YOUR PHI

The following categories detail the various ways in which EEHMD may use or disclose your PHI. EEHMD may provide exatnples for each category of uses or disclosures. Please note that not every use or disclosure will be listed below. However, each way in which EEHMD may use or disclose your PHI will fall into one of the following categories

1. **SIGNED AUTHORIZATION.** In specific situations, EEHMD will not use or disclose your PHI without you signing an authorization form. The authorization form will describe what information will be disclosed, to whom, for what purpose, and when. You have the right to revoke authorization in writing, except to the extent EEHMD already relied upon it. These situations include:

   - Uses and disclosures of alcohol and drug abuse/dependency records, HIV-related information, and psychotherapy notes

   - Uses and disclosures of PHI for marketing purposes, including marketing communications paid for by third parties, and

   - Disclosures which constitute sales of PHI

   EHMD will not use or disclose your PHI without a signed authorization from you except and to the extent as outlined below.

2. **TREATMENT.** EEHMD may use your PHI in connection with the provision of medical care and treatment to you that, for this purpose, also includes the identification and evaluation of alternative treatment options and health benefits available to you. For instance, EEHMD physicians and paramedical personnel involved in your care will use your PHI to plan a course of treatment for you that may include procedures, medications, tests, and etc. EEHMD may disclose your PHI to other health care providers who are also involved in your medical care and treatment.

3. **COVERAGE, AUTHORIZATION AND PAYMENT.** EEHMD may disclose your PHI to health plans and/or other third party guarantors in connection with the following activities related to the provision of medical care and treatment to you: (a) confirming coverage, (b) securing required authorizations, and (c) billing and collecting payment. For instance, EEHMD may forward your PHI to your insurance company to arrange payment for medical services provided to you.

4. **HEALTH CARE OPERATIONS.** EEHMD may use and/or disclose your PHI in connection with our health care operations, including but not limited to the following activities: (a) appointment scheduling, (b) utilization review and management, (c) quality assesstnent and improvement, (d) peer review and corrective action, (d) clinical education and training, and (e) patient grievance and satisfaction. For example, EEHMD may use your PHI to remind you about appointments or to follow up on your visit. EEHMD may also use your PHI to evaluate the quality of care you receive from EEHMD physicians and paramedical personnel, or to review the performance of staff.

5. **HEALTH INFORMATION EXCHANGE (HIE).** EEHMD may disclose your PHI to a local, regional and/or national Health information Exchange (HIE), but only for purposes related to treatment, paytnent, or health care operations, or as required by law. A HIE provides a mechanism for health care providers to share PHI electronically, with the goal of improving patient care while protecting the privacy and security of their PHI.

6. **BUSINESS ASSOCIATES.** EEHMD may disclosure your PHI to outside individuals or organizations, commonly referred to as "business associates," who are not workforce members but who are engaged by EEHMD to furnish services in support of the operations of EEHMD, and who reasonably require access to your PHI in order to furnish such services. For example, EEHMD may disclose your PHI to a third party who is engaged by EEHMD to perfom billing and collection services. In all cases, EEHMD requires business associates to agree in writing to safeguard the privacy and security of your PHI as required by applicable law.

7. **RESEARCH.** EEHMD may use and disclose your PHI for medical research, subject to your explicit authorization and/or oversight by an Institutional Revievv Board (IRB), the cmnmittee which is responsible for approving the project and for protecting the privacy rights and safety of hmnan subject research. For instance, the IRB may approve the use of your PHI with litnited identifying information solely for the purpose of conducting outcomes research on the clinical efficacy of a particular procedure. The IRB will evaluate and impletnent confidentiality requiretnents to protect your PHI in all instances where you have not provided written authorization.

8. **OTHER USES AND DISCLOSURES.** EEHMD may use or disclose your PHI without prior written consent or authorization from you in the following additional circumstances:

   - EEHMD may release your PHI for any purpose required by law

   - EEHMD may release your PHI for public health reasons, such as for required reporting of disease, injury, birth and death, and for required public health investigations

   - EEHMD may release your PHI to certain governmental agencies if EEHMD suspects child abuse or neglect, or if EEHMD believes you are a victim of abuse, neglect, or domestic violence

   - EEHMD may release your PHI to entities which are regulated by the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls

   - EEHMD may release your PHI to your employer if EEHMD provided medical care and treatment to you for purposes related to occupational health and safety, provided that in most cases you will receive written notice of disclosure to your employer

   - EEHMD may release your PHI if required by law to a governrnent oversight agency conducting audits, investigations, inspections and health related oversight functions

   - EEHMD may use or disclose your PHI in emergency circumstances, such as to prevent a serious and imminent threat to a person or the public

   - EEHMD may release your PHI if required to do so by a court or administrative order, subpoena or discovery request, provided that in rnost cases you will receive written of such release

• EEHMD may release your PHI to law enforcement officials in order to identify or locate suspects, fugitives, witnesses, or victims of crime, or for other allowable law enforcement purposes

• EEHMD may release your PHI to coroners, medical examiners, and/or funeral directors EEHMD may release your PHI, if necessary, to arrange an organ or tissue donation frorn you or a transplant for you

• EEHMD may release your PHI if you are a member of the military for activities set out by certain military command authorities as required by armed forces services

• EEHMD may also release your PHI, if necessary, for national security, intelligence or protective services activities

• EEHMD may release your PHI if necessary for purposes related to your workers' compensation benefits

YOUR RIGHTS WITH RESPECT TO PHI

1. **ACCESS TO YOUR PHI.** Generally, you have the right to access, inspect, and/or receive paper and/or electronic copies of your PHI maintained by EEHMD. Requests for access tnust be in writing and be signed by you or your representative. EEHMD charges for copies of medical records in accordance with a schedule of fees established by state law. You can obtain an access request fonn fron1 the EEHMD office.

2. **AMENDMENTS TO YOUR PHI.** You have the right to request that your PHI maintained by EEHMD be amended or conected. EEHMD is not obligated to make all requested amendments but will give each request careful consideration. All amendment requests must be in writing and signed by you or your representative, and must state the reasons for the amendment/correction request. EEHMD may also ask its workforce and business associates if your amendment/correction request is necessary. In all events, EEHMD cannot delete any PHI already documented in your medical record even if EEHMD makes your requested amendment/correction. You can obtain an amendment/correction request form from the EEHMD office

3. **ACCOUNTING FOR DISCLOSURES OF YOUR PHI.** You have the right to receive an accounting of certain disclosures made by EEHMD of your PHI, other than disclosures made for purposes of treatment, payment, health care operations and certain other limited circumstances. The accounting would include only those disclosures made during the 6-year period prior to the date of the accounting request. Accounting requests must be in writing and signed by you or your representative. EEHMD will not charge you for the first accounting request in any 12-month period; however, EEHMD will charge you a reasonable, cost-based fee for each subsequent request during the 12-month period. You can obtain an accounting request form from the EEHMD office.

4. **RESTRICTIONS ON USE AND DISCLOSURE OF YOUR PHI.** You have the right to request restrictions on certain uses and disclosures by EEHMD of your PHI for treatment, payment, and/or health care operations. EEHMD will attempt to accommodate reasonable requests. However, EEHMD is not required to agree to your restriction request. In addition, EEHMD retains the right to terminate any previously agreed-to restriction requests if necessary and appropriate, in which case EEHMD will notify you in writing. Without limiting the generality of the foregoing, if you request any restrictions on disclosures of your PHI to your health plan, then EEHMD cannot honor any such requests unless you or someone on your behalf, other than your health plan, pay for the health care item(s) or service(s) in full. EEHMD is not

required to inform other providers of your request not to disclose your PHI, but EEHMD will attempt to do so where feasible. You can obtain a restriction request form from the EEHMD office.

5. **CONFIDENTIAL COMMUNICATIONS.** You have the right to request communications regarding your PHI from EEHMD by alternative means or at alternative locations. EEHMD will endeavor to accommodate reasonable requests by you in that regard. Any requests for alternative communications of confidential information must be in writing and signed by you or your personal representative. You can obtain a confidential communication request form from the EEHMD office.

6. **BREACH NOTIFICATION.** EEHMD is required to notify you in writing of any breach of your unsecured PHI as soon as possible, but in no event later than sixty (60) days after EEHMD discovers the breach.

7. **PAPER COPY OF NOTICE.** You have the right to obtain a paper copy of this Notice of Privacy Practices, even if you requested a copy by e-mail or other electronic means.

ADDITIONAL INFORMATION

1. **COMPLAINTS.** If you believe your privacy rights have been violated, you may file a complaint in writing with EEHMD or with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. All complaints must be made in writing and in no way will affect the quality of care you receive from EEHMD.

2. **FURTHER INFORMATION.** If you have questions or require further assistance regarding this Notice of Privacy Practices, then please contact EEHMD either by telephone at (818) 500-9545 or in writing to Eli Hendel, M.D., 1500 South Central Ave, Suite #117, Glendale, CA 91204

ELI HENDEL M.D.
Pulmonary and Sleep Specialist

HEALTH HISTORY

IDENTIFYING DATA

MEMBER NAME		DATE
INS. PLAN	SS#	
SEX	MARITAL STATUS	DATE OF BIRTH
OCCUPATION		PAST OCCUPATION
PRIOR M.D.		DATE OF LAST EXAM

ALLERGIES/REACTIONS TO MEDICATIONS

1
2
3
4
5
6

MEDICATION: PRESCRIBED AND NON-PRESCRIBED

	DRUG NAME	DOSE	TAKEN HOW OFTEN
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

CURRENT IMMUNIZATION STATUS

TYPE	APPROX. DATE	HAVE HAD DISEASE
INFLUENZA		
MUMPS		
MEASLES		
RUBELLA/GERMAN MEASLES		
TETANUS		
B.C.G.		
PNEUMONIA VAC.		
HEPATITIS B VAC.		
OTHER		

SURGERIES AND PROCEDURES — YEAR

ACCIDENTS / INJURIES — YEAR

SOCIAL

NUMBER OF CAFFEINE CUPES/DAY

TOBACCO - NUMBER OF PACKS/DAY

STRESS
(HIGH / MEDIUM / LOW)

LIFESTYLE

WORK FACTORS

TOXIC OCCUPATIONAL EXPOSURE

DO YOU WEAR SEAT BELTS?

HABITUAL ALCOHOL USE?
HOW MUCH?

HABITUAL DRUG USE?
TYPE & HOW MUCH?

FAMILY HISTORY (Please indicate any blood relative with history of the following)

CANCER	STROKE
HIGH CHOLESTEROL	ALZHEIMER'S
LEUKEMIA	BLEEDING PROBLEMS
DIABETES	EMPHYSEMA
HIGH BLOOD PRESSURE	ALCOHOLISM
HEART DISEASE	MENTAL ILLNESS
HEART ATTACK	OTHER HEREDITARY DISEASES
SUDDEN DEATH	

SEE OTHER SIDE

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YES	NO	GENERAL
		RECENT WEIGHT CHANGE
		POOR APPETITE
		FEVERS
		CHILLS
		FATIGUE
		NIGHT SWEATS
YES	NO	**EYES**
		BLURRED VISION
		GLAUCOMA
		CATARACTS
		DISCHARGE
		REDNESS, BURNING, TEARING OR ITCHING
YES	NO	**EAR, NOSE, THROAT**
		HISTORY OF EAR INFECTIONS
		NASAL DISCHARGE
		POST-NASAL DRIP
		SNEEZING
		ITCHY NOSE OR MOUTH
		SWOLLEN GLANDS
		MOUTH SORES
		HOARSENESS
		DIFFICULTY SWALLOWING
		SORE THROAT
YES	NO	**CARDIO-RESPIRATORY**
		COUGH
		WHEEZING
		SPUTUM PRODUCTION
		COUGHING UP BLOOD
		SHORTNESS OF BREATH
		CHEST TIGHTNESS
		CHEST PAIN
		ANKLE SWELLING
YES	NO	**GASTRO-INTESTINAL**
		NAUSEA OR VOMITING
		DIARRHEA
		CONSTIPATION
		CHANGE IN BOWEL HABITS
		ABDOMINAL PAIN
		HEARTBURN
		BLACK STOOL
		BLOOD FROM RECTUM
		JAUNDICE OR HEPATITIS
		PEPTIC ULCER DISEASE
		GALLSTONES
YES	NO	**HEMATOLOGY**
		ANEMIA
		EASY BRUISING OR BLEEDING
		HISTORY OF TRANSFUSION

YES	NO	GENITO-URINARY
		KIDNEY OR FLANK PAIN
		BURNING ON URINATION
		FREQUENCY OF URINATION
		GET UP AT NIGHT TO URINATE
		BLOOD IN URINE
		HISTORY OF KIDNEY STONES
		HISTORYOF URINARY TRACK INFECTIONS
YES	NO	**MALE**
		LUMPS IN TESTICLES
		DIFFICULTY STARTING URINE OR DECREASED FORCE OF STREAM
		PROSTATE PROBLEMS
YES	NO	**FEMALE**
		LAST MAMMOGRAM _____
		POST-MENAUPOSAL
		LUMPS IN BREAST
		PREVIOUS BREAST SURGERY
		HORMONE THERAPY
YES	NO	**MUSCULOSKELETAL**
		BACK PAIN
		JOINT SWELLING OR JOINT PAIN
		VARICOSE VEINS
YES	NO	**SKIN**
		RASHES
		NON-HEALING HIVES
		ITCHING
		HISTORY OF SKIN CANCER / MELANOMA
YES	NO	**NEURO PSYCHIATRIC**
		HEADACHE
		SEIZURES
		PARALYSIS
		NUMBNESS
		DIZZINESS
		DEPRESSION
		PREVIOUS PSYCHIATRIC TREATMENT
YES	NO	**ENDOCRINE**
		DIABETES
		LOW BLOOD SUGAR
		THYROID PROBLEMS
		RADIATION TO THE NECK, FACE OR TONSILS