West Coast Neurology

Office: (626) 598-3770 Fax: (626) 598-3797

Edward G. Barton, MD | Christopher K. Cheng, MD
Arnold A. Brizuela, MD | Charles E. Imbus, MD

Adult Neurology, Pediatric Neurology, Clinical Neurophysiology, and Sleep Medicine

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Date: ________________________________ **Home Phone:** ________________________________

Email: ________________________________ **Cell Phone:** __________________________________

Patient: ____

Last Name **First Name** **Middle Initial**

Street Address: ____

City: __________________________________ **State:** _____________ **Zip Code:** _________________

Sex: M ☐ **F** ☐ **Age:** ________ **Birth Date:** ____________ **Height:** __________ **Weight:** ______

Occupation: _______________________ **Race/Ethnicity:** ________________ **Language:** ___________

Emergency Contact: ____

Relation: ______________________________________ **Contact Number:** ______________________

Referring Physician: __________________________________ **Phone:** ___________________________

Address: _______________________________________ **City:** _________________ **Zip Code:** _________

Primary Physician: ___________________________________ **Phone:** ___________________________

Address: _______________________________________ **City:** _________________ **Zip Code:** _________

Patient Agreement	**Assignment and Release** **I have insurance coverage with _________________________________, and assign directly to West Coast Neurology all medical benefits, if any. Otherwise payable to me for services rendered that I am financially responsible for all charges whether paid or not paid by insurance I hereby authorize the doctor to release all information necessary to secure the payment of benefits, I authorize the use of this signature on all my insurance submissions.** _____________________________ ___________________ **Signature of insured/ Guardian** **Date**
Workers Compensation/Auto Insurance Information	****Only if Work/ Accident Related**** **Date of Injury:** ____________________________ **Insurance Company Name:** ____ **Address:** ____________________________________**Phone:** ____________________ **City:** ________________________________ **State:** _________ **Zip:**_________________ **Adjuster:** __________________________________ **Claim #:** ________________________

Reason for visit (Physical Symptoms):

____

____

Have you recently had any of the following tests: Labs: ☐ EEG: ☐ MRI: ☐ Other: _______________

Social History:
Never Smoked: ☐ Former Smoker: ☐ Quit Date: ________ Current Smoker: ☐ Packs/day: _________

No Known Drug Allergies: ☐ Please List Drug Allergies:

____

Past Medical History (Diagnoses):

____

____

Family Medical History of Importance (please include family member and diagnoses):

____

Current Medications (dose, # taken daily):

____

____

____

Pharmacy (name, street and city):

____

REVIEW OF SYSTEMS: (circle all that apply)

General: Chills and Fever.

Skin: Itching, New Lesions and Rash.

HEENT: Excessive Tearing, Ear Pain and Sinus Pain.

Neck: Swollen Glands.

Respiratory: Cough and Sputum Production.

Breast: Breast Mass and Breast Pain.

Cardiovascular: Chest pain and Murmur.

Gastrointestinal: Abdominal Mass and Vomiting Blood.

Musculoskeletal: Joint Pain and Leg Cramps.

Neurological: Decreased Memory, Loss of Consciousness and Seizures.

Psychiatry: Delusions and Hallucinations.

Endocrine: Excessive Sweating and Heat Intolerance.

Hematology: Painful Lymph Nodes and Spontaneous Bleeding

Sleep Disorder Symptoms Assessment

Please check any of the following you may have:			
☐ High Blood Pressure	☐ Heart Disease	☐ Stroke	☐ Insomnia
☐ Frequent Urination at Night (Nocturia)	☐ Diabetes	☐ Depression	☐ Overweight
☐ Restless Legs	Neck Size (If known) _____________ inches		

Snoring:	
1. Do you snore often (3 or more nights a week)?	☐ YES ☐ NO ☐ Don't Know
2. Is your snoring loud enough to be heard through a closed door Or annoy other people?	☐ YES ☐ NO ☐ Don't Know
3. Have you notice or been told that during sleep, you frequently Stop breathing or grasp for air?	☐ YES ☐ NO ☐ Don't Know

Epworth Sleepiness Scale:	Never Would doze off	Slight Chance of dozing	Moderate Chance Of dozing	High Chance of dozing
1. Do you get sleepy, or doze off, while sitting and reading?	0 ☐	1 ☐	2 ☐	3 ☐
2. Do you get sleepy, or doze off, while watching TV?	0 ☐	1 ☐	2 ☐	3 ☐
3. While sitting or inactive in a public place (e.g. a theater)?	0 ☐	1 ☐	2 ☐	3 ☐
4. As a passenger in a car for an hour without a break?	0 ☐	1 ☐	2 ☐	3 ☐
5. Lying down to rest in the afternoon?	0 ☐	1 ☐	2 ☐	3 ☐
6. Sitting and talking to someone?	0 ☐	1 ☐	2 ☐	3 ☐
7. Sitting quietly after lunch without alcohol?	0 ☐	1 ☐	2 ☐	3 ☐
8. In a car, while stopped for a few minutes at a traffic light?	0 ☐	1 ☐	2 ☐	3 ☐
Total Score				

CPAP:
Are you currently using CPAP? ☐ YES ☐ NO ☐ If yes, for how long? ________________________

Notice of Privacy Practices

Our Assurance Regarding Medical Information

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive from our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information. These privacy practices are currently in effect and will remain in effect until further notice.

Our Legal Duties

The law requires us to keep your medical information private, give you this notice describing our legal duties, privacy practices, and your right regarding your medical information, as well as follow the terms of the current notice. We have the right to change our privacy practices and the terms of this notice at any time, provided that the change is permitted by law. We have the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

Use and Disclosure of Your Medical Information

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

- **For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you.
- **For Payment:** We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

Additional Uses and Disclosures

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes:

- **Notification:** We may use and disclose medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray , imaging or medical information for you.
- **Disaster Relief:** We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.
- **Research in Limited Circumstances:** We may use medical information for research or health survey purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.
- **Funeral Director, Coroner, and Medical Examiner:** To help them carry out their duties, we may share the medical information, of a person who has died, with a coroner, medical examiner, funeral director, or an organ procurement organization.

- **Specialized Government Functions:** Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.
- **Court Orders and Judicial and Administrative Proceedings:** We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement official. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.
- **Public Health Activities:** As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for the purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.
- **Victims of Abuse, Neglect, or Domestic Violence:** We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.
- **Workers Compensation:** We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.
- **Health Oversight Activities:** We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.
- **Law Enforcement:** Under certain circumstances, we may disclose your health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request enforcement official, reporting death, crimes on our premises, in our presence, and crimes in emergencies.
- **Appointment Reminders:** We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of appointments. Including, but not limited to, voicemails of future appointment date and time.
- **Alternative and Additional Medical Services:** We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

Your Individual Rights

You have the right to:

- Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photo copies. We will use the format you request, unless it is not practical for us to do so. There may be charges for copying and for postage if you want copies mailed to you.
- Receive a list of all the times we and our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.

- Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of emergency).
- Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or different locations must be made in writing.
- Request that we change certain parts of your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
- Please be aware that this notice does not necessarily catalog an exhaustive list of your rights. It is your responsibility to be aware of all your rights as pertaining to protected health information.

Questions and Complaints

If you have any questions about this notice, please send us written correspondence. If you think that we have violated your privacy rights, you may speak to the Privacy Officer and submit a written complaint.

I hereby acknowledge that I received a copy of the Notice of Privacy Practices, and I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I fully understand and accept the terms of this Notice of Privacy Practice, pages 4-7.

___________________________	____	__________
Patient Name	Patient Signature (or responsible party, if minor)	Date

Patient Consent to Treatment and Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Health Care Operations (HIPAA)

I understand that as part of my health care, this organization named above originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. In regards to sleep studies and electroencephalogram (EEG) studies, I understand that digital videotapes, and photographs will be recorded to document my care, and I consent to this. I understand that the information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which third-party payer can verify that services billed were actually provided, and
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- conduct, plan and direct my treatment and follow-up among the multiple health care provider who may be involved in the treatment directly and indirectly,
- obtain payment from third party payers, and
- conduct normal health care operations such as quality assessments and physician certifications.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices. This organization reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. I understand that I have the following rights and privileges:

- The right to review and receive a printed copy of this notice prior to signing this consent,
- The right to inspect and copy, amend, or submit correction to, my protected health information,
- The right to receive confidential communications about your medical condition and treatments, and
- The right to request restrictions as to how my health information may be used or disclosed.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions. See Notice of Privacy Practices for more details.

I understand that I may revoke this consent in writing at any time, except to the extent that you have already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations. I understand that as part of this organizations treatment, payment, or heath care operations, it may become necessary to disclose my protected heath information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax, email, phone, voice.

I fully understand and accept the terms of this consent and I hereby acknowledge that I received and a copy of the Notice of Privacy Practices, and I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

____________________	________________________________	____________
Patient Name	Patient Signature (or responsible party, if minor)	Date

AUTHORIZATION TO SHARE MEDICAL INFORMATION
WITH FAMILY MEMBERS

Patient Name: ____

DOB: ____

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I hereby give my consent for West Coast Neurology, Inc. to share protected patient health information with the following person(s) regarding my medical care, medical needs, and medical status.

Name	Relationship
______________________________	______________________
______________________________	______________________
______________________________	______________________
______________________________	______________________
______________________________	______________________

I understand that I may revoke this authorization at any time by notifying West Coast Neurology, Inc. in writing at:

630 S. Raymond Ave Ste 310
Pasadena, CA 91105

______________________________ ______________________
Patient Signature Date

IF MINOR, BY PARENT OR LEGAL GUARDIAN:

______________________________ ______________________
Parent/Legal Guardian Signature Date