## PERSONAL HISTORY

**NAME:** ____________________ ____________ ______________________________

First Name | Middle Initial | Last Name

**AGE:** ____________

__ Right Handed
__ Left Handed
__ Ambidextrous

**ALLERGIES** (medications): ______________________________

## SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No ☐ Stopped
How many packs a day? ____________
When did you stop smoking? ____________

Do you drink alcohol? ☐ Yes ☐ No ☐ Stopped
How often do you drink? ____________
When did you stop drinking? ____________

Are you married? ☐ Yes ☐ No ☐ Divorced ☐ Single ☐ Separated

Do you have children? ☐ Yes ☐ No

Occupation: ______________________________

Education: ☐ High School ☐ Some College ☐ College graduate

Do you feel depressed? ☐ Yes ☐ No
Do you feel rested after sleep? ☐ Yes ☐ No
Do you awaken frequently at night? ☐ Yes ☐ No
How is your appetite? ☐ Good ☐ Fair ☐ Poor
Have you gained or lost weight? ☐ Same ☐ Lost ☐ Gained

**MEDICATIONS**

Including over the counter and herbal medicines

| Medicine | Dose | Reason Taken | | How many times daily? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## MEDICAL HISTORY

Please check any medical conditions present in your family and yourself.
Please provide pertinent details

| Family | Patient | Condition | Family | Patient | Condition |
|---|---|---|---|---|---|
| ☐ | ☐ | Irregular heartbeat | ☐ | ☐ | Kidney problems |
| ☐ | ☐ | Coronary Artery Disease | ☐ | ☐ | GI problems |
| ☐ | ☐ | Stroke/TIA | ☐ | ☐ | Bleeding problems |
| ☐ | ☐ | Heart Attack | ☐ | ☐ | COPD/Asthma |
| ☐ | ☐ | Diabetes | ☐ | ☐ | Seizures |
| ☐ | ☐ | Thyroid problems | ☐ | ☐ | Headaches |
| ☐ | ☐ | Fainting Spells | ☐ | ☐ | Multiple Sclerosis |
| ☐ | ☐ | Liver problems | ☐ | ☐ | Parkinson's Disease |
| ☐ | ☐ | | ☐ | ☐ | Dementia |

Details:

| **Surgeries** | | |
|---|---|---|
| Year | Surgery Performed | Details |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Physicians** | | |
|---|---|---|
| Name | Specialty | Address |
| | | |
| | | |
| | | |
| | | |
| | | |

| Account # | | **Patient Registration** | ☐ Ela |
|---|---|---|---|

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Last Name | | First Name/Initial | | | | | |
| Address | | | | | | | |
| City | | State: | | Zip: | | | |
| Phone # | | Have you been examined by our doctors before? | ☐ Yes | ☐ No | | | |
| Date of Birth | | Marital Status | ☐Married | ☐Single | ☐Other | | |
| Social Security # | | Referred by | | | | | |
| Employer | | Occupation | | | | | |
| Address | | Is this visit related to work injury? ☐Yes ☐No | | | | | |
| | | Date of Injury | | | | | |
| City | | State | | Zip | | | |
| Spouse | | Work Phone | | | | | |
| Spouse D.O.B | | Spouse's Work Phone | | | | | |
| Parent/Guardian (For Minor) | | Relationship | | | | | |

## *Insurance Information*

*Please be aware that we will bill your insurance as a courtesy. This office does not accept liens for personal injury, auto accidents or workers' compensation cases.*
*Does your insurance require authorization for referral to a specialist?* ☐Yes ☐No
*If you have your insurance identification cards, please give them to receptionist*

| | | | | | |
|---|---|---|---|---|---|
| **Insurance #1** | | | | | |
| Address | | | | | |
| Address | | State | | Zip | |
| Phone | | Copay | | | |
| Policyholder | | Relationship | ☐Self ☐Spouse ☐Child | | |
| Identification | | Group # | | | |
| **Insurance #2** | | | | | |
| Address | | | | | |
| Address | | State | | Zip | |
| Phone | | Copay | | | |
| Policyholder | | Relationship | ☐Self ☐Spouse ☐Child | | |
| Identification | | Group # | | | |

| | | | |
|---|---|---|---|
| Authorization | I authorize my insurance company to make payments directly to this practice. I understand that I am financially responsible to the practice for any service denied by my insurance company. I authorize the release of any information requested with respect to this claim. | | |
| Signature | | Date | |

# FINANCIAL RESPONSIBILITY WAIVER

**INSURANCE AUTHORIZATION, VERIFICATION AND CO-PAYMENTS ARE THE RESPONSIBILITY OF THE MEMBER. I UNDERSTAND THAT IF MY INSURANCE BENEFITS AND/OR ELIGIBILITY ARE NOT APPROVED BY MY HEALTH PLAN OR INDEPENDENT PHYSICIANS ASSOCIATION THEN I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY FOR ALL CHARGES RELATED TO SERVICE PROVIDED BY THOMAS W. ELA M.D.**

I am selecting the following health plan option:

- ☐ HMO (Health Maintenance Organization) with Primary Care Physician/IPA authorization and co-pay as indicated on insurance card
- ☐ POS (Point-of-Service) without prior Primary Care Physician/IPA authorization and with higher co-pay and/or deductible.
- ☐ PPO (Preferred Provider Organization) with appropriate co-pay, deductible and/or percentage of allowed charges.
- ☐ Indemnity plan or automobile insurance with deductible and/or percentage of allowed charges. NO LIENS ACCEPTED.
- ☐ Workers' Compensation as authorized by the insurance carrier.
- ☐ Medicare without HMO enrollment.
- ☐ HMO (Health Maintenance Organization) Self-referring with no authorization from Primary Care Physician/IPA. I understand and agree that I am financially responsible for this visit.

**PATIENT NAME:** ______________________________

Signature of responsibility ______________________ Date ______________

THIS WAIVER WILL REMAIN VALID FROM THIS DAY FORWARD TO INCLUDE ALL FUTURE SERVICES, RELATED TO THIS PATIENT.

**THOMAS W. ELA, M.D., INC.**
DIPLOMATE AMERICAN BOARD OF NEUROLOGY
CERTIFIED IN THE SUBSPECIALTY OF CLINICAL NEUROPHYSIOLOGY
**2282 N. State College Blvd., Fullerton, CA 92831**

Phone: 714-780-9770 Fax:714-780-9773

| **PERIPHERAL NERVE DISORDERS** | **ADULT NEUROLOGY** | **NEURODIAGNOSTIC TESTING** |
|---|---|---|

# NOTICE OF PRIVACY PRACTICES

*TO OUR PATIENTS*: This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**Uses and Disclosures of Protected Health Information (PHI):** This practice is permitted to make disclosures of your PHI for the purpose of treatment, payment and health care operations. Examples include, but are not limited to, the following:

- We may consult with other health care providers regarding your treatment (prescriptions labwork, x-rays, etc).
- We may disclose PHI so we may bill your insurance and collect payment for you.
- We may use PHI to identify you for information about treatment or education.

**Other uses and Disclosures of PHI Without Authorization:** This practice is permitted or required by the HIPAA Privacy rule to use or disclose PHI without your written authorization as may be required by law or for the public-good. The uses and disclosures not otherwise described in this notice will only be made with your written authorization. Examples include but are not limited to, the following:

- We may report to the Department of Health, PHI that may place you or the public at risk, such as your ability to safely operate a motor vehicle.
- As authorized by Workers' Compensation laws, we may report to your carrier/employer, information related to workplace injuries or illnesses.
- In response to a court or administrative order, we may provide your PHI to the requesting party.

**Your Individual Rights:**

- ***Restriction Request:*** You have the right to request restrictions on the use and disclosure of PHI for treatment, payment or health care operations or that only certain individuals be involved in your care. Although the practice is not required to agree to such restrictions, we will accommodate reasonable requests, except when otherwise required by law.

- ***Alternative Communication:*** You have a right to request alternate means of communication. You may request that we contact you at a certain location or in a particular manner. We will accommodate reasonable requests.
- ***Inspect and Copy:*** You have a right to inspect and obtain a copy of your PHI and billing records. You must submit your request in writing to this practice's Privacy Official.
- ***Amendment:*** You have a right to request an amendment to your PHI if you believe it is incorrect or incomplete. You must make your request in writing and submit it to the Privacy Official. You must provide us with a reason that supports your request for amendment.
- ***Accounting:*** You have a right to receive an accounting of all disclosures of your PHI.
- ***Paper copy:*** You have a right to obtain a paper copy of this notice at any time.
- ***Complaints:*** You have a right to file a complaint if you believe your privacy rights have been violated. This must be filed in writing with the Privacy Officer. You will not be intimidated, threatened, coerced or discriminated against for filing a complaint.
- ***Privacy Officer:*** Any employee or physician of this practice can provide you the name of the Privacy Officer, who can be reached at the address and telephone number on this document.
- ***Effective Date:*** This notice takes effect upon acknowledgment by you..

## The Medical Practice's Duties:

- ***Legal Duties:*** This medical practice is required by law to maintain the privacy of your PHI and is required to abide by the terms of the "Notice of Privacy Practices".
- ***Revisions:*** Revisions of amendments to this notice will be provided upon request and posted in the Reception Room.
- ***Training:*** It is the responsibility of the practice to train it's employees on current regulations. If they are unable to assist you, they will refer you to the Privacy Officer.

**Right to Revoke This Authorization:** You may revoke this authorization at any time, except to the extent we have taken previous action based on the authorization.

I hereby acknowledge that I have been presented this "Notice of Privacy Practices".

Date: ______________________ Patient: ____________________________

Signature: ______________________________________________

For more information about HIPAA or to file a complaint:

the U.S

# AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name: ______________________________ Date of Birth: ____________

Last First Middle

**Authorization for Use/Disclosure of Information:** I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

| | |
|---|---|
| Name of Provider: | **Thomas W. Ela, M.D., Inc.** |
| Address of Provider: | **2282 N. State College Blvd.** |
| | **Fullerton, CA 92831** |
| Phone Number: | (714) 780-9770 |
| Fax Number: | (714) 780-9773 |

**Recipient and address for Delivery of Records:**

**Purpose:** I understand that the specific purpose of this Authorization is

**Information to be disclosed:** This Authorization permits the above named health care provider to disclose the following medical records:

All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-rays, HIV/AIDS status, genetic testing, psychotherapy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above-named health care provider may hold.

All of my health information described above except for the following:

Only the following records of health information: (Insert dates of treatment, types of treatment or other designation.)

**Terms:** This Authorization will remain in effect for one (1) year from the date this authorization is signed.

**Redisclosure:** I understand that once my health care provider discloses my health information to the recipient identified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization of applicable federal and state law governing the use and disclosure of my health information.

**Refusal to sign/right to revoke:** I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider.

**Revocation:** I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

**Questions:** I may contact my health care provider for answers to my questions about the privacy of my health information at my health care provider's regular office telephone number. I understand that I have right to receive a copy of this authorization from my health care provider.

**Photocopy:** A photocopy, fax or electronic copy of this authorization shall be considered as effective and as valid

| Signature | Date | Signature of Witness |
|---|---|---|

Name: ______________________________

If individual is unable to sign this Authorization, please complete the information below.

| Signature of Personal representative | Legal Relationship | Date | Signature of Witness |
|---|---|---|---|

Name: ______________________________