DANNY BENMOSHE, M.D. NEUROLOGY / ELECTROMYOGRAPHY / ELECTROENCEPHALOGRAPHY
2001 SANTA MONICA BLVD. TEL: (310) 688-8800
Suite 880 West; SANTA MONICA, CA 90404 FAX: (888) 971-3594

PATIENT INFORMATION

First Name Last Name	Birthdate	Age	Sex ☐M ☐ F
Patient's Address			
City State Zip code			
Home Phone / Mobile Phone	Social Security Number		
Marital Status (Please Check One) ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Dominate hand? ☐L ☐ R		
Occupation	Language Spoken		
Employer's Name	Office Phone		
Primary Care Physician	Phone / Fax		
Referring Physician	Phone / Fax		
If not referred by a physician, how did you hear about us?	Email Address		
Preferred Pharmacy:			

PERSONAL INSURANCE INFORMATION - PRIMARY

Subscriber's Name / Subscriber DOB:	Relationship to Subscriber:
Insurance	ID Number

PERSONAL INSURANCE INFORMATION - SECONDARY

Subscriber's Name / Subscriber DOB:	Relationship to Subscriber:
Insurance	ID Number

Emergency Contact

Name / Relationship:	Phone

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Danny Benmoshe MD, Inc. to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance benefits.

Patient or Guardian Signature: _____ Guardian or Power of Attorney Name:	Date

Patient Name: Date:

COMPREHENSIVE PATIENT HISTORY

What is the main reason for your visit today? (Please Describe and include current symptoms)

Current Symptoms:

Diet: How many times a day do you eat? _____ Do you eat Meals on time? ☐Y ☐ N

Caffeine Intake Cups/Cans/etc. per day _____ **Water Intake** Cups/Oz, etc. per day _____

Exercise: How often do you exercise? _____ What kind of exercise: _____

MEDICAL HISTORY (Please indicate if you have or have had any of the following by checking Yes or No, followed by a brief explanation, including dates)

High Blood Pressure	☐NO ☐YES	_____
High Cholesterol	☐NO ☐YES	_____
Diabetes	☐NO ☐YES	_____
Cardiac Disease	☐NO ☐YES	_____
Strokes	☐NO ☐YES	_____
Seizure Disorders	☐NO ☐YES	_____
Migraines	☐NO ☐YES	_____
Hyper/hypothyroid	☐NO ☐YES	_____
Lung Disease (Type)	☐NO ☐YES	_____
Liver Disease/Hepatitis	☐NO ☐YES	_____
Kidney Disease	☐NO ☐YES	_____
Cancer	☐NO ☐YES	_____
Bleeding Disorder/Tendency	☐NO ☐YES	_____
Gastrointestinal Disorder	☐NO ☐YES	_____
Depression/Anxiety	☐NO ☐YES	_____
Other Conditions (Specify)	☐NO ☐YES	_____

(Women) Number of Pregnancies: _____ Vaginal Deliveries: _____ C-sections: _____

FAMILY HISTORY (List any History: high blood pressure/ cholesterol, diabetes, strokes, seizures, migraines, any other diseases)

Mother: Father:

Brother(s): Sister(s):

SURGICAL HISTORY (Please list all operations that you have had and when they were done)

Diagnostic Imaging or Labs (Please list related imaging or labs done in last 3 years)

Patient Name: Date:

MEDICATION/ ALLERGY LIST

ALLERGIES TO FOOD/MEDICATION ☐No Known Drug Allergies (NKDA)

FOOD/MEDICATION ALLERGY	(INCLUDE TYPE OF REACTION)
1)	
2)	
3)	
4)	

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY USING
Include prescription medications, over the counter medications (Tylenol, Aspirin, Advil, etc.), and any vitamins or herbs. Try to be specific as possible about the amount and frequency of use of these medications.

Medication Name	Dose (mg or # of pills)	Doses per Day	Days per Week

PLEASE LIST ALL MEDICATIONS YOU'VE TAKEN IN THE PAST FOR YOUR SYMPTOMS
ALL medications you have taken in the past for your symptoms. Include prescription medications, over the counter medications. Please indicate why you are no longer taking the listed medication(s).

Medication Name	Reason for Discontinuing

Patient Name: Date:

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last *2 weeks*, how often have you been bothered by any of the following problems?

(*use "✓" to indicate your answer*)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself- or that you are a Failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so fidgety or restless that you have been moving around a lot more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead, or of hurting yourself	☐ 0	☐ 1	☐ 2	☐ 3
		add columns ☐ + ☐ + ☐		
		TOTAL: ☐		

10. If you checked off any problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

DANNY BENMOSHE, M.D.
NEUROLOGY
ELECTROMYOGRAPHY ELECTROENCEPHALOGRAPHY

2001 SANTA MONICA BLVD., STE 880 WEST
SANTA MONICA, CA 90404
TEL: (310) 688-8800
FAX: (888) 971-3594

Release of Information

FROM:

PATIENT NAME:_____ DOB:_____

PLEASE RELEASE MY MEDICAL RECORDS INCLUDING:

X-RAYS, REPORTS, LABORATORY TEST RESULTS,

DRUGS/MEDICATION RECORDS, ETC. **TO**:

DANNY BENMOSHE, M.D.

NEUROLOGY

FAX: 888-971-3594

I understand that such information cannot be released without my specific consent, except in accordance with applicable HIPAA laws.

_____	_____	_____
Patient/ Guardian Name	**Patient/ Guardian Signature**	**Date**

DANNY BENMOSHE, M.D. INC. **FINANCIAL POLICY and DISCLOSURE**

Office Policy for Tests Results: *Dr. Benmoshe requires an in-office follow-up visit to review ALL test results, including: EEG, Labs, and Imaging* unless life threatening.

Office Policy for Phone Calls and Electronic Correspondence: *Please allow 3 business days for all responses.*

Financial Policy and Disclosure:

For Doctor Appointments:

1. **Cancellation / No Show Fees and Policy**
   We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However; when you do not call to cancel an appointment, you may be preventing other patients from getting much needed treatment.

   If an appointment (initial or follow-up) is not cancelled at least 48 hours in advance you will be charged a one hundred dollar ($100) fee; this will Not be covered by your insurance company.

2. **Scheduled Appointments**
   We understand delays can happen; however, we must try to keep all patients and the doctor on time.
   If a patient is 15 minutes past their appointment time we may re-schedule the appointment. Late cancellation fee of one hundred dollars ($100) applies.

For Self-Pay Policy

- If you are a self pay patient, you will be required to pay for the office visit before services are rendered
- In addition, any remaining balance on your account will be collected at discharge

For Insurance Policy

- Our office is contracted with certain insurance plans; However, we do not verify insurance. It is the responsibility of the patient to verify eligibility to ensure Dr. Benmoshe is contracted within the particular plan.
- If your insurance is out of network we will collect payment upfront.
- We do not bill out of network insurances (OON) and any OON reimbursements are based on patient submission.

Collections Policy: In addition to the principle amount owed, I also agree to pay 30% of the unpaid balance if my account is turned over to a collection agency or attorney in an effort to collect any outstanding balance. This may include, but is not limited to, filing fees, court costs, collection agency fees and attorney fees.

I acknowledge that I have read and understand the policy outlined above, and authorize Dr. Danny Benmoshe to charge the credit card (C.C.) I provided to the office at time of scheduling my appointment for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within 90 days after I receive a statement. If I am an uninsured patient, I authorize payment at time of service. I agree to update all C.C. account information.

Patient/ Guardian Name	Patient/ Guardian Signature	Date

Patient Name: Date:

HIPAA NOTICE of PRIVAY PRACTICES

YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.

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.

Danny Benmoshe, M.D., Inc.
2001 SANTA MONICA BLVD.
Ste. 880 W.; SANTA MONICA, CA 90404
Privacy Officer: Samantha Kern Samantha@DrBenmoshe.com TEL: (310) 688-8800 FAX: (888) 971-3594

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
    - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
    - We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes • Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures: How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.

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Run our organization

• We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services

• We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

• We can share health information about you for certain situations such as:
  • Preventing disease
  • Helping with product recalls
  • Reporting adverse reactions to medications
  • Reporting suspected abuse, neglect, or domestic violence
  • Preventing or reducing a serious threat to anyone's health or safety

Do research

• We can use or share your information for health research.

Comply with the law

• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

• We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

• We can use or share health information about you:
  • For workers' compensation claims
  • For law enforcement purposes or with a law enforcement official
  • With health oversight agencies for activities authorized by law
  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

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Our Responsibilities:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of This Notice: *May 18, 2020*

This Notice of Privacy Practices applies to the following organization: *Danny Benmoshe, MD, Inc.*

Privacy Officer:
Samantha Kern
TEL: (310) 688-8800
FAX: (888) 971-3594
Samantha@DrBenmoshe.com

By signing, I acknowledge I have read the above Notice of Privacy Practices.

_____	_____	_____
Patient/ Guardian Name	**Patient/ Guardian Signature**	**Date**