Selena Ellis, M.D.

Board Certified Neurologist

Name_____ Sex: M ( ) F ( ) Transgender ( ) Date of Birth: _____ Age: _____

Address_____

Street Apt# City State Zip

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Permission to leave medical-related messages on following voicemails: ( ) Home ( ) Cell ( )Work

Permission to send SMS/Text messages to the Cell Phone number listed above? ( ) Yes ( ) No

E-mail Address: _____

Soc. Security Number _____ Occupation: _____

Employer_____

Ethnicity – please circle one: Hispanic or Latino Not Hispanic or Latino

Primary Language: _____

Race: Please circle one: American Indian or Alaska Native | African American / Black | Asian | Native Hawaiian | Pacific Islander | White | Other: _____

Primary Care Physician: _____ Phone Number: _____

Who referred you to this office? _____

In case of emergency, please notify: _____ _____ _____

Name **Relation to patient** **Phone#**

Primary Insurance _____ Member ID Number: _____

Group Number: _____ **Primary Subscriber's Name:** _____

Primary Subscriber's DOB: _____ **Relationship to You**: _____

Secondary Insurance _____ Member ID Number: _____

Group Number: _____ **Primary Subscriber**: _____

Primary Subscriber's DOB: _____ SSN: _____

Are your symptoms the result of an injury? Yes_____ No_____ If yes, date of injury_____

If yes, is this an auto injury? _____ Yes _____No If yes, is this a work-related injury? Yes _____ No _____

This time is reserved exclusively for you. Forty-eight hour notice of cancellation/change is required for all patient consultations and established follow-up appointments. If you fail to notify us of any change/cancellation of your appointment within the above time limits you will be charged a $100 fee as we will not have time to fill your appointment space.

I authorize assignment of insurance benefits directly to Selena W. Ellis, M.D.
I authorize release of any medical records or information necessary to process insurance claims.

_____ _____

Signature of patient or legal guardian Date

Patient Name _____ **Date** _____ **New Patient?** Yes / No **Age** _____

Do you live alone? Yes ( ) No ( ) PCP: _____ **Do you have children?** _____ **If so, how many?** _____

Occupation _____ **Tobacco ( ) How much?** _____ **Alcohol ( ) How much?** _____

What pharmacy do you use? Name: _____ **Street & City:** ____ _____

Height: _____ ***Weight:*** _____

Please List Any Medical Illness (such as Diabetes, High Blood Pressure (Hypertension), High Cholesterol, Epilepsy, etc.)

Please List Any Significant Surgeries (include dates):

Current Medications or Supplements:

Name	Dose	Frequency

Describe Any Allergies to Medications:

Medication	Reaction

Family History of any Medical Illnesses (Especially Neurological)

Check All that Apply to You:	***Yes***	***No***		***Yes***	***No***
Weight Loss or Gain			Urinary Problems		
Night Sweats			Skin Rash		
Fevers			Food Allergies		
Difficulty Breathing			Pain		
Trouble Sleeping			Headaches		
Unusual behavior during sleep			Seizures		
Feelings of sadness/depression			Dizziness, Spinning, Vertigo		
Anxiety			Tremors/Shaking		
Involuntary Movements			Difficulty Speaking or word finding		
Hallucinations			Difficulty Swallowing		
Changes in personality or behavior			Clumsiness/Difficulty Walking		
Changes in sense of direction			Loss of Vision		
Chest Pain			Double Vision		
Palpitations			Memory Loss		
Leg Edema			Weakness		
Constipation			Tingling/Numbness		
Diarrhea			Nausea/Vomiting		
Poor Appetite			Hearing Loss or Ringing in the Ears		
Fatigue			Loss of Consciousness		

NOTICE OF PRIVACY PRACTICE – SELENA W. ELLIS, M.D.
3000 Colby Street, Suite 302, Berkeley, CA 94705

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

The law permits us to use or disclose your health information to those involved in your treatment. An example of this would be a specialist doctor who we involve in your care. We may also use or disclose your health information for payment of services. For example, we may send a report of medical progress to an insurance company. We may use or disclose your healthcare information for our normal office operations. For example, one of our staff will enter your information into our computer system. We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy. We may also use your information to contact you. We may want to contact you to confirm appointments. If you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency we may disclose your health information to a family member or another person responsible for your care. We may release some or all of your health information when required by law. If this practice is sold, your information will become the property of the new owner. Except as described above, this practice will not use or disclose your healthcare information without your prior written authorization. You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your healthcare information beyond the above normal uses. As we will need to contact you from time to time, we will use whatever address or telephone number you indicate. You have the right to transfer copies of your health information to another practice, and we will assist with this transfer. You have the right to receive a copy of your health information with a few exceptions. Give us a written request regarding the information you want to see. If you also want a copy of your records we may charge you a reasonable fee for the copies.

You have the right to request an amendment or change to your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment, we will not remove or alter earlier documents, but will add new information.

You have a right to receive a copy of this notice. If we change any of the details of this notice, we will notify you of the changes in writing. You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, D.C. 20201. You will not be retaliated against for filing a complaint. However, before filing a complaint, or for more information or assistance regarding your health information privacy, please contact our privacy officer, Selena Ellis, M.D. at 510-644-2282. This notice goes into effect April 1, 2008.

ACKNOWLEDGEMENT

I have received a copy of the Selena W. Ellis, M.D. Notice of Privacy Practices.

_____	_____	_____
Name	Signature	Date

DESIGNATION of FAMILY MEMBERS, CAREGIVERS or OTHER SIGNIFICANT PARTIES:

I designate the following person/s listed to receive information about my health care in a limited fashion and only as relevant to their involvement with my healthcare or payment relating to my healthcare. (I understand that I am not required to list anyone, and that I may change this list at any time in writing).

Print Name_____ Last 4 digits of his/her SSN:_____

Print Name_____ Last 4 digits of his/her SSN:_____

_____	_____
Signature	Date

Selena Ellis, M.D.

Diplomate American Board of Psychiatry and Neurology
Diplomate American Board of Electrodiagnostic Medicine

FINANCIAL POLICIES

We realize medical bills involving health insurance can be very complicated. Our goal is to help you become aware of your responsibilities as an insured member. Our billing department can be reached at (510) 644-2282 if you have any questions regarding this.

Please bring your insurance card to the office for every visit.
You must bring your insurance card and a valid ID on your first visit, and your new insurance cards if at any time your insurance coverage changes. When you book your initial exam our office staff can confirm that we are contracted with your insurance carrier. It is ultimately the patient's responsibility to confirm directly with their insurance company that we are contracted providers before being seen. A customer service representative at your insurance company can confirm that information for you with the following:

Dr. Ellis' NPI: 1265412993

We strongly recommend that you get a reference or tracking number for all calls to your insurance company.

Your Copay is due at the time of service.
If you do not bring a method of payment for your copay at the time of your visit, **we will add a $20.00 billing fee on top of your copay amount.**

If you have no insurance, or if we are not able to verify your insurance eligibility, we ask that you pay for the visit at the time of service.
If we do not have verification that you are covered by an insurance plan, you will be expected to pay the charges in full at the time of visit. If we receive a payment from your insurance company, we will promptly refund any credit on your account.

Third-party insurance companies
We do not accept auto insurance. If you have been injured in an auto accident, you must inform the front office staff when you check in. We require payment in full at the time of service. We will provide a claim form to assist you in seeking reimbursement from your auto insurance provider.

Cancellations
Please provide a minimum **48 business hours'** notice for appointment cancellations. There is a **$100** fee for all missed appointments and appointments cancelled with less than **48-hour notice**. Please be aware that if you miss two or more visits, you will be discharged from our practice.

I have read and understand the above noted policies

Patient or Guardian_____ **Date** _____

Selena Ellis, M.D.
Diplomate American Board of Psychiatry and Neurology
Diplomate American Board of Electrodiagnostic Medicine

Notice of Open Payments Database

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at:

https://openpaymentsdata.cms.gov

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_____	_____	_____
Name	Signature	Date