Welcome to Our Medical Office

We Value the Opportunity to Serve You

Instructions: If you do not see your name below, please type in your FIRST NAME by double clicking in the highlighted area. Press "Tab" and enter your LAST NAME and press "Tab" again. The Entire document will then populate with your name.

Dear FIRST NAME LAST NAME,

By joining our medical office as a patient, you are entering into a **Doctor-Patient Relationship**. This relationship is one of the most important agreements you will create with a healthcare provider. A healthy **Doctor-Patient Relationship** is essential to deliver ongoing and effective care. Maintenance of such a relationship requires a commitment not only from the physician and office staff, but also from you, the patient. As healthcare providers, our office team is dedicated to giving you the finest care that we believe can bring you the best treatment results. In return, we ask our patients to **Show a Strong Sense of Responsibility** for their own health and well-being.

To maintain our high standards and avoid any misunderstanding, we would like to communicate our policies to you. Please take your time reading this agreement. It's important that you understand what we expect from you and, also, what you may expect from us. We appreciate your time and cooperation.

Our Goal:
To provide you with Highest Quality Care and make our interactions a pleasant experience

Our Belief:
People who value their health do whatever it takes to get the care they deserve

Our Vision:
Achieving a high level of Patient Satisfaction by providing Access to Quality Care

Our Team:
Physicians, our staff, you…and each of our patients

The office staff is dedicated to helping you. We invite you to give us your feedback about your interactions with staff and your overall experience with our office. You may speak directly or write to your physician or email us at **Feedback@LAintegrativeGI.com**

Welcome to our office. We look forward to sharing a positive healthcare experience with you!

~ Farshid Sam Rahbar, M.D., FACP, ABIHM & Staff

To-Do List… Check-in List for Patients

Dear Patient,

Please make sure that you have reviewed and completed the following items prior to giving it back to our front staff. Thank you.

1. **Complete Registration Form**.
    - Use a computer to fill in the form, then print.
    - Or, print first and fill out the form. Please write legibly.
    - Use CAPITAL LETTERS.

2. **For Date**: Enter the date of Your Appointment.

3. **Review and Sign** the Office Policies and Arbitration Agreements.

4. **Review and Complete** the "**MEDICAL HISTORY**" Page:
    - Specify main reason for the visit
    - Specify any Allergies
    - Specify any medical conditions and surgeries in the past
    - Specify any symptoms associated with different body parts
    - Specify Family history and Social history

5. **Specify the medications** you are taking including prescribed and over the counter.

6. **Bring your latest labs**, and any medical records available to you.

7. You may **FAX your completed forms to 310-553-5590.**

8. Include a copy of your **insurance card**, if applicable.

9. **PLEASE turn off your Cell Phone** when your medical evaluation starts, or let your doctor know if you are expecting an urgent call.

10. **Bring all original signed forms to your visit.**

Thank you,

~ Farshid Sam Rahbar, M.D., FACP, ABIHM & Staff

PATIENT REGISTRATION

Last Name (USE CAPS LOCK)	First Name	MI
LAST NAME	FIRST NAME	

Address:	Apt:	City, State, Country	ZIP

Sex	Birth Date:	SSN:	Marital Status		Driver's License
			☐ Single ☐ Widow(er)	☐ Married ☐ Divorced	

GUARANTOR'S INFO
Complete if Patient is a Minor or a Dependant

Last Name	First Name	MI

Billing Address: If Different than Patient Address, Complete Third Party Billing Below

Relation to Patient (please check) ☐ Parent ☐ Relative ☐ Legal Guardian ☐ Other

Insurance Company (Primary)		Insurance Company (Secondary)	
Name:	**Subscribers DOB**:	Name:	**Subscribers DOB**:
Insurance Company Address		Insurance Company Address	
Member Policy Number	Group Number	Member Policy Number	Group Number
Subscriber Name (if NOT Patient)	**Relat. To Subscriber**	Subscriber Name (if Not patient)	Relat. To Subscriber

THIRD PARTY BILLING: Special Circumstances Only

Third Party Name & Contact Phone:

Address:		City:		State:		Country:	

Please Check: WHAT IS THE BEST WAY TO REACH YOU? Mobile ☐ Home Phone ☐ Work Phone ☐ Fax ☐ Email ☐

CONTACT INFORMATION – REQUIRED

Home Phone:	**( ) -**	**Work Phone:**	**( ) -**	**Pager**:	**( ) -**
Cell Phone:	**( ) -**	**Fax**:	**( ) -**	**E-mail**:	

Name of Referring or Primary Care Physician

Name:	Telephone **( ) -**

EMERGENCY CONTACT INFORMATION - REQUIRED

Name:		Tel:	**( ) -**	Tel:	**( ) -**	Relationship:	
Name:		Tel:	**( ) -**	Tel:	**( ) -**	Relationship:	

Patient or Guarantor Name x_____

Patient or Guarantor Signature x_____ Date: x _____

If a Minor, who is the Legal Guardian? x_____ Date: x _____

[A Parent must be Legal Guardian. However, a Legal Guardian may not be Parent]

OFFICE POLICIES AND AGREEMENT

This Agreement is Between: **FIRST NAME LAST NAME**
And **Los Angeles Integrative Gastroenterology & Nutrition, Inc.**

Notice of Privacy Practices & Supplement Policies

- By signing this agreement, you acknowledge that you have been presented with Los Angeles Integrative Gastroenterology & Nutrition, Inc.'s Notice of Privacy Practices and Supplement Policies, which are both attached with this Agreement (also posted in the reception area/website).

How We May Communicate with You

- We may contact you regarding appointments, test results and other matters related to your health care, at any of the addresses, fax, and/or telephone numbers that you have provided on the Registration Form.
- You hereby agree to notify us of any change of address or other contact information as soon as possible.
- We may also communicate with you through Patient Portal. A valid email is required for Patient Portal. You agree to log in to Patient Portal upon receiving an email notification from our office.

How You May Communicate with Our Office

- You may communicate with us by telephone, fax, mail, or Patient Portal.
- Email should not be used for matters that require professional opinion.
- Please do not use email, fax, mail or Patient Portal for urgent inquiries.
- Patient Portal use requires review and signature of additional documents: "Online Communication Rules of Engagement" and "Patient Portal Terms and Conditions".
- The nature and extent of an inquiry, may prompt us to recommend a dedicated office or telephone consultation time for an interactive response.
- Our intention is to respond to every inquiry in a timely manner. If you have sent a message and have not received a response in a time frame that you were expecting, you may page the physician after hours.

Policy for Communicating Test Results to You

- As a patient, I agree to actively participate and communicate with this office to obtain my test results. We encourage this policy to ensure that we have indeed received your test results.
- After review, your doctor may recommend an "office visit" or a "phone visit" to review results and plans with you.
- If we receive abnormal test results ordered by another physician, we believe that the ordering physician should counsel you directly about those results. However, you may request additional consultation from Los Angeles Integrative Gastroenterology & Nutrition, Inc.'s physician by scheduling an office visit.

Responsibilities as a Patient

- Ask questions when you don't understand any part of your medical care.
- Cooperate with the planned treatment program or explain why cooperation is not possible.
- Communicate to us any special needs you may have, or if you need anything while waiting in reception area.
- Keep scheduled appointments or call to cancel on time (see cancellation policy).
- Update personal and insurance information whenever there is a change.
- Update your doctor regarding any new medical conditions and complete medication and supplement list with each visit.

Proof of Identity

- Patients are required to provide proof of identity (e.g., driver's license, passport, etc.).
- I consent to having my picture taken for office records.

No Show & Cancellation Policy

- Please call our office 24 hours prior to a scheduled appointment if you need to change or cancel it.
- For Monday appointments, our office should be notified of any changes or cancellations no later than Friday at noon.
- We reserve the right to charge a $100 fee if you miss your appointment or do not cancel it in a timely fashion, and a $200 fee for a missed procedure such as an Endoscopy or Colonoscopy.
- In addition to the fee required, recurrent no show or late cancellation, may result in our request for patient to review and re-sign the office policies and agreements.
- If you need to cancel your outpatient procedure/surgery with less than 24 hours for a good reason, please contact our office immediately through the urgent line and PAGE the doctor. We will notify the Facility and Anesthesia service.

Waiting Room Etiquette

- Please arrive on time and inform our staff of your arrival.
- If you arrive late, we may ask you to reschedule.
- While we strive to see every patient at the time of his/her appointment, emergencies and other circumstances beyond our control may delay your appointment. The office staff will do their best to estimate your appointment time given these circumstances.
- Please be understanding when your appointment is delayed — allow flexibility in your schedule.
- If you are unable to wait, please notify the scheduler to find you a prompt appointment acceptable to you.
- Maintain confidentiality and privacy of other patients and healthcare providers.
- Please be courteous to our staff and other patients.

Medication Renewal

- As a patient, I understand that my medication renewal is subject to my physician's periodic review of my health status to assess need and to monitor therapy.
- As a patient, I must maintain my status as an "active" patient by visiting the physician at least once a year in order to be eligible for any prescription(s) renewal.
- The physician may require evaluating you in the office prior to authorizing a prescription renewal.
- As a patient, I agree to promptly make a follow up office visit when I am notified of this requirement.

Doctor-Patient Relationship

- The patient or the doctor can terminate this agreement without providing an explanation.
- If you choose to terminate this agreement, please send us a letter stating that you no longer wish to be a patient. If you send us a termination letter, we will honor your courtesy by giving you a digital copy of your medical records without charge.
- If the doctor decides to terminate this Agreement, he/she will provide you with at least 15 days advance notice and the final date that he/she will be available for you.
- Upon receiving a termination letter, you should act promptly to find another doctor.
- "Support and Convenience Programs" renewal is based on availability and we reserve the right to decline renewal.

Release of Medical Information to and by Los Angeles Integrative Gastroenterology & Nutrition

- I hereby authorize any prior or present treating physician, hospital or other health institution, to release all of my medical information for the purpose of treatment, payment and healthcare operations, by any means of communication, to Los Angeles Integrative Gastroenterology & Nutrition, Inc., and authorize Los Angeles Integrative Gastroenterology & Nutrition, Inc. to use and disclose my protected health information to carry out treatment, payment, and healthcare operations.

Treatment Authorization

- I hereby authorize the physician and/or assistant at Los Angeles Integrative Gastroenterology & Nutrition, Inc. to administer such treatment and medication as may be deemed necessary or advisable in the treatment and diagnosis of my condition. I give this authorization voluntarily and I hereby acknowledge that no guarantees have been made to me as to the results of treatments and examinations.
- If the patient is a minor or legally incapacitated, the PARENT and/or Legal Guardian agrees that he/she has the legal authority to authorize Los Angeles Integrative Gastroenterology & Nutrition, Inc. to evaluate and treat the patient.

Copying Policy

- Request for records must be in writing.
- You can request a copy of your entire file or part of your records on a CD for a flat fee of $25, plus postage (priority mail or similar). Preparing a paper copy may cost more.
- There is no fee for a one time copying of pertinent records being sent to another physician upon written request.
- If you made your request in writing for the records to be sent to you directly, we have 15 days to provide copies to you according to CA Medical Board.
- If you need your results for any purpose, you agree to access and print results through your Patient Portal, and contact us for access issues or reports not posted.

Patient/Guarantor Signature: _____ **Date: _____**

Policy for Patients Less than 18 Years of Age

- Proof of identity of the child should be provided at the time of first visit (school ID, birth certificate, etcetera).
- Child must be accompanied by a parent or guardian during each visit and for all tests and procedures performed in or out of the office.
- If the parent is the subscriber to insurance and is requesting that our office submit insurance claims, then the subscriber must also provide proof of identity.

Pregnancy and Medications

- Proof of identity of the child should be provided at the time of first visit (school ID, birth certificate, etcetera).
- Child must be accompanied by a parent or guardian during each visit and for all tests and procedures performed in or out of the office.
- If the parent is the subscriber to insurance and is requesting that our office submit insurance claims, then the subscriber must also provide proof of identity.

Fees for Additional Services ("Personal Services", Generally not Covered by Insurance)

- Telephone visits: pre-arranged just like any other appointment. May be requested by patient, but requires physician's approval. Fee will be based on elapsed time (generally, in ten minute increments), or may be set prior to the visit. Secure payment in advance is required. Ask for details when you are ready to schedule a telephone visit.
- Report preparation: payment is due when the report is ready. Advance payment or a method of payment guarantee is required. Examples of reports:
    - School, Immigration, Airlines, Health Clubs.
    - Life & Health Insurance, Disability Reports, Medical-Legal.
    - Exemption from Jury Duty (when there is a medical reason).
- Obtaining prior authorization for specific test or treatment: You may request this when there are circumstances that require additional information to be provided to your insurance carrier to obtain an authorization. An example is entering an appeal process for a denied test or treatment. The physician will charge a fee based on the amount of time that is required to support your case.

Elements of Costs Associated with Procedures & Services

- Physician's fee, anesthesia fee, facility fee, pathology fee, fee for personal services.
- Imaging services (professional fee for doctor who interprets the results plus technical/or facility fee).
- Other testing fees: lab fee, an interpretation fee, draw fee and processing fee may also apply.

Lab Testing

- Insurers and Medicare may regard several of our testing models as "investigational", "not medically necessary", "not validated" or "not US based" and outside the range of their usual disease treatment coverage.

Must Read

- As part of being a patient of this practice, I acknowledge that I have reviewed the "MUST READ" section of the website www.LAintegrativeGI.com, or plan to promptly do so within 5 days of signing this agreement.

Disclosure, Disclaimers and Consents

- I acknowledge that I have been presented with Disclosures and Disclaimers and Consents related to Los Angeles Integrative Gastroenterology & Nutrition, Inc. These are posted on our website www.LAintegrativeGI.com, or available as hard copy upon request.

Changes and Updates to Practice Agreement

- Periodically, we make changes or updates to this practice agreement.
- We may send notifications of changes or updates by mail, email, or Patient Portal.
- Any change or update shall become effective after it is posted. If a change or update relates to the functionality of a new service or a change in the law, the change will be effective immediately. Your continued use of our practice services, following any effective change and/ or update, indicates your agreement to the change(s) and/or update(s).

Los Angeles Integrative Gastroenterology & Nutrition, Inc. and Insurance Companies

- Los Angeles Integrative Gastroenterology & Nutrition, Inc. has no agreement with any health insurance, including PPO, POS, HMO, EPO, IPA, Medicare, Medicaid, Medi-Cal, or any government program. All patients are required to pay directly at the time of service(s).
- For some services (e.g. Endoscopy & Colonoscopy), Los Angeles Integrative Gastroenterology & Nutrition, Inc. may agree to bill your insurance.
- When applicable, we will provide you with advanced payment options after the doctor determines the services you need & we understand your insurance benefits.

Grievance Procedure - Making a Complaint

- Your satisfaction is very important to us. As such, we have set a protocol to address areas of patient dissatisfaction. To address an issue, we require that you write to us and let us know what caused your dissatisfaction, what you believe should have been done for you, and how you wish to resolve the issue. You may email us at Feedback@LAintegrativeGI.com, or use other methods of communication.

Reputation

- Whereas we appreciate a positive feedback from our patients on online or other media, due to HIPAA privacy regulations, we cannot enter an interactive discussion with a patient in a cyberspace or public zone concerning their private health information. If there are areas of dissatisfaction that you wish to express, we require that you communicate with us using the grievance procedure shown above.

Confidentiality

- Patient agrees that neither patient nor patient's family members will directly or indirectly, without prior written consent, divulge, disclose or communicate information concerning matters affecting or relating to the medical care provided by doctor to patient to any person or entity not involved in treatment, payment, or healthcare operations at any time. Of course, feedback and patient referrals are always appreciated and valued by the doctor.

Financial Obligations and Assignment of Benefits

- As a patient, I agree to pay for all medical services, insurance deductibles, co-payments, co-insurance or any prior unpaid balance before or at the time of service.
- I understand that I am financially responsible for all the charges whether or not they are paid by insurance.
- I agree to pay any balance upon receipt of my first statement.
- I understand that Los Angeles Integrative Gastroenterology & Nutrition, Inc. requires advance payment for certain in-office or outpatient services.
- I understand, I am required to be familiar with my insurance coverage and its policies and know my copay, coinsurance, deductible, total out of pocket expense, effective date of coverage, any pre-existing conditions, and whether I am receiving service from a contracted or out-of-network physician or other healthcare provider /facility.
- I hereby authorize my insurance company to pay Los Angeles Integrative Gastroenterology & Nutrition, Inc. directly. I also authorize Los Angeles Integrative Gastroenterology & Nutrition, Inc. to submit appeals to my insurance company on my behalf.
- If I have an open balance, LA Integrative Gastroenterology & Nutrition, Inc. has the option to charge my credit card on file.
- If I have an open balance and I receive a check from my insurance, I agree to immediately endorse the back of the check to: "Los Angeles Integrative Gastroenterology & Nutrition, Inc." and send the check to 2080 Century Park East, Suite 1804, Los Angeles, CA 90067-2001.
- I hereby authorize the release of all necessary information to secure the payment of benefits.
- If for any reason any portion of the bill is not paid by my insurance within 30 days the claim was submitted, I agree to contact my insurance company and make arrangements for prompt payment. We may also transfer the entire balance to you directly.
- If the account becomes delinquent, we reserve the right to request a retainer fee and/or re-signing of the office agreements prior to granting additional services.
- For returned checks, we will apply an additional fee of $ 25.
- Late fee of 10% and other charges may apply if payments are not received in 60 days from first billing.
- A copy of this Agreement is deemed as valid as the original.
- If I am not enrolled in Support & Convenience Programs, I agree to pay for every charge associated with post-visit services.
- Payments for Support & Convenience Programs is not refundable and renewal is subject to availability and approval.

I have reviewed above Policies & Agreement and hereby agree to comply with Los Angeles Integrative Gastroenterology & Nutrition, Inc.'s Policies. THIS AGREEMENT BECOMES EFFECTIVE UPON FIRST VISIT WITH THE DOCTOR, NOT PRIOR.

MEDICAL HISTORY

Patient Name: **LAST NAME**, **FIRST NAME** Age: Date:
Please circle any that apply.

IDENTIFY THE MAIN REASON FOR THE VISIT

EXAMPLES: **A**bnormal Labs, Abnormal X-Ray, **C**heck-Up, **D**rug Monitoring/Therapeutic Monitoring, **F**ollow-Up of Previously Identified Problems, **G**eneral Follow-Up,

Digestive Symptoms – (**A**bdominal Pain, Acidic Stomach Altered Bowl Habits, **B**loating/Gas, **C**onstipation, **D**ark Urine, Diarrhea, Difficulty Swallowing, **F**eeding Difficulties, Food Intolerance, **H**eartburn, "**I**ndigestion", Irregular Bowl Movements, **L**ack of Appetite, **N**ausea/ Vomiting, Need for Laxatives, **R**ectal Bleeding, **W**eight Loss/Weight Gain)

Non-Digestive Symptoms – (Back Pain, Chest Pain, Extremity and Joint Pain, Headache, Influenza, Respiratory Symptoms, Other)

Comments:

ANY ALLERGIES OR SIDE-EFFECTS OF MEDICATIONS OR ANESTHESIA?

Latex Allergy?: YES / NO **Aspirin Use**: YES / NO

PAST MEDICAL HISTORY: - **A**cid Reflux, Asthma, **B**leeding Problems, Blood Transfusions, **C**ancer, Convulsions, Crohns/ Colitis, **D**epression, Diverticulitis, Diabetes Mellitus, **E**pilepsy, **G**out, **H**igh Blood Pressure, Heart Attack, Heart Disease, Hemorrhoids, Hepatitis, **I**BS, **J**aundice, **K**idney Stones, Kidney/Bladder Infections, **L**iver Disease, Nervous Breakdown-Requiring Formal Psychiatric Evaluation, **P**eptic Ulcer Disease, **S**eizure Disorder, Sleep Disorder/ Apnea, Stroke, **T**hyroid disease, **T**B,
Comments:

PAST SURGICAL HISTORY: – **A**bdominal, Appendix, **B**reast, **C**ancer, Cosmetic, **F**oot, **G**allbladder, **H**eart, Hemorrhoids, Hernia, Hysterectomy, **P**olyp Removal, **R**emoval of Ovaries, **S**kin, **T**onsillectomy, **U**lcer, **V**aricose Veins, **GI: C**apsule Endoscopy, Colonoscopy, **E**ndoscopy, Endoscopic Ultrasound, ERCP, **L**iver Biopsy, Other:

FAMILY HISTORY: - Cancer, Diabetes, Heart Disease, High Blood Pressure, Ulcer

SOCIAL HISTORY: – Single, Married, Widowed, Divorced **Number of Children:** ____
Smoking History: Y. N. # of Yrs? ____Per Day? ____ Alcohol Consumption: Y. N. ___day, wk, mo
# of Yrs?____ Recreational Drug Use: Y.N. Coffee/Tea: Y. N ___ day, wk, mo, yr

General Tire Easily/Weakness Night Sweats Persistent Fever **Skin** Eruptions (Rash) Change in Color Change in Hair Change in Nail	**Eyes** Trouble Seeing Eye Pain Inflamed Eyes Double Vision **Ears** Loss of Hearing Ringing in the Ears Discharge	**Nose** Loss of Smell Frequent Colds Obstruction Excess Discharge Nosebleeds **Mouth** Sore Gums Soreness of Tongue Dental Problems	**Throat** Postnasal Drainage Soreness Hoarseness **Breasts** Lumps Discharge

Obtained by: _____ **Reviewed by Physician:** _____

PLEASE CIRCLE ANY THAT APPLY

Cardio Respiratory Systems
- Cough Persisting
- Sputum (Phlegm)
- Bloody Sputum
- Wheezing
- Chest Pain or Discomfort
- Pain on Breathing
- Shortness of Breath
- Difficulty Breathing While Lying Down
- Swelling of Ankles
- Bluish Fingers or Lips
- High Blood Pressure
- Palpitations

Gentourinary System
- Increase in Frequency of Urination Day/Night
- Feel Need to Urinate Without Much Urine
- Unable to Hold Urine
- Pain or Burning
- Blood in Urine
- Impotence
- Lack of Sex Drive
- Pain with Intercourse

Endocrine
- Thyroid Trouble
- Adrenal Trouble
- Cortisone Treatment
- Diabetes

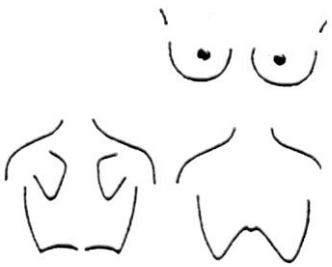
Locomotor
- Muscle Cramps
- Muscle Weakness
- Pain in Joints
- Swollen Joints
- Stiffness
- Deformity of Joints

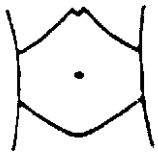
Nervous System
- Anxiety
- Headaches
- Dizziness
- Fainting
- Convulsions or Seizures
- Nervousness
- Sleeplessness
- Depression
- Change in Sensation
- Memory Loss
- Poor Coordination
- Weakness or Paralysis

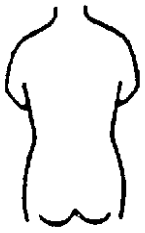
FOR PHYSICIAN USE ONLY

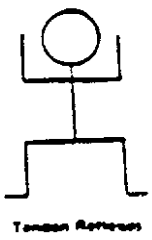
Patient Name:			Primary Physician:			
Date:	Ht:	Wt:	BP:	T:	P:	R:

	NL	ABN			NL	ABN	
Skin	☐	☐		Heart Rate	☐	☐	**Sight**
Character	☐	☐		Rhythm	☐	☐	**R Eye:** **L Eye:**
Pigmentation	☐	☐		L.V.	☐	☐	
Hair	☐	☐		R.V.	☐	☐	
Lesions	☐	☐		P.A. Pulsation	☐	☐	
Skull	☐	☐		Thrill	☐	☐	
Irregularities	☐	☐		Rub	☐	☐	
Tenderness	☐	☐		Sounds	☐	☐	
Eyes	☐	☐		Murmurs	☐	☐	
Lids	☐	☐		Svs. Ejection	☐	☐	
Conjuctives	☐	☐		Pan. Systolic	☐	☐	
Sclera	☐	☐		Dias. Imm.	☐	☐	
Corners	☐	☐		Dias. Delayed	☐	☐	
Medis	☐	☐		Abdomen	☐	☐	
Lens	☐	☐		Enlargement	☐	☐	
Discs	☐	☐		Scars	☐	☐	
Retinee	☐	☐		Tenderness	☐	☐	
Pupils	☐	☐		Rigidity	☐	☐	
Reactions	☐	☐		Masses	☐	☐	
EOM	☐	☐		Liver	☐	☐	
Exophthalmos	☐	☐		Kidney	☐	☐	
Fields	☐	☐		Spleen	☐	☐	
Av Radio	☐	☐		Hernia	☐	☐	
Ears	☐	☐		Bowel Sounds	☐	☐	
Canals	☐	☐		Rectal	☐	☐	
T.M.	☐	☐		Hemorrhoids	☐	☐	
Hearing	☐	☐		Masses	☐	☐	
Nose	☐	☐		Tenderness	☐	☐	
Septum	☐	☐		Stool O.B.	☐	☐	
Obstruction	☐	☐		Genital (cross out one)	☐	☐	
Discharge	☐	☐		Female Male	☐	☐	
Mouth	☐	☐		Vulva Penis	☐	☐	
Teeth	☐	☐		Vagina	☐	☐	
Tongue	☐	☐		Scrotum	☐	☐	
Mucous	☐	☐		Cervix Testee	☐	☐	
Palate	☐	☐		Corpus	☐	☐	
Tonsils	☐	☐		Prostate	☐	☐	
Pharynx	☐	☐		Adnexes	☐	☐	
Neck	☐	☐		Back	☐	☐	
JVP Pressure	☐	☐		Posture	☐	☐	
Character	☐	☐		Deformities	☐	☐	
Carotid Pulse	☐	☐		Spine Tenderness	☐	☐	
Rise Time	☐	☐		CVA Tenderness	☐	☐	
Volume	☐	☐		Motion	☐	☐	
Stiffness	☐	☐		Presacral Edema	☐	☐	
Thyroid	☐	☐		Extremities	☐	☐	
Trachea	☐	☐		Deformities	☐	☐	
Lymph Notes	☐	☐		Cyanosis	☐	☐	
Supraclavicular	☐	☐		Skin	☐	☐	
Cervical	☐	☐		Edema	☐	☐	
Axillary	☐	☐		Varicosities	☐	☐	
Inguinal	☐	☐		Joints	☐	☐	
Femoral	☐	☐		Neurological	☐	☐	
Breasts	☐	☐		Cranial Nerves	☐	☐	
Development	☐	☐		Sensation	☐	☐	
Scars	☐	☐		Balance	☐	☐	
Discharge	☐	☐		Gait	☐	☐	
Masses	☐	☐		Strength/Tone	☐	☐	
Thorax & Lungs	☐	☐		Movements	☐	☐	
Contour	☐	☐		Coordination	☐	☐	
Expansion	☐	☐		Speech	☐	☐	
Tactical Fremitus	☐	☐		Toe Signs	☐	☐	
Resonances	☐	☐		Mental Status	☐	☐	
Breath Sounds	☐	☐		Orientation	☐	☐	
Raise	☐	☐		Intellect	☐	☐	
Wheezes or Rubs				Affect			









ALL CURRENT MEDICATIONS AND SUPPLEMENTS

PATIENT NAME: ____

PRIMARY PHYSICIAN: ____________________________ **DATE:** _______________________

ALLERGIES: ____

PHARMACY: ____________________________________ **PHONE:** ______________________

Meds / Supplements	Dosage	Frequency	Start Date	Comments

NOTICE OF PRIVACY

This notice describes how health information about you may be used and disclosed, and how you can get access to this information. This notice is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We reserve the right to make changes to our Privacy Notice. The terms of our New Notice of Privacy Practices will then be effective for all health information that we maintain including health information we created or received before we made the changes.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). We are required by law to maintain the confidentiality of your health information and we must provide you with the following important explanations regarding Treatment, Payment and Healthcare Operations (TPO). We may use or disclose your health information for treatment (such as use or disclosure to your physicians, your pharmacists, or your other healthcare providers), for payment (such as use or disclosure to your insurance carrier or any person responsible for payment for your healthcare), and for healthcare operations (such as our transcription, billing, and copying services). In addition, the following special circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Patient Name: LAST NAME, FIRST NAME
Patient/Guarantor Signature: _____ Date: _____

NOTICE OF PRIVACY (CONT.)

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests. Your request must be in writing.

2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. We are not required to agree to your request for restriction of use or disclosure; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. We may disclose your health information to a family member or another part involved with your healthcare, although we will only disclose health information in our professional judgment is relevant to the person's involvement in your car. You have the right to restrict disclose of your health information to such family members or responsible parties. Your request must be in writing. We will follow you rest unless there is an emergency circumstance or if otherwise required by law.

4. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Farshid Rahbar, MD at 2080 Century Park East, Suite 1804, Los Angeles, CA 90067, Tel: 310-289-8000, Fax: 310-553-5590.

5. You may ask us to amend your health information if you believe it is incorrect or incomplete. You must provide us with a reason that supports your request. Your request must be in writing and submitted to Farshid Rahbar, MD, 2080 Century Park East, Suite 1804, Los Angeles, CA 90067, Tel: 310-289-8000, Fax: 310-553-5590. We may deny your request under certain circumstances.

6. You are entitled to receive a copy of our Notice of Privacy Practices at any time. To obtain a copy of this notice, contact our front desk receptionist.

7. You have the right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Farshid Rahbar MD at 2080 Century Park East, Suite 1804, Los Angeles, CA 90067, Tel: 310-289-8000, Fax: 310-553-5590 All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. You have the right to provide authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures of your health information that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Farshid Rahbar MD at 2080 Century Park East, Suite 1804, Los Angeles, CA 90067, Tel: 310-289-8000, Fax: 310-553-5590.

Patient Name: LAST NAME, FIRST NAME
Patient/Guarantor Signature: _____ Date: _____

SUPPLEMENTS POLICIES

Please review the following information prior to requesting a supplement or product:

Who Can Buy:
We only sell supplements to patients who have an established medical record with our office. All other interested individuals, please contact us at **Kimialogic@LAIntegrativeGI.com.**

Choice of Supplements:
To reduce the confusion about nutraceutical supplements, we have created a directory of our hand-selected supplements. Even though we recommend our selected supplements, patients ultimately have their own choice to make.

Product Purity:
Most of our products are free from allergens derived from gluten, yeast, and artificial colors and flavors. Patients, however, should read each product description, ingredients, and the suggested use to make sure that they are not allergic or intolerant of any of the contents. Many of our products are made to be acceptable to vegetarians.

What You Should Do Before Taking Supplements:
- Read the product label. We also sincerely recommend that every patient discuss their supplement use with their health-care providers—even though these products are available without prescription.
- Please always consider the issue of drug/herb/nutrient interaction and discuss with your health-care provider.

Potential Side Effects:
- Any individual taking any type of nutraceutical supplement, medical or functional food, may experience true allergy, intolerance, reaction of some sort, worsening of their medical condition, etc. due to allergy, inherited intolerance, sub-optimal dosing or drug/nutrient interactions. Please stop the product and check with your health-care provider if you believe any of the above has occurred.
- Discuss with your physician if you are or want to become pregnant and are taking nutraceutical supplements

Supplement Storage:
Most of our products are stored at room temperature unless otherwise stated on the product label.

Supplements Return Policy:
- All supplements purchased through the online store are subject to a 15% restocking fee.
- The product must be unopened and in normal condition.
- You return the product within 20 days from the date of purchase.
- We cannot refund you if: the product is opened, has expired, seal is broken, it was a special order or refrigerated or on-sale item.

DISCLAIMER: None of the information expressed here is intended to prevent or treat any disease or specific medical condition. We do not guarantee any products or their results. Please always consult with a health-care provider.

FDA DISCLAIMER: These products are not intended to diagnose, treat, cure, or prevent any disease. The FDA has not evaluated these statements.

WARNING: If you are pregnant, nursing, have any allergic reaction to trace minerals or have any chronic recurring symptoms or illness, please consult a health care professional before using any products.

KEEP OUT OF REACH OF CHILDREN. Store at room temperature. Keep out of direct sunlight.

Patient Name: LAST NAME, FIRST NAME
Patient/Guarantor Signature: _____ Date: _____