GOLDEN CABINET MEDICAL 2019 Sawtelle Blvd., West Los Angeles, CA 90025 (310) 575-1955

PLEASE PRINT

Last Name_____ **First Name**_____ **Middle Int.**_____

Home Address_____

City_____ **State**_____ **Zip Code**_____

Home Phone_____ **Cell**_____ **Work**_____

Date of Birth ___/____/_____ **Sex** ___**F** ___**M** **Marital Status S M D W**

Soc. Sec. #_____/_____/_____ **Driver's License** _____**Employer**_____

Work Address_____ **Occupation**_____

E-Mail Address_____

Whom may we thank for your referral?_____

METHOD OF PAYMENT

_____**Self Pay:** _____**Cash** _____**Check** _____**Credit Card**

_____**Private Insurance** _____**Workers Comp/Accident** _____**Attorney** _____**Other**

Date of Injury (Work Comp/ Attorney): _____/_____/_____

ASSIGNMENT OF INSURANCE BENEFITS

If my Insurance Carrier denies payment, I agree to be personally and fully responsible for payments.

I hereby instruct and direct my insurance company to pay by check made out and mailed to Golden Cabinet Medical, the professional and medical expense benefits allowable under my current insurance policy for services rendered to my dependant or me. This is a direct assignment of my rights and benefits under this policy. A photocopy of this Assignment shall be considered as effect and valid as the original. I understand and agree that, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all information on this sheet and have completed the above answer. I certify this is information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Note: Drew Francis, O.M.D., L.Ac. Is Not a contracted Healthcare provider with any insurance carrier. Therefore, upon receipt of the explanation of benefits from your insurance carrier for services rendered by this office, your account will be reviewed for benefit payments. Depending upon your coverage, your coinsurance payment arrangement with this office may change making you responsible for a higher coinsurance after payment review. If you have any questions, please contact our business office at (310) 575-1955.

Signature of Subscriber of Beneficiary: _____**Date:**_____

HEALTH HISTORY
(Confidential)

Name_____ Today's Date_____

Age_____ Birthdate_____ Date of last physical examination_____

What is your reason for visit?_____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

GENERAL
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GENITO-URINARY
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL
- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram?_____

Are you pregnant?_____

Number of children_____

CONDITIONS Check (✓) conditions you have or have had in the past.

- ☐ AIDS
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gonorrhea
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine Headaches
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Typhoid Fever
- ☐ Ulcers
- ☐ Vaginal Infections
- ☐ Venereal Disease

MEDICATIONS List medications you are currently taking

Pharmacy Name_____ Phone_____

ALLERGIES To medications or substances

(All information is strictly confidential)

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relatives had any of the following: Disease	Relationship to you
Arthritis, Gout	
Asthma, Hay Fever	
Cancer	
Chemical Dependency	
Diabetes	
Heart Disease, Strokes	
High Blood Pressure	
Kidney Disease	
Tuberculosis	
Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome

PREGNANCY HISTORY

Year of Birth	Sex of Birth	Complications if any

Have you ever had a blood transfusion? ☐ Yes ☐ No
If yes, please give approximate dates._____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Caffeine	
	Tobacco	
	Drugs	
	Other	

OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____
Signature Date

_____ _____
Reviewed By Date

Please list all PRESCRIPTIONS, OVER THE COUNTER MEDICATIONS, VITAMINS/MINERALS, HERBS, or OTHER SUPPLEMENTS you currently take on a regular basis, including birth control pills and allergy injections:

Name of product	Dose (mg, ML, IU)	How often do you take it?	How long have you taken it?	If you have side effects, please specify

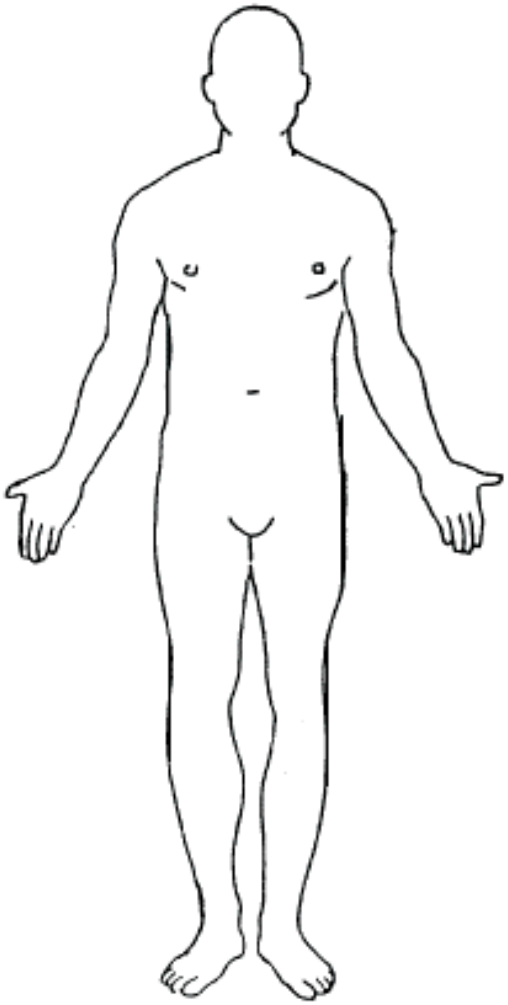
Drug Adverse Reactions: Please list ANY medication / anesthetics / immunizations you have had to stop taking because of side effects or allergic reactions:

Name of medication/ immunization	Type of side effects or allergic reaction that caused you to stop it	Age	Year

Using the symbols below, mark the areas on your body where you feel the described sensations. If you are not experiencing any pain in the body, please check here: _____ No Pain

Front ***Back***

RIGHT LEFT LEFT RIGHT



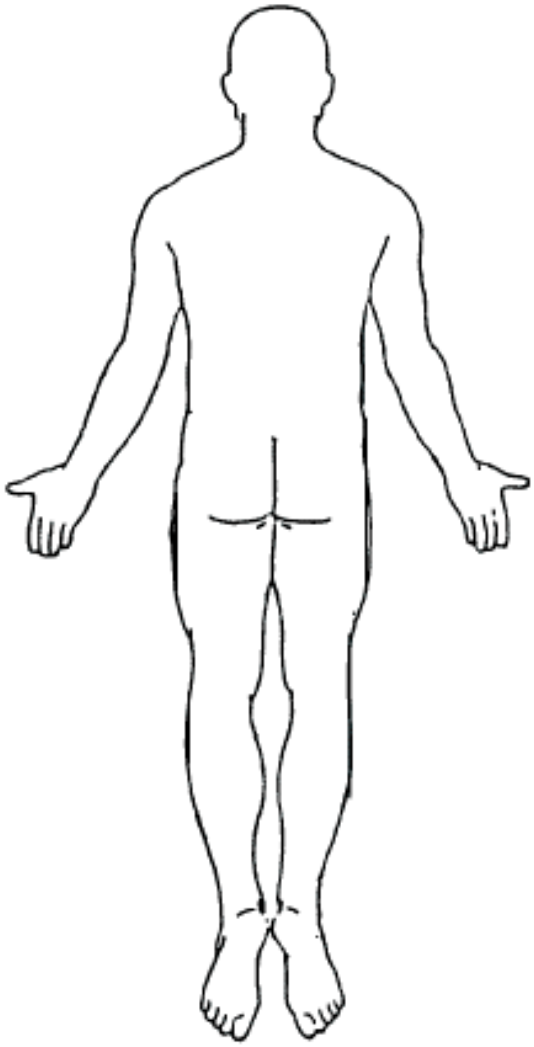
Numbness
ll ll ll ll

Pins and Needles
0 0 0 0 0

Burning
xxxxx

Stabbing
//////

Ache
^^^^



GOLDEN CABINET MEDICAL

BUSINESS POLICIES & CREDIT CARD AUTHORIZATION RELEASE

Golden Cabinet Medical takes pride in the quality of care we offer our patients. As such, the office does not double book appointment times - we reserve the time exclusively for you. *In order to do this, we have a 48-hour cancelation policy.* Therefore, if you reschedule/ cancel in less than 2 business days prior to your appointment or do not show as scheduled, we will impose a charge for the full amount of the visit. There are no exceptions. Due to the long list of patients who desire appointments, we ask you to please call our office should you need to cancel or reschedule. If you arrive more than 10 minutes late to your initial appointment, we cannot guarantee you will be seen.

I, _____ authorize Golden Cabinet Medical to charge the credit card below for consultations with the doctor (via phone, office visit, or email), supplement orders, lab fees, cancelation fees, and insurance co-payments or related charges. *There are NO refunds for custom-packaged supplements.

VISA MC AMEX DI (please circle)

_ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _ EX: _ _ / _ _ Security Code: _ _ _ _

x _____ _____

(please sign) (date)

PHYSICIAN BILLING: Dr. Drew Francis and Dr. Kristin Pressman bill at an hourly rate. This includes but is not limited to consultations via phone, in office appointments, email correspondence, review of lab results, & supplement protocol summations and preparations.

PAYMENT AND INSURANCE: We are “out of network” providers. As the responsible party, you assume full liability for charges accrued in this office. Payment in full is due at the time of service. Upon request, we can provide you a superbill to submit to your insurance provider for your out of pocket charges. Depending on your policy, insurance coverage may be helpful for some of the lab work.

RETURNED CHECKS AND COLLECTIONS: Returned checks are subject to a $50 service charge fee. If for any reason you may have an unpaid balance, your account will be sent to collections in 60 days.

PRESCRIPTION REFILLS: You are responsible for making sure that you have an appointment scheduled with the doctor or phlebotomist prior to the expiration of refills. No refills will be given otherwise. At the previously agreed-upon follow-up appointment, new prescriptions will be given. Always check the number of refills on your bottles and schedule appropriately.

I, _____ declare that I have read the above and agreed to these terms and conditions. I had adequate time to inspect and question its contents.

2019 Sawtelle Blvd.
West LA, CA 90025
office: 310-575-1955 fax: 310-575-9855

HIPAA PRIVACY CONFIDENTIALITY STATEMENT

This notice describes how medical information about you may be used and disclosed and how you have access to this information. Please review the below carefully.

Disclosure of Information

We may disclose information to other healthcare professionals and/or your insurance carrier for treatment, payment, or healthcare operations. Additional disclosures may be necessary to comply with Workers Compensation or in the event of an emergency. Be assured that we will not disclose any information without your expressed written consent unless required to do so by legal authority.

Appointment Reminder Policy

In the event that our office gives you a courtesy call to remind you of your appointment time, it is our policy to leave a message that does not disclose any confidential information.

Facility Organization

While our examination and treatment rooms are private, our office does have some open areas (i.e. front lobby). Staff and Doctors will uphold policies to ensure privacy, but there may be some amount of inadvertent disclosure to others in the facility at the same time. If there is private information that needs to be discussed, please request to have such discussions in a private room.

Your Rights

- You have the right to inspect and have a copy of your health information. There is no cost for the first copy, and copy thereafter will be $25. Please send written request to view or obtain a copy of the information we have about you.
- You may also use a written request to amend any personal information that you believe to be incomplete or inaccurate. If we did not create the information, we will refer you to the sources, such as other doctors. Please note that we have the right to disagree with your amendments. If there is a disagreement you will be provided with information about our denial of your amendment and how you may appeal the denial.
- You have the right to a written request for additional restrictions on uses and disclosures of your health information. We are not required to agree to these requests and in some instances they may be prohibited by law.
- You may request that we communicate with you about medical matters using reasonable alternative means or at an alternative address. Please submit request in writing.
- You have the right to receive a history of our disclosure of your medical information, except when those disclosures are made for treatment, payment or health care operations, or as the law otherwise restricts the release of this information.
- You have the right to a copy of this notice upon request.

Complaints

Complaints about your privacy rights or how your privacy is handled at this office, can be directed to JR Privacy by calling this office or directing a letter to his attention. If you are not satisfied with how this office handles your complaint, you may submit a formal complaint to:

DHHS Office of Civil Rights
200 Independence Ave, S.W. Room 509F
Washington D.C. 20201

I have read the Privacy Notice and understand my rights as they are presented in this notice. By signing this form, I provide authorization and consent to use and disclose my protected health information as noted above.

Patient Name (print):_____

Patient Signature:_____ Date:_____

NEW CENTER for PSYCHOANALYSIS
los angeles

2014 Sawtelle Blvd. Los Angeles, CA 90025
310-478-6541

Parking Permit

(for lot located at 2013 Beloit Ave.)

Golden Cabinet Medical

Spaces 22, 24, and 26 ONLY

There is NO parking in the lot on Wednesdays.

Please display this permit on your windshield.

You may park in spaces 22, 24 and 26. If you are parked behind someone it is an employee at the office.

After you park, look West and go through the NW gray side gate.
You will walk through another parking lot bringing you to Sawtelle Blvd.
You will see Golden Cabinet's black awning across the street.

***Failure to comply with parking instructions may result in your vehicle being towed.

Alternative Parking Options:

Free parking along Beloit Ave & Corinth Ave.
2 hr meters along Mississippi Ave and La Grange Ave.
1 hr meters along Sawtelle Blvd.

(Please be mindful of all parking signage)

Golden Cabinet Medical is not responsible for feeding parking meters.

Golden Cabinet Medical / Dr. Drew Francis
2019 Sawtelle Blvd. Los Angeles, CA 90025
310-575-1955