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	Check (✓) if, your blood relatives had any of the following:	Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependency	
						Diabetes	
						Heart Disease, Strokes	
Sisters						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.

	Substance	
	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 __________

GENETIC PROFLE QUESTIONNARIE

Patient Name ____________________________

Date ____________

Please circle any medical conditions of lifestyle factors that have affected you or your blood related family members. If an item or diagnosis does not apply, leave it un-circled. Providing a personal and family medical history can make your genetic risk screening more focused.

If you are adopted or don't know you family history, please indicate in the Personal Notes section below.

CardioGenomic™ Profile	**OsteoGenomic™ Profile**	**ImmunoGenomic™ Profile**	**DetoxiGenomic™Profile**
High cholesterol	Low bone mineral density (Osteoporosis, Osteopenia)	Heart disease	Regular medication use (prescription, over-the-counter)
Heart disease (heart attack, coronary artery disease)	Age related bone fractures (Vertebral compression fractures, humped spine in the elderly)	Autoimmune diseases Lupus, Rheumatiod Arthritis, Scleroderma, Sjorgens)	Toxins at work/home
Overweight	Arthritis	Allergies	Pesticide or fungicide exposure
High blood pressure (hypertension)	Low body weight or "small boned"	Asthma	Multiple Chemical Sensitivity
Blood clotting problems (Thrombosis clots in arteries or veins, phlebitis, pulmonary embolus)	Menopause	Inflammatory Bowel Disease (Crohns or Ulcerative Colitis)	Cancer
Stroke	Early or surgical menopause	Recurrent viral infections	Chronic Fatigue Syndrome
Use of Hormone Replacement Therapy	Missed periods	Cancer	Depression, anxiety
Excessive intake of sweets	Sedentary lifestyle	Arthritis	Daily use of alcohol
Excessive intake of fried foods (more than 3 times per/wk)	Long-term use of acid blocking drugs	Eczema	Sensitivity to caffeine
	Long-term treatment with cortisone, prednisone, or anti-convulsants	Stomach Ulcers	Smoking or frequent tobacco smoke exposure
	More than 3 cups of coffee or 36oz of soda per day	Low bone mineral density (Osteoporosis, Osteopenia)	Weekly diet of barbecue or or charred foods
			Exhaustion after exercise
			History of drug addiction

Personal Notes (eg., adopted, father's side of the family history unknown, etc)

____

____

____

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 and strives to keep your wait time minimal. In order to do this we have a strict 48-hour cancellation policy. Please read and sign below.

We reserve the time exclusively for you. 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**.

I, ______________________ authorize Golden Cabinet Medical to charge the credit card given below, for cancellation fees, supplements orders and insurance co-payments or related charges. There are No Refunds for custom-packaged supplements.

VISA MC AMEX (PLEASE CIRCLE)

____ - ____ - ____ - ____ Ex __ /__ ___ 3 DIGIT SECURITY CODE

x______________________________ (PLEASE SIGN) __________ (DATE)

PAYMENT AND INSURANCE: We are "out of network" providers. Check your plan for coverage of benefits that apply. As the responsible party, you assume full liability for charges accrued in this office. We will give you a receipt for submittal to your insurance provider. Payment in full is due at the time of service. In addition to cash and personal checks (with proper ID), we accept Visa, MasterCard, and American Express credit/debit cards.

RETURNED CHECKS AND COLLECTIONS: Returned checks are subject to a $50 service charge. If for any reason you 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 prior to the expiration of refills. No refills are given. 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 (print name) ______________________ declare that I have read the above and agreed to its terms and charges. I had adequate time to inspect and question its contents.

2019 SAWTELLE BOULVARD
west los angeles, ca 90025
310-575-5611, 310 575-9885 fax

PRIVACY CONFIDENTIALITY STATEMENT

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

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

It is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home at the time of our call, it is our policy to leave a message on your answering machine or with the person answering the phone. We will not leave any message that discloses confidential information.

Facility Organization

While our examination and treatment rooms are private, our office does utilize an open exercise/rehabilitation area. 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 you 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, any copy thereafter will be $25. Please send us a written request to view or obtain a copy of the information that we have about you.

- You may also use a written request to amend any personal information that you believe is incomplete or inaccurate. If we did not create the information, we will refer you to the source, such as other doctors or sources. Please note that we have the right to disagree with your amendments. If there is 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. As with all requests, please submit this 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 *J.R. 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 HHH Building
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____________________

Golden Cabinet Medical

2019 Sawtelle Blvd.
310-575-5611

TO ALL VALUED PATIENTS…

PLEASE BE ADVISED THAT THERE IS PARKING MADE AVAILABLE TO YOU IN THE PARKING LOT LOCATED ON **BELOIT AVE.**

BELOIT IS LOCATED PARALLEL TO SAWTELLE AND RUNS ALONG THE 405 FWY.

DIRECTIONS: EAST ON LA GRANGE TO BELOIT (STOP SIGN). MAKE A RIGHT ONTO BELOIT, GO DOWN ½ A BLOCK AND MAKE A RIGHT INTO THE PARKING LOT ON THE RIGHT HAND SIDE. THE SIGN READS **NEW CENTER FOR PSYCHOANALYSIS.**

THE SPACES THAT ARE AVAILABLE TO YOU ARE: 22,24 & 26 PLEASE USE THE SILVER GATE FOR YOUR CONVIENCE TO WALK THROUGH TO SAWTELLE BLVD. PLEASE DO NOT WALK THROUGHT THE NCP.

***WE ARE NOT PERMITTED TO PARK IN THIS LOT ON: WEDNESDAYS OR SATURDAYS**

THESE ARE ALTERNATIVE OPTIONS FOR PARKING LOCATED ON MISSISSIPPI AND ON LA GRANGE, (2 HOUR METERS) AND FREE PARKING ON CORINTH AND BELOIT.

PLEASE BE SURE NOT TO PARK IN THE LOT BEHIND THE RESTAURANTS- YOU WILL BE TICKED AND TOWED.
GOLDEN CABINET MEDICAL IS NOT RESPONSIBLE FOR FEEDING PARKING METERS.

NEW CENTER FOR PSYCHOANALYSIS

2014 Sawtelle Blvd. Los Angeles, CA. 90025

Parking Permit

(Parking lot at: 2013 Beloit Ave.)

Spaces: 22, 23, 24, 25, 26, 27, & 38

Golden Cabinet

Conditions of this permit

1. Permit must be displayed while parked in the 2013 Beloit Ave. (Owned by NCP) parking lot
2. The issuer or its agents are not responsible for damages to or loss of vehicle, its contents or accessories.
3. You must park in designated area(s) assigned to you or risk further actions.

Any questions call (310) 478-6541 Ext. 18 or 14