

File #: _____

Mar Vista Institute of Health

FOR OFFICE USE: Print ICD-9 or description:

3030 Sawtelle Blvd., Los Angeles, CA 90066

Last Name: _____ First Name: _____

Home Address: _____ City: _____

State: _____ Zip: _____ Home Telephone: _____ Cell Phone: _____

Notify in case of emergency: _____ Tel: _____

Date of Birth: ____/____/____ Sex: ___F ___M Soc. Sec. #: ____/____/____

Marital Status: S M W D Age: _____ E-mail: _____

Employer: _____ Occupation: _____ Work Phone: _____

Whom may we thank for referring you? _____

METHOD OF PAYMENT

Self-Pay: ___Cash ___Check ___Credit Card _____Private Insurance _____Medicare

_____Work comp/Accident _____Attorney _____Other _____Date of Injury (Wc/Acc): ____/____/____

INSURANCE INFORMATION

Insured Name(if other than patient) _____ Insured Subscriber #: _____

Insured Date of Birth: _____ soc. Sec # of insured: _____

Medical Insurance _____ Subscriber Number: _____

Policy: _____ Group: _____ Tel: _____

Address: _____

Worker's Comp/ Auto accident / Attorney: _____

Claim #: _____ Adjuster: _____

Address: _____ City: _____ State: _____ Zip: _____

Tel: _____ Fax: _____

ASSIGNMENT OF INSURANCE BENEFITS / PATIENT INFORMATION

I hereby instruct and direct my insurance company to pay by check made out and mailed to **Mar Vista Institute of Health**, the professional and medical expense benefits allowable under my current insurance policy for services rendered to me or my dependent. This is a direct assignment of my rights and benefits under this policy. A photocopy of this Agreement shall be considered as effective and valid as the original. I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered. I have read all information of this sheet and have completed the above answers I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in the above information.

Signature of Patient or Beneficiary: _____ Date: _____

Please Turn Over

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? Yes No Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

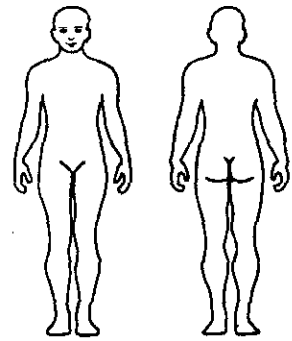
Type of pain: Sharp Dull Throbbing Numbness Aching Shooting
 Burning Tingling Cramps Stiffness Swelling Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your Work Sleep Daily Routine Recreation

Activities or movements that are painful to perform Sitting Standing Walking Bending Lying Down



What treatment have you already received for your condition? Medications Surgery Physical Therapy

Chiropractic Services None Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____

Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

- | | | | |
|--|---|---|---|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | Miscarriage <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Alcoholism <input type="checkbox"/> Yes <input type="checkbox"/> No | Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | Mononucleosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergy Shots <input type="checkbox"/> Yes <input type="checkbox"/> No | Fractures <input type="checkbox"/> Yes <input type="checkbox"/> No | Multiple Sclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Suicide Attempt <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anorexia <input type="checkbox"/> Yes <input type="checkbox"/> No | Goiter <input type="checkbox"/> Yes <input type="checkbox"/> No | Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Appendicitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Gonorrhea <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Gout <input type="checkbox"/> Yes <input type="checkbox"/> No | Parkinson's Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumors, Growths <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Pinched Nerve <input type="checkbox"/> Yes <input type="checkbox"/> No | Typhoid Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Breast Lump <input type="checkbox"/> Yes <input type="checkbox"/> No | Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No | Polio <input type="checkbox"/> Yes <input type="checkbox"/> No | Vaginal Infections <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Hemiated Disk <input type="checkbox"/> Yes <input type="checkbox"/> No | Prostate Problem <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bulimia <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Prosthesis <input type="checkbox"/> Yes <input type="checkbox"/> No | Whooping Cough <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Other _____ |
| Cataracts <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatoid Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No | _____ |
| Chicken Pox <input type="checkbox"/> Yes <input type="checkbox"/> No | Measles <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraine <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

EXERCISE

- None
- Moderate
- Daily
- Heavy

WORK ACTIVITY

- Sitting
- Standing
- Light Labor
- Heavy Labor

HABITS

- Smoking
- Alcohol
- Coffee/Caffeine Drinks
- High Stress Level

Packs/Day _____
 Drinks/Week _____
 Cups/Day _____
 Reason _____

Are you pregnant? Yes No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

**MAR VISTA INSTITUTE OF HEALTH
NOTICE OF PRIVACY PRACTICES**

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.

Mar Vista Institute of Health is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example) *“On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Mar Vista Institute of Health.”; “It is our policy to provide a substitute health care provider, authorized by Mar Vista Institute of Health to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider’s absence due to vacation, sickness, or other emergency situation.”*

Payment We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example) *“As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Mar Vista Institute of Health for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received.”*

Workers’ Compensation We may disclose your health information as necessary to comply with State Workers’ Compensation Laws.

Emergencies We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings. We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement. We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons. We may disclose your health information to coroners or medical examiners.

Organ Donation. We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research. We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety. It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies. We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing. We may contact you for marketing purposes or fundraising purposes, as described below: (example) *“As a courtesy to our patients, 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, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.” “It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Mar Vista Institute of Health sponsored fund-raising events.”*

Change of Ownership. In the event that Mar Vista Institute of Health is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Mar Vista Institute of Health is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.

- You have the right to inspect and copy your health information.
- You have a right to request that Mar Vista Institute of Health amend your protected health information. Please be advised, however, that Mar Vista Institute of Health is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by Mar Vista Institute of Health.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Mar Vista Institute of Health reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Mar Vista Institute of Health is required by law to comply with this Notice.

Mar Vista Institute of Health is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Wayne Higashi by calling this office at 310-391-2617. If Wayne Higashi is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Red Flag Regulations

Issued in final form on October 31st, this rule required us to develop a written identity theft prevention program, ABC's program includes existing policies and procedures, and is designed to detect, prevent, and mitigate the risk of identity theft to consumers. Should our system security be breached, we will investigate and notify all government agencies of the breach, and take measures to insure that our security is locked down and secure. Additionally we will notify all patients whose records have been accessed and offer additional guidance on the incident.

Complaints

Complaints about your Privacy rights, or how Mar Vista Institute of Health has handled your health information should be directed to Wayne Higashi by calling this office at 310-391-2617. If Wayne Higashi is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201

This notice is effective as of May 1, 2009

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide Mar Vista Institute of Health with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date