Welcome to Our Practice

1628 Cravens Avenue * Torrance, CA 90501 * (310) 787-8104

Jonathan H. Serebrin, M.D., F.A.C.E.P. ~ Eric J. Grenda, D.C. ~ Brandon Hodges, D.C. ~ Fred Ragsdale, L.Ac., Dipl.O.M.

Name _____ Home phone _____ Cell phone _____

Address _____ Work phone _____ Other_____

City _____ State _____ Zip _____ E-mail Home: _____

SSN _____ Date of birth _____ E-mail Work: _____

Driver Lic # _____ Male ☐ Female ☐ Age _____ Height ____ Weight _____ Single ☐ Married ☐ Divorced ☐ # of children_____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

Name and relationship of nearest relative _____ Phone _____

Spouse name _____ Spouse occupation _____

Spouse SSN _____ Spouse driver Lic # _____ Work phone _____

How were you referred to our office? _____

Have you ever had Physical Therapy before? _____ If yes, when? _____

Have you ever had Chiropractic care before? _____ If yes, when? _____

Have you ever had Acupuncture before? _____ If yes, when? _____

If you are experiencing any health problems, please list your chief complaints in order of severity (pain, symptoms, etc.)

1. _____ For how long? _____
2. _____ For how long? _____
3. _____ For how long? _____
4. _____ For how long? _____

List all other doctors consulted for these conditions or any other condition:

1. Dr._____ Phone _____ 2. Dr._____ Phone _____

3. Dr._____ Phone _____ 4. Dr._____ Phone _____

Name of family physician _____

Do you ever experience any of these complaints while working? _____ If yes, describe what activities at work that may be causing you to experience these complaints: _____

_____

Are there any other activities, incidents, or events outside of work that may have caused these complaints? _____ If yes, please explain:

_____

_____

If this is due to an injury or accident, what is the date of injury or accident? _____

Has this problem been getting better, worse, or staying the same? _____

What activities make your condition worse? _____

Have you ever had any surgeries or hospitalizations? _____ If yes, please list: _____

Please list any injuries or illnesses that you have had that are not listed above: _____

Please list medications (over the counter & prescription) you are currently taking :_____

_____

Have you been involved in an auto accident in the last 12 months? _____ If yes, when? _____

Health Insurance _____ Policyholder _____

Claims address _____ Policy number _____

Spouse's health insurance _____ Policyholder _____

Claims address _____ Policy number _____

The rating scale below is designed to measure the degree to which several aspects of your life are presently disrupted by your health condition (pain and/or symptoms you may be experiencing). In other words, we would like to know how much your health condition (pain and/or symptoms you may be experiencing) is preventing you from doing what you would normally do, or from doing it as well as you normally would. Respond to each category by indicating the overall impact of pain in your life, not just when the pain is at its worst.

For each of the six categories of daily living listed to the right, **PLEASE INDICATE THE NUMBER WHICH BEST DESCRIBES YOUR TYPICAL LEVEL OF ACTIVITIES.**
0 means no disability at all, and 10 means that all of the activities in which you would normally be involved have been totally disrupted or prevented by your health condition (pain and/or symptoms you may be experiencing).

1. **FAMILY/HOME RESPONSIBILITIES:** activities related to the home or family including chores and duties performed around the house (yard work, doing dishes, errands, favors for other family members, driving children to school, etc.) ☐
2. **RECREATION:** hobbies, sports, and other similar leisure time activities. ☐
3. **SOCIAL ACTIVITY:** activities which involve participation with friends and acquaintances other than family members including parties, theater, concerts, dining out, and other social functions. ☐
4. **OCCUPATION:** activities that are a part of or directly related to one's job including nonpaying jobs as well, such as that of a homemaker or volunteer worker. ☐
5. **SELF CARE:** activities which involve personal maintenance and independent daily living (taking a shower, driving, getting dressed, etc.) ☐
6. **LIFE SUPPORT ACTIVITY:** basic life supporting behaviors such as eating, sleeping, and breathing. ☐

In signing below, I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account upon receipt. I permit this office to endorse co-issued remittances for the conveyance of credit to my account. **However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.** I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

NOTICE: Not all patients require x-rays to determine type and duration of care. If your exam warrants x-rays, the following office policy prevails: All first visit charges are payable when services are rendered. The fee paid for x-rays is for analysis only. California State Law requires we maintain your x-rays and the film itself is the property of this office. Films may be loaned to another facility with authorization only.

I also hereby request and consent to the performance of basic medical, physiotherapy, acupuncture, and chiropractic diagnostic and treatment procedures, including but not limited to diagnostic x-rays and other diagnostic procedures, various medical procedures, various physiotherapy modalities, rehabilitative exercises, acupuncture, and specific chiropractic on me (or on the patient named below, for whom I am legally responsible) by Jonathan H. Serebrin, M.D. and/or Eric J. Grenda, D.C. and/or other licensed doctors and/or acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back up for Jonathan H. Serebrin, M.D. and/or Eric J. Grenda, D.C., including those working at our clinic at 1628 Cravens Avenue, Torrance, CA 90501 or any other office of this clinic.

I have had an opportunity to discuss with Jonathan H. Serebrin, M.D. and/or Eric J. Grenda, D.C. and/or with other office or clinic personnel the nature and purpose of the medical and/or physical rehabilitation and/or acupuncture and/or chiropractic procedures performed in this office.

I understand and am informed that in the practice of medicine, acupuncture, physical rehabilitation, and chiropractic there are some risks to treatment, including but not limited to fracture, disc injuries, strokes, dislocations, and sprains. I do not expect the doctor to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below, I agree to the above named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. The names of the doctors who will be treating me: Jonathan H. Serebrin, M.D. and/or Eric J. Grenda, D.C., and/or Brandon Hodges, D.C., and/or Fred Ragsdale, L.Ac.

To be completed by patient or representative, if necessary, eg., if a patient is a minor or physically or legally incapacitated:

Print Patient's Name	Signature of Patient	Date

Print Name of Patient Representative	Relationship to Patient	Signature of Patient Representative	Date

To the best of my knowledge, I am not pregnant, nor is pregnancy expected at this time. Sign here _____

To be completed by doctor or staff:

Print Name of Witness to Patient's Signature	Signature of Witness	Date

Print Name of Translator	Signature of Translator	Date

HIPAA 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition related to health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the physicians practice, and other use required by law.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage you health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for hospital stay may require that your relevant protected health care information be disclosed to the health plan to obtain approval for the hospital admission.
- **Healthcare Operations**: We may use or disclose, as needed, your protected health information in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school student that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate you physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected information, as necessary, to contact you to remind you of you appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration Requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research; Criminal Activity: Military Activity and Naional Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time. In writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information:

- You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.
- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of you protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members of friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Our request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even is you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we den your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal .

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**. This notice was published and become effective on/before **April 14, 2003**.

We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Print Name:_____ Signature:_____ Date: _____

REVIEW OF SYSTEMS

Name: _____ **Today's Date**: _____

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask your doctor.

Overall Health ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: _____

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: _____

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking.
Other: _____

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: _____

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: _____

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence.
Other: _____

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain.
Other: _____

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes.
Other: _____

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss.
Other: _____

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions.
Other: _____

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive.
Other: _____

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas.
Other: _____

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: _____