Welcome to Our Medical Office

We Value the Opportunity to Serve You

Instructions: Please print and complete the entire document. Thanks

Dear Patient,

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 & 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 & 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 866-687-6402**

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 !

PATIENT REGISTRATION

Last Name	First Name	MI

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, Parent and/or Legal Guardian Signature X_____ **Date: X** _____

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

OFFICE POLICIES AND AGREEMENT

Los Angeles Integrative Gastroenterology & Nutrition, Inc.

This Agreement is Between: _____

And **ENTITY: Los Angeles Integrative Gastroenterology & Nutrition, Inc.**

Notice of Privacy Practices & Supplement Policies

- By signing this agreement you acknowledge that you have been presented with ENTITY Notice of Privacy Practices and Supplement Policies, which are both attached with agreement (also posted in reception area).

How We May Communicate with You

- We may contact you regarding appointments, test results and other matters related to your healthcare, at any of the Addresses, Fax, and/or Phone 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.**

How You May Communicate with Our Office

- You may communicate with us by Phone, Fax, or Mail.
- For **Online Communication** with Physician—please review & sign separate **Online Agreement**.
- Please DO NOT use Email, Mail or Fax for ANY urgent matters.
- Our intention is to respond to all of our patient inquiries. If you have left a message, sent a fax, or mailed and have not received a response in a reasonable amount of time, PLEASE…call us to make sure that we know you need to reach us.

Policy for Communicating Test Results to You

- As a patient, I agree to actively participate & communicate with this office to obtain my test results.
- **As a patient, I agree to call this office 5-7 working days after I have completed a test.** 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 & plans with you.
- If we receive abnormal test results ordered by another physician, we believe that physician should counsel you directly about those results. However, you may request additional counseling from our ENTITY 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** with us any special needs you may have, or if you need anything while waiting.
- **Keep** scheduled appointments or call to cancel on time (see cancellation policy).
- **Update** personal information and insurance information whenever there is a change.
- **Update** your doctor with any new medical condition & complete Medication List with each visit.

Proof of Identity

- Patients are required to show proof of identity (e.g. Drivers License, Passport…etc)
- I consent to having my picture taken for office records.

Patient Name: _____

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

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 no later than Friday noontime.
- 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 missed procedures** such as an Endoscopy or Colonoscopy.
- If you need to cancel your out-patient procedure/surgery in less than 24 hours **for a good reason**, please contact our office immediately through the urgent line and PAGE the doctor. We will notify Facility & 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 its 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 for 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, 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, he/she will provide you in writing with at least 15 days of emergency treatment & prescriptions 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.

Release of Medical Information to and by ENTITY:

- 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 and Healthcare Operations, by any means of communication, to **Los Angeles Integrative Gastroenterology & Nutrition (ENTITY**), and authorize ENTITY to use and disclose protected health information **(PHI**) to carry out Treatment, Payment, and Healthcare Operations.

Treatment Authorization:

- I hereby authorize the physician and/or assistant at ENTITY 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 ENTITY to evaluate and treat the patient.

Copying Policy

- 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 to another physician upon written request

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, etc.).
- Child must be accompanied by a parent or guardians 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

- As a patient, should I become pregnant, I agree to promptly notify this office, and any other treating physician, if I am taking any medications that this medical practice has prescribed.
- I also agree to discuss with my physician(s) if I am planning to become pregnant.
- As a male patient, I agree to notify my physician(s) if I am planning to have a child with my partner.

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, or may be set prior to the visit. Secure payment in-advance is required. Ask for details when ready to make one. Costs are generally between $50-$100. After 30 minutes, every fifteen minutes will result in a $75 charge.
- **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…etc**
    - **Life & Health Insurance, Disability Reports, Medical-Legal reports…etc**
    - **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 & processing fee may also apply.

ENTITY and Insurance Companies

- ENTITY 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), ENTITY may agree to bill your insurance.
- When applicable, we will provide you with **Payment Options** after the doctor determines the services you need & we understand your insurance benefits.

Financial Obligations & 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 **Prior to 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 this ENTITY **requires Advance Payment** for certain in-office or out-patient services.
- I understand, I am required to be familiar with my insurance coverage and its policies and **Know** my co-pay, co-insurance, 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 ENTITY to submit appeals 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.** & send it to medical office at 2080 Century Park East, #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 thirty days** the claim was submitted, I agree to **contact my insurance company** and make arrangements for prompt payment.
- For returned checks, we will apply an additional fee of $19.50.
- Late fees and other charges may apply if payments are not received in a timely manner.
- A copy of this agreement is deemed as valid as the original.

I have reviewed above Policies & Agreement and hereby agree to comply with ENTITY Policies
THIS CONTRACT BECOMES EFFECTIVE UPON FIRST VISIT WITH THE DOCTOR, NOT PRIOR.

Patient Name: _____

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

Administrator Signature: _____ **Date:** _____

MEDICAL HISTORY

Patient 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?: Y. N. **Aspirin Use**: Y. N

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

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

Obtained by: _____ Reviewed by Physician: _____

FOR PHYSICIAN USE ONLY

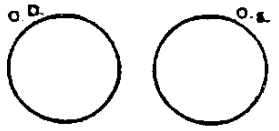
Date: _____ Ht::_____ Wt: _____ BP: _____ T: _____ P: _____ R: _____

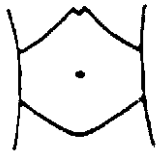
General	NL	ABN
Appearance		
Skin	☐	☐
Character	☐	☐
Pigmentation	☐	☐
Hair	☐	☐
Lesions		
Skull	☐	☐
Irregularities	☐	☐
Tenderness		
Eyes	☐	☐
Lids	☐	☐
Conjuctives	☐	☐
Sclera	☐	☐
Corners	☐	☐
Medis	☐	☐
Lens	☐	☐
Discs	☐	☐
Retinee	☐	☐
Pupils	☐	☐
Reactions	☐	☐
EOM	☐	☐
Exophthalmos	☐	☐
Fields	☐	☐
Av Ratio		
Ears	☐	☐
Canals	☐	☐
T.M.	☐	☐
Hearing		
Nose	☐	☐
Septum	☐	☐
Obstruction	☐	☐
Discharge		
Mouth	☐	☐
Teeth	☐	☐
Tongue	☐	☐
Mucous	☐	☐
Palate	☐	☐
Tonsils	☐	☐
Pharynx		
Neck	☐	☐
JVP Pressure	☐	☐
Character	☐	☐
Carotid Pulse	☐	☐
Rise Time	☐	☐
Volume	☐	☐
Stiffness	☐	☐
Thyroid	☐	☐
Trachea		
Lymph Nodes	☐	☐
Supraclavicular	☐	☐
Cervical	☐	☐
Axillary	☐	☐
Inguinal	☐	☐
Femoral		
Breasts	☐	☐
Development	☐	☐
Scars	☐	☐
Discharge	☐	☐
Masses		
Thorax and Lungs	☐	☐
Contour	☐	☐
Expansion	☐	☐
Tactile Fremitus	☐	☐
Resonances	☐	☐
Breath Sounds	☐	☐
Raise	☐	☐
Wheezes or Rubs		

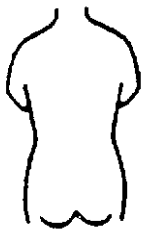
	NL	ABN
Heart Rate		
Rhythm	☐	☐
L.V.	☐	☐
R.V.	☐	☐
P.A. Pulsation	☐	☐
Thrill	☐	☐
Rub	☐	☐
Sounds	☐	☐
Murmurs		
Svs. Ejection	☐	☐
Pan. Systolic	☐	☐
Dias. Imm.	☐	☐
Dias. Delayed	☐	☐
Abdomen		
Enlargement	☐	☐
Scars	☐	☐
Tenderness	☐	☐
Rigidity	☐	☐
Masses	☐	☐
Liver	☐	☐
Kidney	☐	☐
Spleen	☐	☐
Hernia	☐	☐
Bowel Sounds	☐	☐
Rectal		
Hemorrhoids	☐	☐
Masses	☐	☐
Tenderness	☐	☐
Stool O.B.	☐	☐
Genital (cross out one)		
Female Male	☐	☐
Vulva Penis	☐	☐
Vagina	☐	☐
Scrotum	☐	☐
Cervix Testee	☐	☐
Corpus	☐	☐
Prostate		
Adnexes	☐	☐
Back	☐	☐
Posture	☐	☐
Deformities	☐	☐
Spine Tenderness	☐	☐
CVA Tenderness	☐	☐
Motion		
Presacral Edema	☐	☐
Extremities	☐	☐
Deformities	☐	☐
Cyanosis	☐	☐
Skin	☐	☐
Edema	☐	☐
Varicosities		
Joints	☐	☐
Neurological	☐	☐
Cranial Nerves	☐	☐
Sensation	☐	☐
Balance	☐	☐
Gait	☐	☐
Strength/Tone	☐	☐
Movements	☐	☐
Coordination	☐	☐
Speech		
Toe Signs	☐	☐
Mental Status	☐	☐
Orientation	☐	☐
Intellect		
Affect		

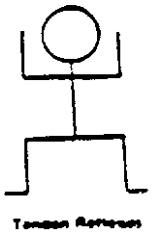
Sight

R Eye: L Eye:









PATIENT EXAMINATION

Patient Identification:

MEDICATIONS

Patient Name: _____ Primary Physician: _____

Allergies: _____ Pharmacy: _____Ph: _____

Medications / Sig.	Dates Reviewed and Updated					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.

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 party involved with your healthcare, although we will only disclose health information that in our professional judgment is relevant to the person's involvement in your care. You have the right to restrict disclosure of your health information to such family members or responsible parties. Your request must be in writing. We will follow your request 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

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 visit **www.Kimialogic.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.