

**PLEASE PUT A “√” NEXT TO THE SYMPTOMS YOU ARE HAVING NOW.
PLEASE PUT AN “X” NEXT TO THE SYMPTOMS YOU HAD IN THE PAST.**

- A. Headaches [] Jaw Pops [] Muscle Cramps [] blood in stool [] Leg cramps at night []
Hernia [] Swollen Joints [] Use Antacids [] Pain in Fingers [] Arthritis []
- B. Dizziness upon rising [] Irritable if missed a meal [] Need coffee to get started []
Night Sweats [] Family history of Diabetes []
- C. Frequent urination [] High Cholesterol [] Difficulty passing urine [] Rose colored urine []
- D. Headaches after eating [] Less than 1 bowel movement daily [] Hepatitis or jaundice []
Intolerant to greasy foods [] Fatigue after eating []
- E. Can't tolerate exercise [] Sensitive to bright lights [] Lack of mental alertness []
- F. Tingling pain sensation [] Loss of grip strength [] Accident prone [] Shingles [] Nervousness []
- G. Eczema/psoriasis [] Use Cortisone [] Migraine Headaches [] Aspirin or Tylenol regularly []
- H. Pain around ribs [] Bronchitis [] Smoker? [] How many daily? _____
- I. Shortness of breath [] Heart attack [] Pain in the left arm [] Chest pains [] Ringing in ears []
- J. Stroke [] Blood pressure problems [] Pains while walking []
- K. FOR WOMEN ONLY: Tender breasts [] Missed periods [] Abortion [] Hot flashes []
Hysterectomy [] Heavy bleeding [] Number of children? _____ Type of delivery _____
- L. Dry skin [] Cold hands and feet [] Depressed [] Cry easily []
- M. Recent weight gain [] Bowel or bladder incontinence [] Recent extremity weakness []
- N. Allergies [] Ear disorder [] Chronic cough [] Sinus trouble [] Hay fever []
- O. Stomach pains [] Gastritis or ulcers [] Nausea or vomiting [] Constipation [] Diarrhea []
- P. Recurrent infections [] Bladder or kidney infections [] Vaginal or yeast infections []

X-RAY CONFIRMATION: This is to confirm that I have been advised by the doctor that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to having x-rays taken.

I hereby request and consent to the performance of medical care, procedures, injections, electrodiagnostics, physical therapy, acupuncture, chiropractic care and MedX spinal rehabilitation.

I understand that neither the practice of medicine nor chiropractic is an exact science, and that my care may involve the making of judgments based upon the facts known to the doctor at the time, that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications, that an undesirable result does not necessarily indicate an error in judgment, that no guarantee as to results has been made to nor relied upon by me.

I further authorize Joint Rehab to release my name and medical information to my insurance carrier for purposes of obtaining payment for services rendered. I authorize disclosure and release of any and all confidential healthcare information, inclusive of alcohol and/or drug abuse, HIV testing/treatment psychiatric notes and/or venereal disease.

Patient's Name _____ Signature _____

Witnesses _____ Date _____

Relationship or authority if not signed by patient _____

I understand that all examinations, treatments, x-rays and lab work are to be paid for as they are rendered or definite financial arrangements made in advance. There is a charge for missed appointments without a 24 hour notification.

SIGNATURE _____ DATE _____



Joint Rehabilitation & Sports Medical Center, Inc.

Office Policy and Procedure

Our goal at Joint Rehabilitation & Sports Medical Center, Inc. is to provide you with the most effective care possible in a relaxed manner.

SIGNING IN: You will be asked to sign your chart each time you arrive.

Going to the treatment rooms: When it's your turn you will be asked or escorted to a specific room. Please remove all heavy garments, jewelry and especially earrings. Please stay in the appropriate room as you may lose that room if someone thinks it is not occupied.

If you miss an appointment try to make that visit up in the same week so as not to delay your progress. We will work hard to get you out of pain fast. You must do your part and stay on track with your appointments.

24 Hour cancellation policy: To prevent being personally charged for a missed visit you must give us 24 hour notification of cancellation. We understand life's emergencies. Please call us as soon as you know you are not going to be able to make your appointment so that we may schedule another patient who really needs us. There is an \$85 cancellation fee when seeing more than one practitioner and \$50 for just one.

All supplies and supplements are to be paid for at the time they are dispensed. These items are typically not billable to your insurance company. They are also not part of any lien.

After reading the above policies and going over them with a member of the doctor's staff, I agree and accept full responsibility for all of these policies.

We are a separate office from Dr. Gary Brazina. We keep a separate chart of your services. Thank you for your cooperation.

Signed _____ Date _____

**ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO JOINT REHABILITATION & SPORTS
MEDICAL CENTER, INC. BILLING SERVICE PRIVATE AND GROUP ACCIDENT HEALTH
INSURANCE**

PATIENT: _____

EMPLOYER: _____

CLAIM/GROUP: _____ **SS#/ID#** _____

I HEREBY INSTRUCT AND DIRECT THAT _____

INSURANCE COMPANY TO PAY BY CHECK MADE OUT AND MAILED TO:

**Joint Rehabilitation & Sports Medical Center, Inc.
11645 Wilshire Blvd. #120, LA CA 90025**

OR

IF MY CURRENT POLICY PROHIBITS DIRECT PAYMENT TO THE DOCTOR, THEN I HEREBY
ALSO INSTRUCT AND DIRECT YOU TO MAKE OUT THE CHECK TO ME AND MAIL IT AS
FOLLOWS:

**C/O Joint Rehabilitation & Sports Medical Center, Inc.
11645 Wilshire Blvd #120, LA CA 90025**

THE PROFESSIONAL OR MEDICAL EXPENSE BENEFITS ALLOWABLE, AND OTHERWISE
PAYABLE TO ME UNDER MY CURRENT INSURANCE POLICY AS PAYMENT TOWARD THE TOTAL
CHARGES FOR THE PROFESSIONAL SERVICES RENDERED. THIS IS A DIRECT ASSIGNMENT OF
MY RIGHTS AND BENEFITS UNDER THIS POLICY. THIS PAYMENT WILL NOT EXCEED MY
INDEBTEDNESS TO THE ABOVE MENTIONED ASSIGNEE, AND I HAVE AGREED TO PAY, IN A
CURRENT MANNER, ANY BALANCES OF SAID PROFESSIONAL SERVICE CHARGES OVER AND
ABOVE THIS INSURANCE PAYMENT.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS
THE ORIGINAL.

I ALSO AUTHORIZE THE RELEASE OF INFORMATION PERTINENT TO MY CASE TO ANY
INSURANCE COMPANY, ADJUSTOR, OR ATTORNEY INVOLVED IN THIS CASE.

DATED AT L.A. COUNTY THIS _____ **DAY OF** _____
(Day) (Month/Year)

SIGNATURE OF POLICY HOLDER

WITNESS

SIGNATURE OF CLAIMANT, IF OTHER THAN POLICYHOLDER