JEFFREY S. GANDIN, M.D.

REGISTRATION FORM

Today's Date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐

Is this your legal name? ☐ Yes ☐ No	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex: ☐ M ☐ F

Home Street address (no PO Boxes Please):	Cell phone no.: ( )	Home phone no.: ( )

City:	State:	Zip Code:	Email:

Occupation:	Employer:	Employer phone no.: ( )

Referred to Dr. Gandin by:

INSURANCE INFORMATION

This office does not accept insurance for office visits. The information in this section will be used for the purpose of getting prescriptions authorized and for addressing billing issues that either you or you insurance company raise

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.: ( )

Is this person a patient here? ☐ Yes ☐ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Please indicate primary insurance Name, Address and Telephone #:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I understand that I am financially responsible for any balance. I authorize Dr. Gandin to contact the above emergency contact in the event that I need emergent assistance or treatment. I also authorize JEFFREY GANDIN, M.D. and my insurance company to release any information required to help me process my claims or authorize my pharmacy prescriptions.

Patient/Guardian signature *Date*

JEFFREY S. GANDIN, M.D.

DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY

TEL 310.497.8900 • 450 North Bedford Drive, Suite 307 • FAX 310.551.4131
Beverly Hills, California 90210
www.drgandin.com

TREATMENT CONTRACT & UNDERSTANDING OF OFFICE POLICIES

The following are DR. JEFFREY GANDIN's office policies. Please read them carefully:

▶**PATIENT PAYMENT OBLIGATIONS.** All outpatient visits must be paid for at the time of visit. You will be provided with a receipt to submit to your insurance company. Jeffrey Gandin, M.D. cannot accept responsibility for negotiating claims with insurance companies or other persons. You are responsible for payment of your medical care regardless of the status of your claim. Any other financial arrangement must be made with Dr. Gandin prior to service.

- **MISSED OR CANCELED APPOINTMENTS WITH LESS THAN 24 *BUSINESS* HOURS NOTICE.** Should you need to cancel a session, please do so at least 24 hours in advance. Otherwise, the time you have booked will not be scheduled for anyone else, and you will automatically be charged at your regular rate for the canceled session.

- **RETURNED CHECKS.** You will automatically be charged for the amount of your returned check plus a $20 fee.

- **OUTSTANDING BILLS.** Outstanding bills will be re-billed monthly. If payment is not received after two successive billings, your account may be sent to a collection service.

▶**ROUTINE CLINICAL QUESTIONS BETWEEN VISITS.** For routine clinical concerns and questions, please leave a message on Dr. Gandin's voice-mail at 310.497.8900. He will call back as soon as possible, usually by the next business day. Note that Dr. Gandin's office does not check his messages on weekends or holidays, or after 4pm on regular weekdays. For emergencies that cannot wait until Dr. Gandin's office checks his messages, please see "Urgent/Emergent Situations." Non-urgent calls of an administrative nature may be returned by an administrative assistant who will maintain Dr. Gandin's confidentiality procedures.

▶**URGENT/EMERGENT SITUATIONS**
Call Dr. Gandin's office phone number 310.497.8900 and listen to the complete outgoing message for instructions on how to page him or the covering physician. In the rare event that you do not receive a callback within 20 minutes, please assume this is due to technical difficulties with the paging system and you may page again. If your situation is so emergent (e.g., life-threatening) that you cannot wait for Dr. Gandin or the covering physician to return your page, then call **911.**

▶**PHARMACY REFILLS.** Please call your pharmacy and have them contact Dr. Gandin's office at least 48 ***business*** hours in advance.

▶**VACATIONS.** Dr. Gandin's outgoing message on 310.497.8900 will notify callers that he is out of the office and will leave instructions on how to contact him or the covering physician.

I agree in the event of non-payment to bear all the costs of collection, court costs and legal fees as are required.

I hereby acknowledge full responsibility for the payment of services rendered by Jeffrey Gandin, M.D.

I have read and understood and I agree with the foregoing, and consent to this evaluation and/or treatment.

A facsimile or photocopy of this signature is as valid as the original.

Patient's name (printed)	Patient's Signature	Date

JEFFREY S. GANDIN, M.D.

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: August 1, 2007

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnoses, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care. This Notice describes how physical & mental health information about you may be used and disclosed, your rights regarding this information, and how you can get access to this information. Please review it carefully. If you have any questions about this Notice, please contact: **THE OFFICE MANAGER at The Office of Jeffrey S. Gandin, M.D., 450 North Bedford Drive, Suite 307, Beverly Hills, California, 90210; 310.497.8900.**

This Notice describes the privacy practices at Dr. Jeffrey Gandin's office.

We are required by law to:

- Maintain the privacy of protected health information as required by law
- Give you this notice of our legal duties and privacy practices regarding your health information
- Follow the terms of the Notice currently in effect.

How we may use and disclose your health information:

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to THE OFFICE MANAGER.

Treatment. We may use and disclose your physical & mental health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your physical & mental health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care. We may also share physical & mental health and substance abuse information about you with other healthcare providers, agencies or facilities who are treating you for a medical or psychological condition, in order to provide or coordinate the different things you need, such as prescriptions or types of therapy. We also may disclose mental health information about you to people who may be involved in your continuing mental health or medical care after you leave our practice, such as other health care providers, transport companies, community agencies and family members.

Payment. We may use and disclose your physical & mental health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Health Care Operations. We may use and disclose your physical & mental health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment Reminders, Treatment Alternatives, and Health-Related Benefits and Services. We may use and disclose your physical & mental health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share your physical & mental health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition. Any such disclosure will be limited to information directly related to the person's involvement in your care. If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.

Disaster Relief. We may disclose physical & mental health information about you to government entities or private organizations (such as the Red Cross) to assist in disaster relief efforts. If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated, we will use our professional judgment to determine what is in your best interest and whether a disclosure may be necessary to ensure an adequate response to the emergency circumstances.

Research. We may use and disclose your physical & mental health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your physical & mental health information.

As Required by Law. We will disclose your physical & mental health information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose your physical & mental health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can help prevent or reduce the threat.

Business Associates. We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Organ and Tissue Donation. If you are an organ donor, we may release mental health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your physical & mental health information as required by military command authorities. If you are a member of a foreign military we may release your physical & mental health information to the foreign military command authority.

Workers Compensation. We may release your physical & mental health and substance abuse information for workers compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Disclosures We may disclose physical & mental health information about you for public health purposes. These purposes generally include the following: (1) preventing or controlling disease (such as cancer and tuberculosis), injury or disability; (2) reporting vital events such as births and deaths; (3) reporting child abuse or neglect; (4) reporting adverse events or surveillance related to food, medications or defects or (5) reporting problems with products; (6) notifying persons of recalls, repairs or replacements of products they may be using; (6) notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; (7) notifying the appropriate government authority if we believe a patient has been the victim of abuse or neglect and make this disclosure as authorized or required by law; (8) notifying the coroner of a patient's death; (9) notifying emergency response employees regarding possible exposure to HIV/AIDS, to the extent necessary to comply with state and federal law; (10) notifying multidisciplinary personnel teams relevant to the prevention, identification, management, or treatment of an abused child and the child's parents or an abused elder or dependent adult.

Health Oversight Activities. We may disclose your physical & mental health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Coroners, Medical Examiners, and Funeral Directors. We may release your physical & mental health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your physical & mental health information in response to a court or administrative order. We may disclose your physical & mental health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release as appropriate your physical or mental health information to law enforcement: (1) pursuant to a subpoena by law enforcement; (2) as needed for the protection of others; or (3) if there is a court order, subpoena, or other legal process for release of the information. Information may also be released to (1) law enforcement without their request in order to protect others whom you threaten to injure and to (2) persons who are in danger from a threat you have made.

Department of Justice. We may disclose limited information to the California Department of Justice for movement and identification purposes about certain criminal patients, or regarding persons who may not purchase, possess or control a firearm or
deadly weapon.

Protection of Elective Constitutional Officers. We may disclose mental health information about you to government law enforcement agencies as needed for the protection of federal and state elective constitutional officers and their families.

National Security and Intelligence Activities. We may disclose your physical & mental health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR PHYSICAL & MENTAL HEALTH INFORMATION

Right to Inspect and Copy. You have the right to inspect and or receive a copy of your physical & mental health information and billing records. In order to do so, you need to send a written request to THE OFFICE MANAGER. If you request a copy of the information, there is a fee for these services. We may deny your request to inspect and/or to receive a copy in certain very limited circumstances.

Right to Amend. You have the right to request an amendment to your records by written request to THE OFFICE MANAGER.

Right to an Accounting of Disclosures. You have a right to an accounting of certain disclosures by written request to THE OFFICE MANAGER.

Right to Request Restrictions. You have the right to request restriction or limitation on your physical & mental health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to THE OFFICE MANAGER. We are not required to agree with your request, but we will try to comply.

Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. You can ask, for example, that we contact you only by mail or at work. Your written request must specify how or where you wish to be contacted and be addressed to THE OFFICE MANAGER. We will accommodate reasonable requests.

QUESTIONS OR COMPLAINTS. If you have any questions about this Notice, please contact THE OFFICE MANAGER. If you believe your privacy rights have been violated, you may file a complaint with THE OFFICE MANAGER. To file a complaint with the Secretary of the Department of Health and Human Services contact the: Department of Health and Human Services, Office of Civil Rights, South United Nations Plaza, Room 322, San Francisco, CA 94102 (PHONE) (415) 437-8310, (FAX) (415) 437-8329, (TDD) (415) 437-8311. *You will not be penalized for filing a complaint.*

OTHER USES OF YOUR HEALTH INFORMATION. Other uses and disclosures of physical & mental health information not covered by this Notice will be made only with your written permission. If you provide us permission to disclose such information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer disclose such information about you for the reasons covered by your written permission. You understand that we are unable to take back any disclosures we have already made with your permission, and that we will retain our records of the care provided to you as required by law.

CHANGES TO THIS NOTICE

We may change this notice and make it effective for medical information we already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to THE OFFICE MANAGER:

OFFICE MANAGER
Jeffrey S. Gandin, M.D.
450 North Bedford Drive, Suite 307
Beverly Hills, California 90210
310.497.8900

- - - - - - - - - - - COMPLETE THE SHORT FORM BELOW, CUT HERE AND SEND TO DR GANDIN BY MAIL, EMAIL OR FAX- - - - - - - - - - - - - -

JEFFREY S. GANDIN, M.D.
450 North Bedford Drive, Suite 307
Beverly Hills, California 90210
fax: 310.551.4131
email: jgandin@ucla.edu

Patient Acknowledgment of Receipt of HIPAA Notice of Privacy Practices

Patient Name: ____ Birth date: _______________

Maiden/other name used (if applicable):____

I acknowledge that I have received a copy of the Notice of Privacy Practices of JEFFREY S. GANDIN, M.D. effective August 1, 2007.

A photocopy or facsimile of this signature is as valid as the original.

Patient Signature: _________________________________ Date: _________________

JEFFREY S. GANDIN, M.D.

DIPLOMATE, AMERICAN BOARD OF PSYCHIATY & NEUROLOGY

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Beverly Hills, California 90210

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME *(Last, First, M.I.)*: ☐ M ☐ F	DOB:
MARITAL STATUS: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
PRIMARY PHYSICIAN :	DATE OF LAST PHYSICAL EXAM:
PERSONAL HEALTH HISTORY	

WERE THERE ANY COMPLICATIONS WHEN YOU WERE BORN?	☐ Yes ☐ No If Yes, Please describe:

PAST & PRESENT GENERAL MEDICAL (AS WELL AS PSYCHIATRIC) DIAGNOSES	DATE	TREATMENTS/INCLUDING ALL MEDICATION TRIALS & THEIR EFFECTS

LIST ALL MEDICAL/PSYCHIATRIC/REHABILITATION HOSPITALIZATIONS

Year	Reason	Hospital

LIST ALL PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS (INCLUDING HERBALS, HOMEOPATHY, VITAMINS AND INHALERS) THAT YOU ARE ***CURRENTLY*** TAKING

Name the Drug	Strength	Frequency Taken	Since When?

ALLERGIES TO MEDICATIONS

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

Exercise	☐ Sedentary (No exercise)			
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)			
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)			
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)			
Diet	Are you dieting?		☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?		☐ Yes	☐ No
	# of meals you eat in an average day?			
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola
	# of cups/cans per day?			
Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	If yes, what kind?			
	How many drinks per week?			
	Are you concerned about the amount you drink?		☐ Yes	☐ No
	Have you considered stopping?		☐ Yes	☐ No
	Have you ever experienced blackouts?		☐ Yes	☐ No
	Are you prone to "binge" drinking?		☐ Yes	☐ No
	Do you drive after drinking?		☐ Yes	☐ No
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day
	☐ # of years	☐ Or year quit		
Drugs	Do you currently use recreational or street drugs?		☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?		☐ Yes	☐ No
	Are you sexually active?		☐ Yes	☐ No

Sex	Are you sexually active?	☐ Yes	☐ No
	If yes, are you trying for a pregnancy?	☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal Safety	Do you live alone?	☐ Yes	☐ No
	Do you have frequent falls?	☐ Yes	☐ No
	Do you have vision or hearing loss?	☐ Yes	☐ No

FAMILY MENTAL HEALTH HISTORY

ANY FAMILY HISTORY OF SUICIDE ATTEMPTS? IF SO WHO AND HOW:

ANY FAMILY HISTORY OF PSYCHIATRIC HOSPIALIZATION? IF SO, WHO & WHY:

	AGE	SIGNIFICANT **MENTAL HEALTH** PROBLEMS		AGE	SIGNIFICANT **MENTAL HEALTH** PROBLEMS
FATHER			***Children***	☐ M ☐ F	
MOTHER				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**GRANDMOTHER** *Maternal*		
	☐ M ☐ F		**GRANDFATHER** *Maternal*		
	☐ M ☐ F		**GRANDMOTHER** *Paternal*		
	☐ M ☐ F		**GRANDFATHER** *Paternal*		

CURRENT (Not past) MENTAL HEALTH

PLEASE ANSWER WHETHER OR NOT YOU ARE <u>CURRENTLY</u> EXPERIENCING THE FOLLOWING PROBLEMS:

Depression	☐ Yes	☐ No
Lack of interest in things you are normally passionate about	☐ Yes	☐ No
Irritable	☐ Yes	☐ No
Physically restless or agitated	☐ Yes	☐ No
Excessive worries or ruminations	☐ Yes	☐ No
Restless or disturbed sleep or insomnia	☐ Yes	☐ No
Poor concentration	☐ Yes	☐ No
Poor memory	☐ Yes	☐ No
Difficulties getting motivated	☐ Yes	☐ No
Trouble completing tasks	☐ Yes	☐ No

Trouble/overwhelmed by making decisions	☐ Yes	☐ No
Chronic pain	☐ Yes	☐ No
Withdrawn/ Isolated	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No
Panic attacks	☐ Yes	☐ No
Anxiety in social situations	☐ Yes	☐ No
Fear/Avoidance of particular situations (please list):	☐ Yes	☐ No
Rage	☐ Yes	☐ No
Weight changes?	☐ Yes	☐ No
Appetite changes?	☐ Yes	☐ No
Pull your hair out	☐ Yes	☐ No
Stutter or lisp	☐ Yes	☐ No
Suicidal thoughts	☐ Yes	☐ No
Ever tried to commit suicide?	☐ Yes	☐ No
Ever cut yourself intentionally?	☐ Yes	☐ No
Tendency to become violent?	☐ Yes	☐ No
Tics, twitches or spasms	☐ Yes	☐ No
Intrusive unwanted disturbing thoughts or images that keep on coming back no matter how much you try to wave them away?	☐ Yes	☐ No
Irresistible urges to perform rituals (such as check, touch, count, clean)	☐ Yes	☐ No
Ever have periods of time when you feel euphoric, on top of the world, with boundless energy, extremely powerful, talkative, impulsive (sexually and/or with spending sprees), racing thoughts, agitation, and maybe even irritated with the incompetence of others?	☐ Yes	☐ No
Eat large quantities of food in one sitting and then cause you to throw up or use laxatives?	☐ Yes	☐ No
Ever hear voices or see visions that other people in the same room do not experience?	☐ Yes	☐ No
Ever experience or witness a life-threatening event, assault or trauma?	☐ Yes	☐ No
Recurrent nightmares?	☐ Yes	☐ No
Fear that someone or people are out to get you, are following you, or listening to your private conversations	☐ Yes	☐ No
Believe you have special powers	☐ Yes	☐ No
Believe you receive messages to you on billboards, TV, books or other media	☐ Yes	☐ No
Feel you have been touched without anyone being near you?	☐ Yes	☐ No
Unusual smells without anything to account for it	☐ Yes	☐ No
See things disappear, change shape, color or position when this should not have occurred	☐ Yes	☐ No
Find yourself in a place with no idea how you got there	☐ Yes	☐ No
Steal things	☐ Yes	☐ No
Gamble more than you can afford to lose	☐ Yes	☐ No
Haunted by a trauma you have experienced	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every ______ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies ______ Number of live births ______		

Question	Yes	No
Are you pregnant or breastfeeding?	☐ Yes	☐ No
If you have a baby, does the baby ingest any of your breast milk?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Do you have recurrent mood or anxiety changes that occur only within the two weeks before your period?	☐ Yes	☐ No

OTHER CURRENT AND PAST MEDICAL PROBLEMS

Check if you had in the past, or presently have any of the following conditions

Past	Present		Past	Present		Past	Present	
☐	☐	Glaucoma	☐	☐	Blood in stool	☐	☐	Diabetes
☐	☐	Other Vision problems	☐	☐	Hepatitis	☐	☐	Polycystic ovarian syndrome
☐	☐	Hearing problems	☐	☐	Cirrhosis	☐	☐	Peri-menopause
☐	☐	Difficulties swallowing	☐	☐	Elevated liver enzymes	☐	☐	Thyroid Disorder
☐	☐	Asthma	☐	☐	Pancreatitis	☐	☐	Other Hormone Problem
☐	☐	Chest pain	☐	☐	Gallbladder disease	☐	☐	Lupus
☐	☐	Circulation problems	☐	☐	Migraines	☐	☐	Arthritis
☐	☐	Heart arrhythmia	☐	☐	Stroke	☐	☐	Other autoimmune problems
☐	☐	Angina/Coronary artery disease	☐	☐	Multiple Sclerosis	☐	☐	Musculoskeletal problems:
☐	☐	Abdominal pain	☐	☐	Alzheimer's Disease	☐	☐	Kidney Disease
☐	☐	Diarrhea	☐	☐	Seizures/convulsions	☐	☐	Bladder Disease
☐	☐	Constipation	☐	☐	Concussion	☐	☐	Sexual problems
☐	☐	Cancer	☐	☐	Infectious Disease	☐	☐	Sexually Transmitted Disease

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Beverly Hills, California 90210

www.drgandin.com

CREDIT CARD CONSENT & AUTHORIZATION FORM

I, ____________________, hereby authorize Jeffrey Gandin, M.D. **to keep my signature on file and to automatically charge my credit card account** as indicated below:

☐ for charges for missed or canceled sessions, with less than 24 hours advance notice from ___/___/___ until Patient (named below) is formally discharged as a patient from the office of Jeffrey Gandin, M.D. unless I revoke such authorization in writing beforehand.

☐ for the amount of each check that does not clear the bank, for whatever reason, plus a $20 returned check charge per incident.

Optional:

☐ for a single charge of ________ for Patient's initial consultation on ____/____/____ .

☐ for recurring charges (ongoing treatments) per visit of __________ from ____/____/____ until Patient is formally discharged as a patient from the office of Jeffrey Gandin, M.D. unless I revoke such authorization in writing beforehand.

CHECK ONE:

☐ MasterCard V code (3 digits in back):______________

☐ Visa V code (3 digits in back):______________

☐ American Express V code (4 digits in front): ______________

A photocopy or facsimile of this signature is as valid as the original.

PATIENT NAME: ____

CARDHOLDER NAME (As printed on card): ____

ACCOUNT NUMBER: ____

EXPIRATION DATE: ____ /____/____

CARDHOLDER BILLING ADDRESS:____

Street Number Zip

CARDHOLDER SIGNATURE: _______________________**DATE SIGNED**: ____/____/____