

Wesley G Bradford, MD, MPH

22750 Hawthorne Blvd, #229 B
Torrance, CA 90505
(424) 222-9601
www.dr-bradford.com

New-Patient Registration

Dear Patient,

Welcome to my practice! Thank you for choosing me as one of your health care providers.

HOW THE PROCESS WORKS:

STEP 1:

- **Prior to your First Appointment**, please **download and fill out the 3 needed PDF Forms** (this Registration Form, Medical History Form, and Nutritional Assessment Form) as described on my website (www.dr-bradford.com), and bring them to the appointment to save time during your visit.
- If possible, try also to bring your medical records to your first appointment to save time in assessing your condition. (You can discuss with me in advance what types of records we need, to be complete without having to bring large amounts of unneeded information.)

STEP 2:

During your First Appointment, I will review your health history, nutritional status and exam findings, and make recommendations for lab tests that are appropriate for your specific health issues.

STEP 3:

Once you have completed your lab tests, I will discuss the meaning of your test results to you in a Return Visit. I will create an individualized lab-based therapeutic program for you that may include diet changes, nutritional supplements, bio-identical hormones if necessary, exercise, ergonomics changes if needed, lifestyle and stress management advice. I may suggest a consultation with a Nutritionist.

STEP 4:

Subsequent Visits are scheduled to monitor your progress. After your progress is satisfactory, I will also design an on-going wellness program that can be reviewed and updated with me periodically as needed.

Please contact me if you have any questions during the course of your treatment. I may be reached at (424) 222-9601 or by message through my website. (Office hours are by appointment only.)

I look forward to assisting you in achieving your current wellness goals, and to guiding you in maintaining wellness throughout your life.

In Health,

Dr Bradford

Wesley G Bradford, MD, MPH

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I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Dr Bradford to release my personal medical information to me.

Patient's Signature: _____

Date: _____

Name:		Date:		
Address:		Country:		
City:	State:	Zip/Postal Code:		
Home Phone:	Work Phone:	Fax:		
E-mail:		Cell Phone:		
Please mark your preference for occasional follow up communication from our office: <input type="checkbox"/> Email <input type="checkbox"/> Phone				
Age:	Birth date:	Sex: M F	Status: M S W D	No. Children:
Occupation:		Employer:		Years Employed:
Spouse's Name:		Occupation:		Employer:
Person responsible for this account:			Referred by:	
What is your major health complaint?				
Other complaints?				
What are your overall health goals once your complaints are resolved?				
How long has it been since you really felt good?				

**Please answer all questions frankly, to the best of your knowledge.
All information is confidential.**

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OFFICE POLICIES AND PROCEDURES

(Please make a copy of this page for your records.)

First Appointment: Your first consultation will be usually be 1 hour (depending on complexity). During this time Dr Bradford will determine the appropriate lab tests to order to address your specific health concerns.

Fee Schedule: \$100 per 1/2 Hour

- Payment is due at time of service.
- Methods of payment are Credit Card or Check.
- All visits are timed from the time the appointment begins; you will only be billed for the actual time used.

Follow-up Appointments are usually 1/2 Hour, depending on complexity.

Cancellations: If you are unable to keep your scheduled appointment, please notify Dr Bradford at least 24 hours before your scheduled time or you may be charged for that appointment.

Lab Tests: Some basic tests can be done at a local lab (like Quest Lab). More complex specialized testing is done by specialty out-of-state laboratories and requires use of a special Test Kit (specimen shipping box) (see instructions on Dr Bradford's website). These tests have about a 2-week turnaround time. Dr Bradford will evaluate them and discuss the results and treatment with you at your next appointment.

Important Notes:

- Dr Bradford does not manage medical emergencies. If you have a medical emergency, you must contact your primary care physician or dial 911!
- Please contact Dr Bradford if you are not clear on any office policies or procedures.
- Dr Bradford is an Out-of-Network Provider for all insurance plans. (Some outside lab tests may be covered by some insurance plans.)

Notice of Patient Privacy Policies:

The Federal HIPAA law regulates the use and disclosure of Personally-identifiable Health Information (PHI) as needed for diagnosis, treatment and billing of healthcare services, limiting any such disclosure to properly qualified persons only, and to the minimum information necessary to accomplish these purposes (unless required otherwise by a government agency or court of law). Patients can request additional restrictions on release of their personal information and have the right to request explanation of these policies from the provider. Patients have the right to view their personal information and to request corrections to it, and to request copies of their medical information. For more information, questions or concerns on healthcare privacy issues, contact Dr Bradford or <http://www.hhs.gov/ocr/privacy/>.

I, _____, have read and understand Dr Bradford's Policies and Procedures.

Date _____

Signature _____

Wesley G Bradford, MD, MPH

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PAYMENT AUTHORIZATION

I (*print name*), _____, authorize Dr Bradford, located at 22750 Hawthorne Blvd, Suite 229 B, Torrance, CA 90505, to bill my credit card as listed below for professional services performed.

Name on Credit Card: _____

Credit Card Holder's Billing Address (*Where your statement is mailed*)

Credit Card Details:

Type of credit card (*please check one*): Visa MasterCard American Express

Card# _____ Exp date _____

Last 3 security digits on back of card (4 for Amex on front) _____

Patient Information:

Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Authorization:

Card Holder's Signature

Today's Date

Patient's Signature

Today's Date

This authorization may be revoked at any time when the following stipulations have been performed:

1. Patient has already made a new financial agreement that has been signed and dated, or card holder/patient has submitted to our office a written request to revoke the card usage (stop billing credit card in writing signed and dated), and
2. Patient's account is paid in full.

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(Please complete this form if you would like us to obtain your healthcare information from another provider or hospital.)

Authorization to Release Medical Information

To: *(Practitioner, Clinic or Hospital name here)* _____

Address: _____

I, _____, request the following information:

Test results History Records Diagnosis

Treatment Reports Progress

Concerning my: Accident Injury Illness

Other _____

To be released to:

Wesley G Bradford, MD, MPH
22750 Hawthorne Blvd, Suite 229 B
Torrance, CA 90505

Phone (424) 222-9601

For the purpose of: *(Specify)* _____

(According to Section 1795 of the California Health and Safety Code, these records must be provided within 15 days of receipt of this notice.)

Signed: _____ Date: _____

Patient Spouse Parent Other _____