16 fax pages from (424) 731-7188

from: Akiko Suzuki
to: Akiko Suzuki MD A Medical Corporation
date: Mar 27, 2020, 12:15 PM EDT

N/P form

Suzuki
The Suzuki Clinic

Primary Care, Internal Medicine
2325 Torrance Blvd. Torrance, CA 90501

New Patient Registration Form

患者様情報登録申込フォーム

Date _____

Patient Information（受診者情報）

Language 言語 ☐English / ☐日本語

Race 人種 _____

Last Name (ローマ字)	**First Name 名** (ローマ字)	MI	Salutation 敬称 ☐Mr. ☐Mrs. ☐Dr. ☐MS. ☐ Rev.
姓（漢字）	**名**（漢字）		

DOB 生年月日 (MM/DD/YYYY) / /	**Gender 性別** ☐M(男) / ☐F(女)	**Social Security 社会保障番号(SSN)**

Patient Address 住所	**City 市**	**State 州**	**Zip 郵便番号**

Home Phone 自宅電話番号	Employer Name 勤務先名
Cell Phone 携帯電話番号	Work Phone 勤務先電話番号
Email Address メールアドレス	

Marital Status 婚姻区分 ☐ Single 独身 ☐ Married 既婚 ☐ Divorce 離婚 ☐ Widow 死別 ☐ Other その他	Spouse / Partner Name 配偶者/パートナー名
	Spouse / Partner Phone 配偶者/パートナー電話番号:
	Emergency Contact Name 緊急時連絡先氏名
	Emergency Contact Phone 緊急時連絡先番号

Insurance Information（保険情報）

Primary Insurance 第 1 保険	
Secondary Insurance 第 2 保険	

Other Information（その他の情報）

Referring Provider (if any)紹介者（もしいれば）	Referring Provider Phone（紹介者電話番号）

Suzuki
The Suzuki Clinic

Suzuki Clinic Medical Questionnaire

Suzuki Clinic Medical Questionnaire
鈴木クリニック 問診票

この問診票へご記入頂く事により、より的確な診断をする事が可能となります。もし答えたくない項目がある場合は、空欄で結構です。また詳しく覚えてない場合は、覚えている範囲内でもっとも妥当であろうと思われる情報をご記入下さい。個人情報の秘匿は守られます。

Your answers on this form will help your health care provider better understand your medical concerns and conditions better. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please provide your best guess. All information given here is strictly confidential. Thank you!

▼ Patient Information(受診者情報)

Last Name 姓_____First Name 名_____ **Gender 性別** (M 男 / F 女)

DOB 生年月日(mm/dd/yyyy) ____/____/19____ Appointment 予約日時 ____/____/20____

Phone 電話番号_____ Occupation 職業_____

Email メールアドレス _____

▼ 今回のご来院はどのような症状のためですか？ What is the medical problem for this visit?

- ☐ 熱がある Fevers _____F / C
- ☐ 寒気 Chills
- ☐ 喉の痛み Sore throat
- ☐ 鼻水 Runny nose
- ☐ せき Cough
- ☐ たん Sputum production
- ☐ 血たん Bloody phlegm
- ☐ 頭痛 Headache
- ☐ 吐き気 Nausea
- ☐ 口渇 Excessive thirst
- ☐ 呂律が回らない Difficulty speaking
- ☐ 胸痛 Chest pain
- ☐ 動悸 Palpitations
- ☐ 胸の圧迫感 Tightness in chest
- ☐ 息切れ Shortness of breath
- ☐ 胸焼け Heartburn
- ☐ 胃痛 Stomachache
- ☐ めまい Dizziness
- ☐ 耳鳴り Ringing in ears
- ☐ 腹が張る Abdominal bloating
- ☐ 腹痛 Abdominal pain
- ☐ 嘔吐 Vomiting
- ☐ 下痢 Diarrhea
- ☐ 血便 Blood in stool
- ☐ 頻尿 Frequent urination
- ☐ 血尿 Blood in urine
- ☐ 排尿痛 Pain with urination
- ☐ しびれ Numbness
- ☐ 腰痛 Backache
- ☐ 発疹 Rash
- ☐ かゆみ Iching
- ☐ むくみ Swelling
- ☐ 高血圧 High blood pressue
- ☐ 体重の増減 Weight loss/gain
- ☐ 食欲不振 Loss of appetite
- ☐ だるい Malaise
- ☐ 疲れやすい Gets tired easily
- ☐ 痛み Pain in... _____が痛い

その他 Other:

※ いつ頃から症状がありますか？ How long has this been a problem? _____

▼ 現在服用している薬やサプリメント CURRENT MEDICATIONS and SUPPLIMENT

現在服用している薬やサプリメントの名前、用量と回数をご記入下さい。Name, Amount and frequency taken

▼ 薬、食べ物その他にアレルギーのある場合はご記載下さい
List any allergies to medication, food and others:

▼既往歴 Past Illnesses and Surgical Histories

☐ 脳血管障害 Cerebovacular disease
☐ 心臓病 Heart disease
☐ 腎臓病 Kidney disease
☐ 痙攣/癲癇 Convulsions/Epilepsy
☐ エイズ HIV
☐ 喘息 Asthma
☐ 肝臓病 Liver disease
☐ B/C 型肝炎 Hepatitis B or C
☐ がん Cancer (種類 What kind? _____)
☐ 甲状腺異常 Thyroid problmes
☐ 糖尿病 Diabetes
☐ 結核 Tuberculosis
☐ 精神疾患 Mental disease
☐ その他 Other _____

上の既往歴のリストにチェックのある場合は、病名、発症年齢、経過等をご記入下さい。
(例:脳卒中、1996 年。軽い脳卒中で倒れ一時的に左腕が麻痺。三週間の入院の後回復した。)
If you checked any of above list, pleas write the name of the illness, date discoverd and current status. (Ex, Stroke, 1996, I had minor stroke which caused temporary paralysis in left arm. I was monitored in hospital for three weeks and recovered.)

▼ 手術歴 Have you had any operations before? ☐YES, ☐NO
手術歴のある場合は、手術を受けた年齢と、手術の種類ご記入下さい。
If YES, when and what kind?

▼ 輸血歴 Have you had a blood transfusion? ☐YES, ☐NO
輸血歴ある場合は、いつどんな種類の手術を受けられたかご記入下さい。
If YES, when and the reason?

▼家族既往歴 Family Health History

☐ 高血圧 High blood pressue
☐ 腎臓病 Kidney diseasev
☐ 遺伝子疾患 Hereditary diseases
☐ 脳血管障害 Cerebovacular disease
☐ 心臓病 Heart disease
☐ 肝臓病 Liver disease
☐ がん Cancer どこの What kind?( )
☐ その他 Other
☐ 糖尿病 Diabetes
☐ 精神疾患 Mental disease

上の既往歴のリストにチェックのある場合は、どなたが、どれくらいの年齢で罹られたかご記入下さい。ガンの場合は、どの種類かもお書き下さい。 If you checked any of above list, please write the name of the illness, who, (if cancer, what kind) and how old.

▼女性のみ Questions for Women

・最終月経の開始日 Starting date of the last period. _____

・妊娠していますか？Are you pregnant?

☐NO ☐YES 何週目ですか_____Weeks , ☐ わからない Not Sure

・授乳中ですか？ Are you currently breastfeeding? ☐NO ☐YES

・避妊用のピルを服用していますか？ Are you taking contraceptive pills? ☐NO ☐YES

・閉経になった年齢 Age of menopause _____

▼生活習慣 Lifestyle

・食事は1日3食とっていますか？ Do you have meals 3 times a day?

☐ YES ☐ NO（1日何食？ How often? _____/day）

・どの様な食べ物を食べていますか？What kind of food do you eat?

_____

・タバコを吸いますか Do you smoke? ☐YES ☐NO

吸われる場合、一日の本数は？ 何年吸っていますか？ If yes, how many a day and how long?

_____

以前吸っていたが今はやめている。Did you smoke before? ☐YES ☐NO

吸っていた場合、一日の本数は？ If yes, how many a day? _____

いつやめましたか? When did you quit? _____

・アルコール Alcohol

定期的にお酒を飲みますか？Do you regulary dring alcohol? ☐YES ☐NO

飲まれる場合、一週間にどれくらいの量飲みますか？If Yes, how much in 1 week?

_____

・カフェイン Caffeine ☐NO ☐YES YESの場合、一日にどれくらい？ If yes, how much a day?

_____

・ 運動 Exercise

定期的に運動していますか？Do you exercise regularly? ☐YES ☐NO

YESの場合、何をどの程度？ If yes, how often and what kind? _____

▼ その他のコメント Other Comments

ご記入ありがとうございました。 Thank You!

Suzuki
The Suzuki Clinic

Primary Care, Internal Medicine
2325 Torrance Blvd. Torrance, CA 90501

Insurance Disclaimer

A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits is subject to all terms, conditions, limitations and exclusions of the member's contract at the time of service.

Insurance Liability for Payment

Your health insurance company will only pay for services that are determined to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures pre authorized by your health insurance company. If your health insurance company determines that a particular service is not reasonable or necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Please note that although I may be contracted by your insurance company, I may not be a preferred provider under your individual plan. To truly confirm my preferred provider status under your plan, you must resort to the list of providers your insurance company provided you with. Furthermore, it is possible that a service, procedure or my preferred provider status not be accurately determined by your insurance carrier until a claim for my service is submitted and processed. Due to the latter please be aware that you are ultimately responsible for all charges and the verification of benefits is only a courtesy to you on our part. If in doubt about your insurance plan and its coverage, please contact your insurance representative prior to your appointment.

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above for the reasons stated. If my health insurance company denies payments, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does not pay for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Signature: _____

Date: _____

Suzuki
The Suzuki Clinic

Primary Care, Internal Medicine
2325 Torrance Blvd. Torrance, CA 90501

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceeding . Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of small claims court against the physician, and the physician's partners, associate, association, corporation or partnership, and the employees, agents and estates of any of them , must be arbitrated including , without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall selectan arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with the other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial office from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relation to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services _____ Your Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ Physicians's or Authorized Representative's Signature _____ Date

By: _____ Your Signature _____ Date

Akiko Suzuki, M.D
2325 Torrance Blvd.
Torrance, CA 90501

By: _____ Print Your Name

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical record.

Suzuki
The Suzuki Clinic

Primary Care, Internal Medicine
2325 Torrance Blvd. Torrance, CA 90501

Assignment and Release

I understand that I am financially responsible for all charges from The Suzuki Clinic, whether or not paid by insurance company and for all the services rendered on my behalf or my dependents.

I authorize the doctor and/or other provider or supplier of services in The Suzuki Clinic to release the information required to secure the payment of benefits and the use of this signature on all insurance submissions.

Signature of responsible party_____

Date_____

Suzuki
The Suzuki Clinic

Primary Care, Internal Medicine
2325 Torrance Blvd. Torrance, CA 90501

Acknowledgement of Receipt of Privacy Notice

I hereby acknowledge that I received a copy of the medical practice's Notice of Privacy Practices explaining how my information may be used and disclosed as permitted under federal and state law.

I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

I further acknowledge that a copy of the current notice will be given and offered a copy of any amended Notice of Privacy Practices at an appointment when any changes occurs.

_____
Signature of patient (or responsible party, if minor)

_____
Please print the name of the patient

_____
Date

Suzuki
The Suzuki Clinic

Primary Care, Internal Medicine
2325 Torrance Blvd. Torrance, CA 90501

Name: _____

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

1. PURPOSE. The purpose of this form is to obtain your consent for a telemedicine consultation with a physician.

2. NATURE OF TELEMEDICINE CONSULTATION. Telemedicine involves the use of audio, video or other electronic communications to interact with you, consult with your healthcare provider and/ or review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken.

3. RISKS, BENEFITS AND ALTERNATIVES. The benefits of telemedicine include having access to medical specialists and additional medical information and education without having to travel outside of your local heath care community. A potential risk of telemedicine is that because of our specific medical condition, or due to technical problems, a face-to-face consultation still may be necessary after the telemedicine appointment. Additionally, in rare circumstances, security protocols could fail causing a breach of patient privacy. The alternative telemedicine consultation is a face-to-face visit with a physician.

4. TEACHING, RESEARCH AND HEALTHCARE INSTITUTION. The Suzuki Clinic is not a teaching institution. However, residents, interns, medical student, students of ancillary health care professions (ie., nursing, x-ray, rehabilitation therapy) and post-graduate fellows may anticipate in telemedicine consultations, under the supervision of the attending physician, as part of the medical education program. Additionally, non-medical technical personnel may participate in the telemedicine consultation to aid in the audio/video link with the physician.

5. MEDICAL INFORMATION AND RECORDS. All laws concerning patient access to medical records and copies of medical records apply to telemedicine. Dissemination of any patient identifiable images or information from the telemedicine consultation to researchers or other entities shall not occur without your consent.

6. CONFIDENTIALITY. All existing confidentiality protections under federal and California law apply to information used or disclosed during your telemedicine consultation.

7. RIGHTS. You may withhold or withdraw your consent to a telemedicine consultation at any time before and/or during the consult without affecting your right to future care or treatment, or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

My Health care provider has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered. I have read and agreed to a telemedicine consultation

_____ _____
Signature of Patient or Patient's Representative Date of Signing

_____
Relationship of Representative to Patient

_____
Signature of Witness (required if patient unable to sign)

REFUSAL: I refused to participate in a telemedicine consultation as described above.

_____
Signature:

Phone: (310) 326-5661 Fax: (310) 326-0347
http://www.suzukiclinic.org

About Telemedicine

WHAT IS TELEMEDICINE?

Telemedicine (also sometimes called telehealth) services are a way to deliver healthcare services locally to a patient when the healthcare provider is located at a distant site. Telemedicine is generally defined as the use of electronic information and communications technology to exchange medical information from one site to another site to provide medical or surgical treatment to a patient and/or to participate in the medical diagnosis of, or medical opinion or medical advice to, a patient.

When a healthcare provider believes a patient may benefit from the use of telemedicine services, telemedicine can maintain a continuity of care with the provider and facilitate patient self-management and caregiver support of the patient. Telemedicine services often provides a broader access to medical care, eliminates transportation concerns, and increases comfort and familiarity for patients and their families when located in their own homes or other local environments.

However, telemedicine uses new communications technology for which there is little research supporting its effectiveness. For example, telemedicine services may not be as complete as in-person healthcare services because the healthcare provider will not always be able to observe subtle non-verbal communications such as a patient's posture, facial expression, gestures, and tone of voice.

Telemedicine may transfer medical information through the use of interactive, real-time audio/visual technology (for example, video conferencing) or electronic data interchange (for example, computer-to-computer exchanges), or it may transfer medical information through the use of store-and-forward technology (for example, emails). While precautions are taken to secure the confidentiality of telemedicine services, the electronic transmission of medical information can be incomplete, lost or otherwise disrupted by technical failures. Additionally, despite such measures, the transmission and storage of medical information can be accessed by unauthorized persons, causing a breach of the patient's privacy.

I read and understand the information provided in this document. I discussed any question I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature

Consent to Use Telemedicine

Patient's Name_____ My Doctor's Name_____

CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive inperson healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "autoremember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. [I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.] OR [No part of the encounter will be recorded without my written consent.]

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature

Suzuki
The Suzuki Clinic

Primary Care, Internal Medicine
2325 Torrance Blvd. Torrance, CA 90501

プライバシーポリシーについて

プライバシーポリシーとは、患者様に関する情報（メディカルレコード）が
アメリカ連邦政府とカリフォルニア州の法律に基づいて、どの様に扱われるかが
具体的に説明されております。

このポリシーは患者様にお渡しし、受領されたことを証明するサインをして頂く事が
法律により義務付けられております。

メディカルレコード（カルテ）とは、患者様の診察記録や検査結果、保険の情報、
患者様とのやり取りなどが含まれております。
これらの情報は基本的には患者様の同意無しで公開する事はありませんが、
以下の例外があります。

1. 保険会社への治療費を請求する場合
2. 他の医療機関へ患者様の治療を行うために必要な場合
3. 特定の病気を公共機関に通告しなければならない義務がある場合（伝染病など）

詳しくは、裏面のプライバシーポリシーをお読み下さい。
御質問等がありましたらお尋ね下さい。

Notice of Information Practices and Privacy Statement For The Suzuki Clinic

Revision Date: 08/19/2009

How We Collect Information About You:
The Suzuki Clinic (TSC) and its employees and volunteers collect data through a variety of means including but not necessarily limited to online forms, letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications or other requests for assistance through our organization.

What We Do Not Do With Your Information:
Information about your financial situation and medical conditions and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information:
Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between TSC and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications, insurance.

If you apply or attempt to apply to receive assistance through us and provide information with the intent or purpose of fraud or that results in either an actual crime of fraud for any reason including willful or un-willful acts of negligence whether intended or not, or in any way demonstrates or indicates attempted fraud, your non-medical information can be given to legal authorities including police, investigators, courts, and/or attorneys or other legal professionals, as well as any other information as permitted by law.

Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources: Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of TSC. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission.

Client will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission.

You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

How To Contact Us:
Should you have other questions or concerns about these privacy policies, please send us an email at inforequest@suzukiclinic.org.

The Suzuki Clinic
2325 Torrance Blvd
Torrance, California 90501

Suzuki
The Suzuki Clinic

Primary Care, Internal Medicine
2325 Torrance Blvd. Torrance, CA 90501

鈴木クリニックへようこそ!

鈴木クリニックの診療時間は、月曜日から金曜日 9時から12時 2時から5時です。
木曜日は午後休診です。 こちらは完全予約制ですので、必ずお電話でご予約を
取ってからご来院ください。

命にかかわる緊急時の場合（胸痛、呼吸困難、意識低下、急性麻痺、急性腹痛、
激しい頭痛、嘔吐、出血など）の際は、すぐに**９１１へ電話**して救急車を呼ぶか、
最寄の病院の **Emergency Room** へ行って下さい。
入院が必要となった場合、病院付きの医師にお願いし、こちらで連絡を取り合います。

紹介病院 Emergency Department

・***Torrance Memorial Hospital*** ３１０－３２５－９１１０
3330 Lomita Blvd. Torrance, CA 90505 (Lomita Blvd と Medical Ctr Dr)

・***Providence Little Company of Mary Medical Center Torrance*** ３１０－３０３－５６００
4101 Torrance Blvd. Torrance, CA 90503 (Torrance Blvd.と Earl St.)

診療時間外の緊急でない場合、鈴木クリニック**３１０－３２６－５６６１**に電話して、
メッセージを残して下さい。
こちらで留守番電話を聞きますので、必ず、**お名前、電話番号を残して下さい。**
万が一、症状が悪化したり、こちらから連絡がない場合は、上記のように
Emergency Room へ行くか、最寄の **Walk In Urgent Care Center** へ行って下さい。

紹介 Urgent Care Center

・***Providence Urgent Care Torrance*** ３１０－６１８－９２００
2382 Crenshaw Blvd. # 5 Torrance, CA 90501 (Crenshaw Blvd.と Sepulveda Blvd.)
月～金 8 a.m.～7 p.m. 土・日 9 a.m.～5 p.m.

Suzuki
The Suzuki Clinic

Primary Care, Internal Medicine
2325 Torrance Blvd. Torrance, CA 90501

Welcome to The Suzuki Clinic

Our office hours are from Monday to Friday 9 am to 12 pm and 2 pm to 5 pm. The office is closed Thursday afternoons. We take patients by appointment only so please make sure to call us before coming to the office.

In Case of Emergency

Please go to the nearest emergency room or call 911 with life threatening conditions, such as chest pain, difficulty breathing, neurological changes, loss of consciousness, severe headache or abdominal pain, intractable vomiting, or profuse bleeding. If you need to be hospitalized, you will be referred to hospitalists for your further care and will be followed-up on the conditions here upon discharge.

Emergency Department

Torrance Memorial Hospital: 310-325-9110
3330 Lomita Blvd. Torrance, CA 90505 (Lomita Blvd and Medical Ctr Dr)

Providence Little Company of Mary Medical Center Torrance: 310-303-5600
4101 Torrance Blvd. Torrance, CA 90503 (Torrance Blvd. and Earl St.)

For your after hour non-emergency matters, please call The Suzuki Clinic at 1-310-326-5661 and leave a message. We will listen to the message so please leave your name and phone number. If your symptom suddenly gets worse, or in case if you don't get your message on time, please go to the nearest Emergency Room or Walk In Urgent Care Center.

Urgent Care Center

Providence Urgent Care Torrance 310-618-9200
2382 Crenshaw Blvd. # 5 Torrance, CA 90501 (Crenshaw Blvd. and Sepulveda Blvd.)
Mon - Fri 8:00 AM - 7:00 PM, Sat and Sun 9:00 - 5:00 PM