PLEASANTON ARTHRITIS AND OSTEOPOROSIS MEDICAL CENTER

PATIENT INFORMATION

Last Name:_____ Legal 1st Name: _____ MI: _____ Date: _____

Patient SSN: _____ Responsible Party: _____ Relation to Patient: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone#: _____ Cell#: _____ Work#: _____

Date of Birth: _____Age: _____ Gender: M F Employer: _____

Reason for Visit: _____

Who may we thank for Referring you? _____

INSURANCE INFORMATION

Primary Insurance Carrier: _____ Medical Group/IPA: _____

ID#: _____ Group#: _____ Subscriber Name: _____

Relation to Patient: _____ D.O.B.: _____ SSN: _____

Secondary Insurance Carrier: _____ Medical Group/IPA: _____

ID#: _____ Group#: _____ Subscriber Name: _____

Relation to Patient: _____ D.O.B.: _____ SSN: _____

WORKER'S COMPENSATION INFORMATION

Worker's Compensation Carrier/Insurance: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Claim#: _____ D.O.I.: _____ Employer: _____ Phone#: _____

Accepted Body Part(s): _____

Adjuster's Name: _____ Phone#: _____

PLEASANTON ARTHRITIS AND OSTEOPOROSIS MEDICAL CENTER

Medical History

Allergies to Medications:_____

_____

Current Medications: _____

_____

Operations: _____

_____

Blood Transfusions:_____

Injuries: _____

_____

Smoking _____ packs per day How long? _____ years

Alcohol: Beer_____ Wine _____ Hard Liquor _____

Street Drug Use: _____

Medical Problems: Cancer _____ Arthritis _____ Ulcers _____

Diabetes_____ Bleeding _____ Gallstones _____

Heart Problems _____ Kidney Stones _____

Hi Blood Pressure _____ Pancreatitis _____

Asthma _____ Seizures _____ Bronchitis _____

PLEASANTON ARTHRITIS AND OSTEOPOROSIS MEDICAL CENTER

Financial Policy

PPO/HMO's We will submit claims directly on your behalf to your respective insurance carrier. The Patient / guardian are responsible for any co-pays or patient responsibility on the day of the visit. Referrals are the responsibility of the patient / guardian to obtain from their primary care physician **PRIOR** to their appointment in this office. **IF REFERRALS ARE NOT OBTAINED, THE PATIENT / GUARDIAN IS FULLY RESPONSIBLE FOR CHARGES INCURRED OR THE OFFICE VISIT WILL BE CANCELED.** We are limited by HMO's to provide treatment only for what is authorized. If you choose to have treatment for additional problems not authorized by your plan, you will be financially responsible for the charges.

Worker's Comp Your Worker's Compensation Carrier / Adjuster must authorize all visits in advance. All services are to be paid by Worker's Comp. In the event the Worker's Comp Carrier should deny a claim, the patient will be responsible for the bill.

Cash Pay A consultation fee of $400.00 will be collected on the day of the patient's initial office visit. A $150.00 office fee will be due and payable for any office visits thereafter, this charge would not include any additional services outside the office visit such as: casting, injections, medications, etc.

Cancelled /No Show Appointments If the patient fails to notify office within 48 hours of the patient's visit, a cancellation charge of $60.00 will be applied to your account.

Returned Check In the event of insufficient funds, a returned check fee of $25.00 will be added to your account balance along with the payment amount which was on the check.

IT IS THE RESPONSIBILITY OF THE PATIENT / GUARDIAN TO INFORM OUR OFFICE OF ANY CHANGES IN THEIR INSURANCE COVERAGE AND BILLING INFORMATION.

Signature of Responsible Party: _____
(Parent / Guardian of minor child)

Date: _____

PLEASANTON ARTHRITIS AND OSTEOPOROSIS MEDICAL CENTER

Important information regarding HIPAA

PATIENT RECORDS OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

( ) Home Telephone: _____
( ) OK to leave a detailed message
( ) Leave message with callback number only

( ) Written Communication
( ) OK to mail to home address
( ) OK to mail to work/office address
( ) OK to fax: _____

( ) Work Telephone: _____
( ) OK to leave detailed message
( ) Leave message with callback number only

( ) Other: _____

_____ _____
Patient Signature Date

_____ _____
Print Name Date of Birth

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual. Health care entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

NOTE: USES AND DISCLOSURES MAY BE PERMITTED IN THE CASE OF AN EMERGENCY.

Please list any other persons, you wish **insert provider** to release information to.

_____

_____

PLEASANTON ARTHRITIS AND OSTEOPOROSIS MEDICAL CENTER

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as 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 proceedings. 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 the small claims court against the physician, and the physician's partners, associates, 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 to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3 : **Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select and arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrator's appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitrations 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, no 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 application 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 or California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring 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 notice thereof is received, the claim, if asserted in a civil action, would be barred by the application 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 relating 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 _____
Patient's or Patient Representative's 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.

_____
Patient's or Patient Representative's signature Date

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

By: _____
Print patient's name

_____
Print or Stamp Name of Physician, Medical Group, or Assoc. Name

_____
If Representative, Print Name and Relationship to Patient

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