To provide the best medical care, it's essential that we have up-to-date and complete information.
Please print and complete all spaces and signatures below prior to your examination.

PERSONAL INFORMATION

Date:			Updated:				
PATIENT INFORMATION							
First Name:			Last Name:				
Date of Birth:	Male		Female				
E-mail:			Phone:				
Address:					Apt #:		
City:		State:		ZIP code:			
EMPLOYER INFORMATION							
Employer:					Occupation:		
Address:							
City:			State:		ZIP code:		
Work Phone:							
SPOUSE INFORMATION							
First Name:			Last Name:				
Date of Birth:					SS#:		
Employer:							
Address:							
City:			State:		ZIP code:		
Work Phone:							
EMERGENCY CONTACT							
First Name:			Last Name:				
Phone:							
PRIMARY INSURANCE COMPANY							
Insurance Company Name: Group						Private	
Insured Name:							
Plan / Policy#:			Other ID #:				
Insurance Co. Phone:							
Insurance Co. Address:					State:	ZIP code:	
SECONDARY INSURANCE COMPANY							
Insurance Company Name: Group						Private	
Insured Name:							
Plan / Policy#:			Other ID #:				
Insurance Co. Phone:							
Insurance Co. Address:					State:	ZIP code:	
HOW WERE YOU REFERRED TO THIS OFFICE?							
Physician		Insurance		Internet search		Family	
Friend		Other					
Referral Name:							
Referral Phone Number:			Referral E-mail:				

MEDICAL HISTORY

First Name:	Last Name:
Date of Birth:	Updated:

Which category best describes your race?

Caucasian	Hispanic	African American	American Indian	Asian	Other:

PLEASE DESCRIBE MAIN REASON FOR YOUR VISIT

MEDICAL HISTORY OF THE PROBLEM

Date when the problem first started:

Any medications/treatment that help? Yes | | No | |

If yes, please list:

Please describe any previous treatment for this problem:

DO YOU HAVE ANY SURGICAL HISTORY? IF YES PLEASE PROVIDE THE FOLLOWING INFORMATION:

Type:	When:	Where:	Pathology results (if known):

ARE YOU CURRENTLY TAKING ANY MEDICATION? IF YES, PLEASE LIST.

Name:	Dose:

DATE OF LAST MAMMOGRAM

HAVE YOU EVER RECEIVED HPV IMUNIZATION?

Yes | | No | | If yes, when? | |

DO YOU HAVE ANY ALERGIES? IF YES PLEASE LIST.

Type:	Since:

DO YOU OR YOUR FAMILY MEMBERS EVER HAD ONE OF THE FOLLOWING:

	No	Yes	Yes, Your family members		No	Yes	Yes, Your family members
Unusual Headaches / Nervous Disorders				Stomach, bowel or gallbladder problems			
Convulsions or Fainting Spells				Kidney or bladder problems			
Eye, ear, nose or throat problems				Diabetes			
Thyroid problems				Jaundice or hepatitis			
Breast problems				Anemia or blood disorder			
Heart condition				Cancer			
High blood pressure				Lung disorder or asthma			
Birth defects or inherited diseases				Other :			

SEXUAL HISTORY							
	Ovarian Cancer		Uterine Cancer		Cervical Cancer		
Heredity diseases, e.g. Down's Syndrome	No		Yes				
If yes, please describe:							

SOCIAL HISTORY								
Marital status	Single		Married		Divorced		Widowed	
Do you take recreational drugs?	No		Yes					
Do you consume alcohol?	No		Yes					
Do you smoke?	No		Yes		If yes how many cigarettes per day?			
Did you have any blood transfusions?	No		Yes					

INFERTILITY PATIENTS					
Ovulation induction	Yes		No		If yes, please describe:
** The following data refers to your partner*					
Previous marriages?	No		Yes		
Previous children?	No		Yes		
Health status:					

MENSTRUAL HISTORY						
How old were you when you got your first period:				Date of last Menstrual period:		
How long does your period usually last: days				How often do you have your period?		
STD	Yes		No		If yes, what type?	
Contraception:	Yes		No		If yes, what type?	
Date of last PAP:		History of abnormal PAP?	Yes		No	
If yes, what treatment?						
Pelvic inflammatory disease:	Yes		No			
If yes, please describe:						

SEXUAL HISTORY						
Are you sexually active:			Coital frequency:		Sexual dysfunction:	
Do you have painful intercourse?	Yes		No			
Do you use any lubricant/douche?	Yes		No			
Other issues/concerns:						

SEXUAL HISTORY							
Heterosexual		Homosexual		Bisexual			

PREGNANCY HISTORY (INCLUDING MISCARRIAGES)					
Year	Weeks Pregnant	Weight of Newborn	Sex	Complications	Vaginal or C Section delivery

EXPLANATION OF THE BILLING PROCEDURE

Dearest Patient,

Thank you for choosing the GYN Emergent Care Center for your gynecological emergency.

We are here to take complete and immediate care of you. This includes labs, imaging, IV therapy, and surgical procedures if needed. We are able to provide these services real time and at one location because our facility is staffed with highly skilled all-female OB/GYNs utilizing state-of-the-art equipment. We promise to take care of your problem with compassion and competence.

The GYN Emergent Care Center operates much like a hospital. Unlike a hospital, however, we are more affordable and can provide highly specialized care. Our facility features significantly reduced wait times, state-of-the-art equipment, and the most advanced gynecological procedures.

For your care today, there may be two separate charges. The two separate charges may be for:

- The professional physician services from Complete Women Care (CWC). If you have any questions about the physician fees, please call CWC's business office at (562) 242-2525.
- The facility services from the GYN Emergent Care Center (ECC). If you have any questions about the facility charges, please call the ECC billing office at (310) 469-5111.

If an outside lab is utilized, you could possibly receive a separate bill from the facility that processed the specimen.

Based on your insurance plan, an emergency co-pay and/or coinsurance may apply, which you will be billed for after your insurance company processes your claim. Should you have any further questions, please do not hesitate to ask.

Sincerely,

GYN Emergent Care Center

AKNOWLEDGMENT

I have read and understand the billing structure for the GYN Emergent Care Center:

PRINT NAME	SIGNATURE	DATE
_____	_____	_____

COMMON QUESTIONS

• Are you in network, and will my claim be paid by my insurance?	If your private insurance has emergency coverage benefits, then your health plan will cover your care the exact same as any in-network facility EVEN if we aren't contracted with them! By law, this included both PPOs AND HMOs, so don't worry, come in and let us solve your OB/GYN emergency. If your insurance benefits only pay for a portion of your visit, rest assured that we offer generous discounts and will work with you to reduce your bill to a reasonable amount. The Gynecology Emergent Care Center (GYNECC), is considered an out of network facility with all HMO's, PPO's, and Indemnity plans. Under California Law, your private insurance is required to pay for emergency claims to out of network providers. The GYNECC will accept in-network emergency rates, and will work diligently with your payer to ensure your claim is paid.
• What is my ECC co-pay? • Do I have to pay up-front?	Your ER co-pay should be listed on your insurance card and it depends on your benefits. The GYNECC's main priority is to treat and solve your problem first, so you will not be charged a co-pay until after your insurance processes your claim. As a courtesy to our patients, if your policy specifies an Emergency Facility co-pay over $100.00, GYNECC will adjust-off the difference and you will only have to pay a maximum co-pay of $100,00. If you have any questions or concerns about the charges from a specific visit, GYNECC's billing department can work with you to find an affordable solution.
• I have Medi-Cal, am I covered?	Currently GYNECC does not accept Medi-Cal, however, the GYNECC does offer greatly discounted cash pricing options for our services. (Refer to Price List on SharePoint page)
• Why is there an Indigence Policy?	In order for the GYNECC to provide generous discounts, based on the needs of each individual patient, we need to have the form signed and kept on file.
• How much will my ECC visit cost? • When will I be billed?	If you have eligible insurance, you will be billed, after your insurance processes the claim. Benefits vary by payor and insurance product. GYNECC does our best to be cost efficient and fair. Be assured you that the GYNECC's fees are fractional to Hospital fees.
• Why are there so many forms to complete?	We are your advocate in getting your insurance claim paid and with your permission on these forms we then have the tools to deal with unpaid or underpaid claims, which we will do. These forms also allow us to provide you with generous discounts.

The GYN Emergent Care Center, is an Emergency Facility exclusively for women. You will be treated by a staff, of all female OB-GYN Board Certified Physicians. We diagnose, treat, and solve, most all gynecological issues in one visit. We can also perform same day emergency surgeries, if needed. We have less wait-time, less cost, and better doctors and equipment. ERs cost a lot of money, they wiill only stabilize you, and then tell you to make a separate follow-up appointment with an OB-GYN specialist. Urgent cares cost less than an ER,, but they do not have an OB-GYN specialist, onsite imaging, onsite lab, or a surgery center. They too will ask you to follow up with an OB-GYN specialist.

PRINT NAME _____ SIGNATURE _____ DATE _____

FINANCIAL POLICY

A copy of this form will be considered as acceptable as the original.

1. LIFETIME AUTHORIZATION OF RESPONSIBLE PARTY

I authorize direct payment of medical benefits to Gynecology Emergent Care Center and/or Complete Women Care (herein 'GYN-ECC & CWC') for any and all servicesrendered to me. If any insurance claim is failed on my behalf, I understand that I am fully responsible for any charges not covered or paid by my insurance carrier. This authorization does not imply in any way that Complete Women Care, Inc. will accept insurance benefits as payment in full. Any charge incurred to recover unpaid debts relating to my account will be my responsibility.

Initial

2. CREDIT CARD ON FILE

(Policy because your insurance requires us to collect your copays and deductibles.) I understand that once the insurance has paid their portion for my care, I will receive an Explanation of Benefits (EOB). The insurance plan EOB will state any balance remaining is to be paid by me. I agree that Complete Women Care may charge my credit card on file for the balance due when they receive a copy of the EOB. If the balance due is more than $200.00, I'll receive a courtesy call prior to my card being charged.

Initial

3. FINANCIAL RESPONSIBILITY FOR ANY DEDUCTIBLES (MEDI-CAL)

As of March 1, 2015, we will no longer accept Medi-Cal as a primary or a secondary payer. All patients with Medi-Cal as a secondary policy will be financially responsible for any deductibles or co-insurance that their primary policy deems patient responsibility.

Initial

4. PHYSICIAN-PATIENT COMMUNICATION AGREEMENT

I give my permission for the staff of Complete Women Care, Inc. to leave messages on my telephone answering machine regarding my health care, insurance benefits, and/or regarding my appointment. As a service to our patients, we provide a courtesy appointment reminder call and other important calls that may be placed using a pre-recorded message. By providing your cell phone or any other contact number, you consent to receiving such calls at that number.

Initial

5. NOTICE OF RETURNED CHECK FEE

I understand if my check payment is returned unpaid, I'll be assessed a $25 return fee in addition to my original payment amount.

Initial

6. REQUEST FOR CERTAIN FORMS

Forms that are requested by a patient take a considerable amount of staff time to process, and often take away from the time spent with a patient. To offset this cost, I understand that I will incur a charge of $25/form for EDD, Work Disability, or other government related forms. Forms that require a company letterhead, such as a 'return to work' authorization will incur a charge of $15/form, and forms for WIC will incur a charge of $5/form. I further authorize CWC to charge my credit card on file in the event I don't pay for these forms by the required due date.

Initial

7. LAB WORK

Complete Women Care will run some of the lab testing in-house. Labs that can't be ran in-house will be sent out to Primex, PathMD, Quest or LabCorp. You will receive a separate bill for any third-party lab services. In some situations, your insurance company dictates that we send out lab work to their preferred lab. It's your responsibility to inform our staff of your preferred lab. If you would like your send-out lab work to be sent to a specific lab, i.e., Quest or LabCorp, you must tell us on every visit.

Initial

My signature below acknowledges that I've read and accept the above statements and attached documents.

PRINT NAME _____ SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES | Effective May 21, 2014

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This *Notice of Privacy Practices* is being provided to you as a requirement of the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes under what circumstances our medical practice (hereto referred as "the Practice") may use and disclose medical information about you to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control medical information about you. Your medical information (i.e., "protected health information" for purposes of HIPAA) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition. We are required by law to maintain the privacy of your medical information and we must abide by the terms of this notice.

In this notice, we provide descriptions of the different ways that we may use and disclose your medical information. In some cases, an example is provided to describe the types of uses and disclosures of your medical information that may be made by us. In addition to the privacy protections provided under federal law (which are described in more detail below), and except in certain limited circumstances, California Law requires us to obtain your written consent (or, under some statutes or rules, written consent from your attorney, guardian, or upon court order) before we can use or disclose your information if you qualify as a patient that:

- Suffers from a sexually transmitted disease;
- Is HIV+ or has Acquired Immune Deficiency Syndrome (AIDS);
- Suffers from a mental disorder;
- Has a problem with substance abuse;
- Is eligible to receive benefits for the State of California for certain developmental disabilities or mental retardation;
- Receives rehabilitative services through the California Medi-Cal program;
- Is eligible to receive certain other benefits through California's Medi-Cal program

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

- Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at any time.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

OUR USES AND DISCLOSURES

We typically use or share your health information in the following ways.**Treat you-** We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization - We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services - We can use and share your health information to bill and get payment from health plans or other entities.

PRINT NAME _____ SIGNATURE _____ DATE _____

APPOINTMENT OF ADMINISTRATIVE REPRESENTATIVE; ASSIGNMENT OF BENEFITS AND RIGHTS; ASSIGNMENT OF CAUSES OF ACTION; AND AUTHORIZATION TO RELEASE INFORMATION

APPOINTMENT OF REPRESENTIVE: The undersigned hereby appoints Gynecology Emergent Care Center & Complete Women Care (herein "GYN-ECC & CWC"), or its assignee, as my duly authorized representative and assignee during any: (1) Administrative claims process; (2) Appeal or Review process for a denied or underpaid claim; or (3) State or Federal legal process, necessary to collect claims submitted on my behalf for health insurance benefits, but denied or underpaid by my plan. The CLAIMS ADMINISTRATOR, PLAN ADMINISTATOR or GROUP INSURANCE ADMINSTRATOR for my medical insurance plan are all hereby notified and directed by me to henceforth regard any and all communications, particularly including all requests for information, received from my representative during the administrative process, as though these communications had been received from me. I understand that the United States Department of Labor has published the national minimum standards for the administrative processing review of claims, found at **29 CPR 2560.503-1**. I ask all administrators to abide by these minimum standards. I demand complete and timely disclosure to my representative of (a) All pertinent documents, including the identity of their signatory or authors, and (b) The identity of any person or entity possessing the discretion to approve or deny my claim. In addition, I demand compliance with applicable California enactments regarding full and fair review of claims.

BUSINESS PURPOSE AND RIGHT TO RECEIVE BENEFITS: The duly authorized representative and assignee named above in (1) is Authorized to directly receive payment for the medical benefits due to me, under my insurance or plan. This assignment of benefits by me is complete. I retain no interest in the benefits due to me under these claims for medical care and facility fees. This assignment is given by me in return for the medical care and related services I have received or will receive, from the health providers associated with my representative and assignee. I understand that if my claims are denied and the denial is upheld, I remain financially responsible for payment of all charges incurred to the extent allowed by law. Additionally, regardless of my insurance benefits, if any, I understand I am financially responsible for the fees for the services rendered to the extent allowed by law. I understand that my assignment of these rights and my appointment of an administrative representative serves a valid business purpose. The purpose is to provide an effective mechanism for my doctors and other health care providers to deal with an administrative or legal process that may be necessary to collect the benefits due for the services provided. The medical and business purpose, my assignee is not necessarily my health care provider for assignments created under federal law in **MISIC v. BUILDING SERVICE HEALTH 789 F2D 1372 (9th CIR. 1986)**. In furtherance of this business purpose, my assignee is not necessarily my health care provider for any specific claim, but is rather the individual(s), organization, group and/or corporation designated by my providers to deal with all administrative and legal matters.

JUDICIAL REVIEW: If my claim for benefits is administratively denied in whole or in part, I hereby assign ALL causes of action for judicial review to the individual(s), organization, group and/or corporation designated in (1). My assignee may 'STAND IN MY SHOES", as that phrase is understood under assignment law. I intend my personal standing under the ERISA civil enforcement procedures (codified at **29 U.S.C. 1132**) to be transferred to my assignee, so that he, she, they or it may seek judicial review of benefits claim denies, under I 132(a)(l)(B). My assignment also includes my right to seek review as a "claimant", under 1132(c), of any administrator's refusal or failure to provide information, 30 days after a written request.

RELEASE OF INFORMATION: I also authorize release of information and payment of medical benefits to the physician or supplier for services described. I certify that the information given by me in the applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

DIRECT PAYMENT BY INSURANCE TO PATIENT: If my insurance company pays me or the Subscriber directly for services performed by GYN-ECC & CWC it is understood that within ten (10) days of receipt I will promptly bring such check and/or payment directly to GYN-ECC & CWC and endorse such check and/or payment directly over to GYN-ECC & CWC. Otherwise, I agree that any discount provided by GYN-ECC may be reversed at GYN-ECC & CWC's sole discretion and I shall be liable for the full amount billed and in addition, any and all actual costs for interest, legal and/or legal proceedings, or from a collection agency.

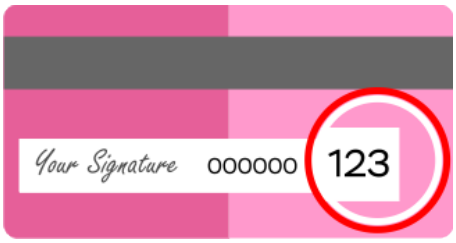
FINANCE CHARGES: a monthly finance charge of 1.5% (18% per annum) may be assessed on any unpaid balances due. This applies to any balance that is determined to be responsibility of patient and/or guarantor.

PRINT NAME _____ SIGNATURE _____ DATE _____

ELECTRONIC PAYMENT AUTHORIZATION FORM BANK ACCOUNT OR CREDIT CARD

PLEASE COMPLETE THE INFORMATION BELOW		
Billing Address:		
City, State, ZIP:		Phone:
Balance Owing ($):	Number of payments:	Start Date:
Amount per Payment ($):	Payment Frequency: ○ Weekly ○ Monthly	

CHECKING / SAVINGS ACCOUNT		CREDIT CARD	
○ Checking ○ Savings		○ Visa ○ Master Card ○ _____	
Name on Account:		Cardholder Name:	
Bank Name:		Credit Card #:	
Account #:		Expiration Date:	
Bank Routing #:		CVV2 (3-digit number on the back of card)	
Bank City & State:			



This form is for authorizing deduction of funds from your checking account, or as charged to your credit card.The undersigned authorizes Gynecology Emergent Care Center and Complete Women care (herein "GYN-ECC & CWC") to charge and/or debit my account as identified above according to the terms stated herein. I understand that if the Balance Owing GYN-ECC & CWC is increased, I authorize this plan to continue as long as the Amount per Payment remains unchanged and/or the final payment is equal to or less than the Amount per Payment. All other changes such as increasing the payment amount, frequency, and bank account or credit card numbers, will require a new Authorization Form. Further, I understand that this payment plan may be cancelled by GYN-ECC & CWC due to Non-Sufficient Funds (NSF). Further, I understand that I will be liable to pay any NSF fees charged by my bank. In the event that GYN-ECC & CWC is charged an NSF fee by the bank or a revoke authorization fee, I understand that I am liable to pay these fees and authorize GYN-ECC & CWC to debit or charge my account for any and all such fee amounts. Furthermore, the undersigned agrees that there is no refund of this transaction through a chargeback process. Undersigned acknowledges that the services may not be processed without a signature and printed name. If the undersigned chooses to fax this sheet, the undersigned agrees that their faxed signature constitutes, and is as good as, their original signature.

I represent and warrant that I am authorized to execute this payment authorization for the process of implementing this electronic payment plan. I indemnify and hold GYN-ECC & CWC harmless from damage, loss, or claim resulting from all authorized actions hereunder.

PRINT NAME _____ SIGNATURE _____ DATE _____

EMERGENCY MEDICAL CONDITION ATTESTATION TREATEMENT

I, _____ , suffer from OB/GYN problems of sufficient severity that I reasonably believe that the absence of immediate medical attention would result in my health being placed serious jeopardy, impairment to my bodily functions, and/or or dysfunction of my bodily organs.

As a result of these reasonable beliefs, I am seeking immediate medical attention for my OB/GYN problems on an emergent/emergency basis at the GYN Emergent Care Center located at 3711 Long Beach Blvd., Suite 101, Long Beach, CA 90807.

I understand and agree that the GYN Emergent Care Center and staff at the center will provide those emergency medical services, which may include medical treatment, laboratory tests, imaging, and/or other services that are necessary to diagnose and treat my OB/GYN problems.

Should my Emergent OB/GYN condition require Emergency Surgery in order to preserve my health, I understand and agree that such procedure(s) may be performed at Complete Care Surgical Center LLC, an Ambulatory Surgery Center, on an emergency basis.

PRINT NAME	SIGNATURE	DATE
_____	_____	_____

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 or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on 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 related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron 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 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 if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of 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 communicate in writing to all parties. Each party shall select an 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 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 officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti 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 3333.2. Any party may bring before the arbitrations 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 once 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 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 relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or 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 Effective as of the date of first medical services.

_____
Patient's or Patient Representative's Initials

If any provision if this arbitration agreement is held invalid of 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.

This agreement has two copies. One signed copy of this document is to be given to Patient. The second one is to be files in Patient's medical records.

_____
Authorized representative's Signature

GYN EMERGENT CARE CENTER
3711 Long Beach Blvd., suite 101B
Long Beach, CA 90807

_____ _____
Patient or Patient Representative's Signature Date

_____
Print Patient's Name

_____
If representative, Print Name and Relationship to Patient

INDENGENCY POLICY

Our indigency discount is no different than all PPO discounts from BCBS or all other commercial insurers in compliance with all applicable federal and state laws with respect to indigency assistance without any routine waiver of cost sharing, advertising, or solicitation, for underinsured or uninsured patients. **Once indigency is determined, collection is no longer undertaken with regard to the patient for the forgiven amount** without waiving any patient financial and legal obligation or responsibilities to the provider's actual total charges AND patient's right and eligibility, assigned to the provider, to claim for the reimbursement, under the health plan coverage, based on the provider's actual total and reasonable charges in accordance with Providers Corporate Indigency Policy, as the Indigency determination itself is a good effort to collect, and hospitals or doctors are NOT required under any federal or state laws, Medicare & PPACA, to take low-income, medically indigent, uninsured or underinsured patients to court, garnish their wages, or seize their homes, or send claims out to a collection agency when those patients don't or can't pay their hospital or doctor bills. New federal Affordable Care Act (ACA) laws protect **middle class** and **low income** Americans with the ACA Indigency Discount. In consideration of my particular medical needs and care expenses to be incurred solely based on such medical needs, and my financial ability to pay for such recommended medical services without or even with applicable insurance coverage, and with understanding and agreement that I am personally financially and legally obligated to and responsible for any and all professional or facility actual total charges regardless of any applicable insurance coverage, I hereby declare that I have financial difficulty to pay for part or all expenses because of the following:

- Middle class income, with high deductible / co-insurance, as medically indigent (see CMS definition below)
- Middle class income, Cash Pay - without any or applicable insurance for treatment from this provider/facility
- Low or a fixed income, with financial hardship, as financially indigent

More importantly, I declare that without the following indigent assistance, seeking for and continuing with medically appropriate and important health care would be impossible for me or would make me indigent if I were forced to pay for charges for my medically necessary care expenses. I also declare that I personally requested for such indigent assistance only after I was fully informed of my important medical treatment options and necessity solely based on my particular medical needs and availability of this provider Indigency Policy. Without my expressed permission, NONE of my private financial information or documents may be released to any 3rd party TPA, Exit for this Indigency Agreement or only medical information as requested by my health plan or TPA.

"Nothing in the Centers for Medicare & Medicaid services' (CMS') Regulations, Provider Reimbursement Manual, or Program Instructions prohibit a healthcare provider from waiving collection of charges to any patients, Medicare or non-Medicare, including low-income, uninsured or medically Indigent individuals, if it is done as a part of the health care provider indigency policy."

*"By "**indigency policy**" we mean a policy developed and utilized by a healthcare provider to determine patients' financial ability to pay for services. By "**medically indigent**" We mean patients whose health insurance coverage, if any, does not provide full coverage for all of their medical expenses and their medical expenses, in relationship to their income, would make them Indigent if they were forced to pay full charges for their medical expenses."*

I specifically request under this provider indigency policy for the following indigent discount assistance for the specific time periods from _____ to _____ , after Determining in good faith that I am in financial need or after reasonable collection efforts failed. Please check off all boxes that you would like to have combined

- ☐ Waiving collection of deductible _____
- ☐ Waiving Collection of co-insurance
- ☐ Waiving collection of co-pays/encounter fees _____
- ☐ Waiving collection of total cost-sharing
- ☐ I can afford to pay _____ for my total balance
- ☐ I am only willing to pay monthly for a total of _____

PRINT NAME	SIGNATURE	DATE
_____	_____	_____