Insurance cards copied ❑
Date: _____

Patient Registration Information

Account # : _____
Insurance # : _____
Co-Payment: $ _____

Please PRINT AND complete ALL sections below!

Is your condition a result of a work injury? YES NO An auto accident? YES NO Date of Injury: _____

PATIENT'S PERSONAL INFORMATION

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed Sex: ❑ Male ❑ Female

Name: _____ (last name) _____ (first name) _____ (initial)
Street address: _____ (Apt. #____) City: _____ State: ____ Zip: _____
Home phone: (____) _____ Work phone: (____) _____ Cell phone: (____) _____
Date of Birth: ____/____/_____ Driver's Lic.: (State & #) _____ SSN _____-____-_____
How do you wish to be addressed? _____ E-mail: _____ Fax # (____) _____
Employer / Name of School: _____ ❑ Full Time ❑ Part Time
Spouse's Name: _____ (last) (first) (initial) Spouse's Work # (____) _____ SSN _____-____-_____

PATIENT'S / RESPONSIBLE PARTY INFORMATION

Responsible party: _____ Date of Birth: ____/____/_____
Relationship to Patient: ❑ Self ❑ Spouse ❑ Other _____ SSN _____-____-_____
Responsible party's home phone: (____) _____ Work phone: (____) _____
Address: _____ (Apt. #____) City: _____ State: ____ Zip: _____
Employer's name: _____ Phone number: (____) _____
Address: _____ City: _____ State: ____ Zip: _____
Your occupation: _____
Spouse's Employer's name: _____ Spouse's Work phone: (____) _____
Address: _____ City: _____ State: ____ Zip: _____

PATIENT'S INSURANCE INFORMATION

Please present insurance cards to receptionist.

PRIMARY insurance company's name: _____
Insurance address: _____ City: _____ State: ____ Zip: _____
Name of insured: _____ Date of Birth: ____/____/_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Other ☐ Child
Insurance ID number: _____ Group number: _____
SECONDARY insurance company's name: _____
Insurance address: _____ City: _____ State: ____ Zip: _____
Name of insured: _____ Date of Birth: ____/____/_____ Relationship to insured: ☐ Self ☐ Spouse ☐ Other ☐ Child
Insurance ID number: _____ Group number: _____
Check if appropriate: ❑ Medigap policy ❑ Retiree coverage

PATIENT'S REFERRAL INFORMATION

(please circle one)

Referred by: _____ If referred by a friend, may we thank him or her? YES NO
Name(s) of other physician(s) who care for you: _____

EMERGENCY CONTACT

Name of person not living with you: _____ Relationship: _____
Address: _____ City: _____ State: ____ Zip: _____
Phone number (home): (____) _____ Phone number (work): (____) _____

Assignment of Benefits • Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made directly to _____, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits.

I further agree that a photocopy of this agreement shall be as valid as the original.

Date: _____ Your Signature: _____

Method of Payment: ❑ Cash ❑ Check ❑ Credit Card

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HISTORIA DE PEDIATRIA

PEDIATRIC PATIENT HISTORY

PLEASE BRING ALL MEDICATIONS, INCLUDING OVER-THE-COUNTER DRUGS, TO EACH DOCTOR'S VISIT

NOMBRE
Name _____ FECHA DE NACIMIENTO Date of Birth _____ EDAD Age _____
FIRST MIDDLE LAST

Telephone Number (____) _____ Sex: ☐ F ☐ M Height: ____ ft. ____ in. Weight: ____
TEL DE CASA ESTATURA PESO

Do you think patient's health is: ☐ Good ☐ Fair ☐ Poor

PATIENT'S ALLERGIES / ALLERGIAS

FOODS ► COMIDA MEDS./DRUGS ►MEIDCINAS

HAS YOUR CHILD EVER HAD A SEVERE REACTION TO AN INJECTION OR "SHOT"? ☐ YES ☐ NO

IF YES, WHAT KIND OF INJECTION?

FOR WHAT CONDITION WAS THE INJECTION GIVEN?

COMMENTS

PATIENT'S FAMILY HISTORY / HISTORIA DE FAMILIA

HAVE ANY MEMBERS OF THE PATIENT'S FAMILY (PARENTS, GRANDPARENTS, AUNTS, UNCLES, BROTHERS AND SISTERS, ETC.) HAD ANY OF THE FOLLOWING DISEASES?

DISEASE	NO	YES	IF YES, STATE RELATIONSHIP AND AGE
ALLERGIES (ASTHMA, ECZEMA, HAY FEVER, HIVES)			
ANEMIA OR JAUNDICE			
SICKLE CELL DISEASE			
BLEEDING DISEASES (INCLUDE HEMOPHILIA)			
HEART DISEASE/HIGH CHOLESTEROL			
HIGH BLOOD PRESSURE			
CANCER			
KIDNEY DISEASE			
TUBERCULOSIS (TB)			
DIABETES (SUGAR)			
SEIZURES (CONVULSIONS)			
MENTAL RETARDATION			
PSYCHIATRIC DISORDERS			
BIRTH DEFECTS			
SCOLIOSIS			
ALCOHOLISM/DRUG ABUSE			
CHILD/SEXUAL ABUSE			

TO BE FILLED IN BY PARENTS

PATIENT'S BIRTH AND DEVELOPMENT

BIRTHWEIGHT	LENGTH	☐ FULL TERM OR ☐ PREMATURE	BABY'S CONDITION AT BIRTH AND IN NEWBORN NURSERY	☐ NORMAL ☐ ABNORMAL

SAT ALONE ____ MO. WALKED ALONE ____ MO. FIRST WORDS ____ MO. TALKED IN PHRASES ____ MO.

COMMENTS

PAST MEDICAL HISTORY / HISTORIA MEDICA

HAS YOUR CHILD HAD ANY OF THE FOLLOWING?

☐ RECURRENT EAR INFECTIONS	☐ ANEMIA	☐ ASTHMA
☐ MENINGITIS (BRAIN INFECTION)	☐ SICKLE CELL DISEASE	☐ ECZEMA
☐ SEPSIS (BLOOD INFECTION)	☐ FRACTURES	☐ SEIZURES (CONVULSIONS)
☐ PNEUMONIA	☐ CONCUSSION OR MAJOR HEAD INJURY	☐ SCHOOL PROBLEMS
☐ URINARY, KIDNEY, BLADDER INFECTION	☐ ABDOMINAL/STOOL PROBLEMS	☐ EMOTIONAL/PSYCHIATRIC PROBLEMS
☐ CHICKENPOX	☐ ALLERGIES	☐ LEAD EXPOSURE

PRIOR HOSPITALIZATIONS, OPERATIONS, OR SERIOUS INJURIES

(PLEASE GIVE DATE)

CIRCULAR

PHYSICIAN'S SIGNATURE

Laboratory tests, X-rays and Authorizations

I understand that any laboratory test requests, x-ray/imaging requests, authorizations obtained for me are EXTREMELY important for my health and that I will follow up on them in a timely manner, so as not to delay treatment or diagnosis. If I do not receive notification of my laboratory results, x-ray results, or authorizations within 2 weeks, I will call the doctor's office.

*Yo entiendo que cualquier examen de sangre estudio de radiografias, o autorizacion que sea obtenido para mi, es **EXTREMAMENTE** importante para mi salud. Voy a sagir altanto de mis estudios o autorizaciones para no prolongar mi tratamiento o diagnostico. Si no recibo notificacion de mis resutlatdso del laboratorio, rayo-x, o autorizacion en 2 semanas, llamare a ,o doctor.*

Change of Information

If I have change in my phone numbers, address, name or insurance information, I will call or write immediately to notify the doctor's office.

Si tengo cambio de telefono, direccion, nombre, o aseguranza, llamare a mi doctor inmediatamente.

Signature/ Firma

Print Name/ Nombre en molde

Date/ Fecha

Susan R. Kawakami, D.O.
8556 Florence Avenue
Downey, CA 90240
(562) 861-0101

Susan R. Kawakami, D.O.
8556 Florence Avenue
Downey, CA 90240

AUTHORIZATION FOR TREATMENT

The undersigned consents, whether he/she signs as agent or as patient, to treatment as necessary or desirable but not restricted to whatever drug, medicine, performance of operations and conduct of laboratory, x-ray, or other studies that may be used by the attending physician, or qualified designate.

Patient Signature_____

Date_____ Print Full Name_____
[] PATIENT [] AGENT

CONSENT TO TREAT MINOR

The above named person is a minor. The Medical Group is authorized to provide treatment whether or not we accompany said minor, or whether said minor comes to your office accompanied by another relative, guardian, or any other party who brings this minor in for said treatment.

Date_____ By_____
[] PATIENT [] GUARDIAN

Witness _____

ASSIGNMENT OF INSURANCE BENEFITS, AND WAIVER

ASSIGNMENT: I hereby assign to the group all benefits provided by my insurance policies for medical, obstetrical, surgical, radiological and laboratory services.

WAIVER: I understand that I am financially responsible for all charges incurred at the group if my available insurance benefits and/or eligibility are declined by the insurer (Indemnity) or Health Plan (HMO).

Signature of Patient_____ Date_____

Signature of Parent/Guardian _____ Date_____

A PHOTOCOPY OF THIS DOCUMENT IS VALID AS THE ORIGINAL _____(INITIAL)

Dr. Susan Kawakami

NOTICE OF PRIVACY PRACTICES

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.

If you have any questions about this notice, please contact the Privacy Official at (562) 861-0101.

This NOTICE is provided to you on behalf of Dr. Susan Kawakami

WHO WILL FOLLOW THIS NOTICE:

This notice describes our medical office's practices and that of:

- **Any health care professional authorized to enter information into your your medical office chart.**
- **All departments and units of the medical office.**
- **All employees, staff and other medical office personnel.**

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at the medical office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the medical office, whether made by medical office personnel or your personal doctor.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

The following categories describe different ways that we use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- For Treatment. We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other medical office personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the orthopedist if you have diabetes so that we can arrange for medications and treatments. Different departments of the medical office also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose medical information about you to people outside the medical office who may be involved in your medical care after you leave the medical office, such as Home Care, family members, hospitals or others we use to provide services that are part of your care.
- For Payment. We may use and disclose medical information about you so that treatment and services you receive at the medical office may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about tests performed on you at the medical office so your health plan will pay us or reimburse you for the tests. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. We may use and disclose medical information about

you to other health care professionals involved in your care to enable these professionals s to obtain payment for the services they have provided to you.

- For Health Care Operations. We may use and disclose medical information about you for medical office operations. These uses and disclosures are necessary to run the medical office and make sure that all of our patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many medical office patients to decide what additional services the medical office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students and other medical office personnel for review and learning purposes. We may also combine our medical information with medical information from other medical offices to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you for this set of medical information so others may use it to study health care and health care delivery without learning who the specific patients are.
- Appointment Reminders. We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or medical care at the medical office.
- Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- Health-Related Benefits and Services. We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- Individuals Identified by You as Involved in Your Care or Payment for Your Care. We may release directly relevant medical information about you to a friend or family member who is involved in your medical care. We may also give information to someone who helps pay for your care. Unless there is a specific written request from you to the contrary, we may also tell your family or friends your condition. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.
- Research. Under certain circumstances, we may use and disclose medical information you for research purposes. For example, a research project may involve comparing the health recovery of all patients who receive one medication to those who receive another, for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' need for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this research approval process, but we may, however disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave the medical office. We will almost always ask for your specific permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the medical office.
- As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law. [This includes but is not limited to information about cancer diagnoses and treatment to the State Cancer Registry who may contact you regarding a cancer diagnosis or a request to participate in a research study that has been identified as beneficial to Public Health Purposes, reporting of certain diseases to the Department of Health Services, certain birth defects to the California Birth Defects Program.]
- To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

SPECIAL SITUATIONS

- Organ and Tissue Donation. If you are an organ donor, we may release medical 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 medical information about you as required by military command authorities. We may also release medical information about foreign military personnel to the appropriate foreign military authority.
- Workers' Compensation. We may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

- Public Health Risks. We may disclose medical information about you for public health activities. These activities generally include the following:
  1. To prevent or control disease, injury or disability
  2. To report births and deaths
  3. To report the abuse or neglect of children, elders and dependent adults
  4. To report reactions to medications or problems with products
  5. To notify people of recalls of products they may be using
  6. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
  7. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by la These oversight activities include, for example, 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 law
- Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose medical information about in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discover request, or other lawful process by someone else involved in the dispute, but only if efforts have been made t tell you about the request (which may include written notice to you) or to obtain an order protecting the information requested.
- Law Enforcement. We may release medical information if asked to do so by a law enforcement official:
  1. In response to a court order, subpoena, warrant, summons or similar process
  2. To identify or locate a suspect, fugitive, material witness, or missing person
  3. About the victim of a crime if under certain limited circumstances, we are unable to obtain the person's agreement
  4. About a death we believe may be the result of criminal conduct
  5. About criminal conduct at the medical office
  6. In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location the person who committed the crime
- Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the medical office to funeral directors as necessary to carry out their duties.
- National Security and Intelligence Activities. We may release information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
- Protective Services for the President and Others. We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct spec investigations.
- Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (. for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we maintain about you

- Right to Inspect and Copy. You have the right to inspect and copy medical information that may be used to make decision about your care. Usually, this includes medical and billing records, but may not include some mental health information.
- To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Medical Office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing o other supplies associated with your request. A form for this purpose is available.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medic information, you may request that the denial be reviewed. Another licensed health care professional chosen by the medical office will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the medical office A form for this purpose is available.

To request an amendment, your request must be made in writing and submitted to the Medical Office. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
2. Is not part of the medical information kept by or for the medical office;
3. Is not part of the information which you would be permitted to inspect and copy;
4. Is already accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you other than our own uses for treatment, payment and health care operations, as those functions are described above.

  To request this list of accounting disclosures, you must submit your request in writing to the Medical Office. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list(for example, on paper or electronically). The first list you request within a 12-month period will be free. For add ional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A form for this purpose is available.

  To request confidential communications, you must make your request in writing to the Medical Office. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. A form for this purpose is available.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

TO OBTAIN A PAPER COPY OF THIS NOTICE, YOU MAY REQUEST A COPY IN PERSON AT THE FRONT DESK OF THE MEDICAL OFFICE.

- CHANGES TO THIS NOTICE

  We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already

  have bout you as well as any information we receive in the future. We will post a copy of the current notice in the medical office. The notice will contain on the first page, in the top right-hand corner, the effective date.

- COMPLAINTS

  If you believe your privacy rights have been violated, you may file a complaint with the medical office or with the Secretary of the Department of Health and Human Services. To file a complaint with the medical office, contact: [Fro office personnel] All complaints must be submitted in writing.

  You will not be penalized for filing a complaint

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Acknowledgement

acknowledge that I received a copy of "Notice of Privacy Practices" from Dr. Susan R. Kawakami,

on_____(date)

Susan R. Kawakami, D.O.
8556 Florence Avenue
Downey, CA 90240

Signature_____

Printed Name_____

AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION

I authorize Dr. Susan Kawakami to use and disclose a copy of the specific health and medical information described below regarding:

(Name of Patient) print name of patient_____

consisting of: medical records

(Describe information to be used/disclosed here)

Name of Recipient: (Those with whom you want us to share your medical information, e.g. family members)_____

_____

for the purpose of:

(Describe purpose of disclosure here)

If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this Authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

This authorization effective date:_____ expiration date_____

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By:_____ Date: _____
(Patient)

Or By:_____ Date: _____
(Patient's Representative)

Description of Representative's Authority _____

_____

Dr. Susan R. Kawakami D.O
8556 Florence Ave,
Downey, Ca 90241

I am aware that I'm responsible to bring my co-payment (CASH ONLY) at the time of visit. _____ (initial)

I am also responsible for providing the physician with a list of my medications to assist with my healthcare. _____(initial)

I am also aware and responsible for canceling/rescheduling 24 hrs in advance or a charge of $ 25.00 will apply or be billed to me the patient._____(initial)

Yo soy responsable de dar mi pago de co-payment (CASH ONLY) al tiempo de mi visita. _____ (inicial)

Yo soy responsible de traer mi lista de medicamentos para asistir en mi cuidado. _____(inicial)

Yo soy responsable en cancelar citas dentro de 24 hrs de la cita original o Habra cobro addicional de $ 25.00. _____(inicial)

_____
Signiture - Firma

_____
Print name – nombre en molde

_____
Date - Fecha

A Message To Our Patients About Arbitration

Our goal is to provide medical care to our patients in a way that will avoid disputes. We know that most problems occur as a result of miscommunication. So, if you have concerns about your medical care, please discuss them with us.

Please read the attached contract entitled Physician-Patient Arbitration Agreement. By signing the contract, we are agreeing that any dispute arising out of the medical services you receive will be resolved in binding arbitration before an arbitration panel instead of by a lawsuit in a court of law.

Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

We believe that the method of resolving disputes in arbitration spares the parties some of the rigors of a court trial and the publicity which may accompany judicial proceedings.

Thank you.

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. However, following the assertion of any claim against the physician, 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 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, 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 Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. 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 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 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.

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

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's 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 Patient's medical records.
(2-08)