YOUR EMAIL:_____

PATIENT REGISTRATION FORM

PATIENT'S ACCOUNT #	NAME (LAST, FIRST INIT.)		DOCTOR
SPOUSE/PARENT/RESP. PARTY	HOME PHONE NO.	DOB	DL#
ADDRESS	CITY	STATE	ZIP CODE
SOCIAL SECURITY NO.	SEX (M/F)	MARITAL STATUS	ETHNICITY
OCCUPATION	EMPLOYER	NATURE OF BUSINESS	
EMPLOYER ADDRESS	CITY	STATE	ZIP CODE
EMPLOYER PHONE NO.	REFERRAL	IN CASE OF EMERGENCY CONTACT PERSON AND PHONE NO.	
PRIMARY INSURANCE INFO. PLEASE PROVIDE COPY OF INSURANCE CARD	INSURANCE NAME & ADDRESS		
SUBSCRIBER NO.	GROUP NO.	COVERAGE FROM	COVERAGE TO
ANNUAL DEDUCTIBLE / DEDUCTIBLE MET / PAY PLAN	CO-PAYMENT	% OF COVERAGE	CLAIM NUMBER
CLAIM NUMBER	INSURED'S NAME	INSURED'S DATE OF BIRTH	
INSURED'S SEX (M/F)	INSURED'S PHONE NO.	INSURED'S SOCIAL SECURITY NO.	
INSURED'S ADDRESS	CITY	STATE	ZIP CODE
INSURED'S EMPLOYER		EMPLOYER'S PHONE NO.	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE
SECONDARY INSURANCE INFO. PLEASE PROVIDE COPY OF INSURANCE CARD	INSURANCE NAME & ADDRESS		
SUBSCRIBER NO.	GROUP NO.	COVERAGE FROM	COVERAGE TO
ANNUAL DEDUCTIBLE / DEDUCTIBLE MET	CO-PAYMENT	% OF COVERAGE	CLAIM NUMBER
CLAIM NUMBER	INSURED'S NAME	INSURED'S DATE OF BIRTH	
INSURED'S SEX (M/F)	INSURED'S PHONE NO.	INSURED'S SOCIAL SECURITY NO.	
INSURED'S ADDRESS	CITY	STATE	ZIP CODE
INSURED'S EMPLOYER		EMPLOYER'S PHONE NO.	
EMPLOYER'S ADDRESS	CITY	STATE	ZIP CODE

I authorize payment of medical benefits be made directly to the physician provider for services rendered.

_____ _____

DATE SIGNED (Insured or Authorized)

I authorize any insurance company, organization, employer, hospital, physician, or pharmacist to release any information to this claim and the expenses reported.

_____ _____

DATE SIGNED (Insured or Authorized)

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.

By: _____ _____
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 Association Name

_____
(If Representative, Print Name and Relationship to Patient)

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

CENTRAL COAST MULTI-SPECIALTY MEDICAL GROUP, INC.

Edward J. Ramirez, M.D.

OUR FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Unless other arrangements have been made in advance, full payment for office services is due at the time of service. For your convenience we will accept **VISA, MASTERCARD & AMERICAN EXPRESS** payments. We also accept personal checks. However, there is a $20 processing fee plus a $5 bank fee for all returned checks and we reserve the right to no longer accept this as a form of payment.

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. Meaning the payment will come directly to the doctor. If your insurance company fails to pay the practice within 60 days, we will send you a statement for payment. If we later receive payment from your insurance we will refund any overpayment to you.

Dr. Ramirez is a network provider for many insurance companies; therefore, we accept a contracted reimbursement for our services to patients with these insurances. Your co-pay, co-insurance and deductible will be expected at the time of service and we will bill your insurance company for the remainder.

If we are NOT network providers for your insurance, we do NOT accept the reduced reimbursement contract. We will accept your payment at the time of services and will courtesy bill your insurance. Your insurance will then reimburse you directly at their "out or network" rate.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered"; you will be responsible for the complete charge. Payment is due upon receipt of statement from our office. We will make every attempt to determine from your insurance company if the services to be provided are "covered", but it is your responsibility to read your handbook and know what your insurance will cover.

Services provided in the hospital for an emergency will be billed to your insurance company. Any balance due is your responsibility. If services to be provided in the hospital are scheduled we will calculate what your estimated insurance payment is and you will be responsible for the co-insurance prior to surgery. Any balances due after your insurance pays will be billed to you.

For all services rendered to minor patients, we will look to the parent or guardian with custody for payment. However, we are able to see patients without parental consent due to the nature of care.

If you need to cancel your appointment, we ask that you call us no less than 24 hours before your appointment to avoid a $50 cancellation charge. You will also be charged $50 for an appointment that you do not show up for.

I have read and understand the financial policy of the practice and I agree to be bound by its terms, I also understand that such terms may be amended from time to time by the management.

Name of Patient:_____Date:_____

Signature:_____