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, 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 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. Filling of any action in any court by the physician to collect any fee from the patient shall 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 an arbitrator (party arbitrator) within thirty days and the third arbitrator (neutral arbitrator) should 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 rate 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 the 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 an 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 with 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 arbitrators a motion for summary judgement 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 rating 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's 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 JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

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

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

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

_____
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

LASER TOUCH MEDICAL CLINIC
1-888-527-3715
www.laser15.com

MEDICAL HISTORY

CHECK THE APPROPRIATE BOX NEXT TO THE CONDITION FOR WHICH YOU HAVE BEEN TREATED FOR:

- ☐ ACNE
- ☐ BURNS/GRAFTED SKIN
- ☐ DIABETES/DEABETES NEUROPATHY
- ☐ HERPES
- ☐ HIGH BLOOD PRESSURE
- ☐ CANCER OR RADIATION CHEMOTHERAPY
- ☐ STEROID/THERAPY
- ☐ HORMONAL THERAPY
- ☐ THYROID DISEASE
- ☐ OTHER:_____
- ☐ KIDNEY DISEASE
- ☐ LUPUS ERYTHMATOSIS
- ☐ MELANOMA
- ☐ PORT WINE HEMANGIOMA
- ☐ PSORIASIS
- ☐ SHINGLES
- ☐ KAPOSI SARCOMA
- ☐ KELOID FORMATION/SCARS
- ☐ HIRSUTISM

SIGNATURE: _____ **DATE:** _____

Brilliant DISTINCTIONS PROGRAM

Brilliant Distinctions™ Program
Members Get More!

Brilliant Distinction – Patient Loyalty Program Registration Sheet

Activation Code (office only):

1. Name (First, Last):

2. Date of Birth (mm/dd/yyyy):

3. Email Address:

4. Mailing Address:

5. Password Default: botox

6. Have you ever been treated with (mark X with all that apply):

   - Botox
   - Juvederm
   - Restylane
   - Collagen
   - Other injectable Dermal Fillers
   - None of the Above

X_____ Date:_____

I Authorize Laser Touch Medical Clinic to enroll me to their Patient Loyalty Program.

Kamran Hakimian , M.D.
Patient Record of Disclosures

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

I have read, understood and received the HIPAA Notice of Privacy Practices.

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

____Home Telephone #_____
____Okay to leave detailed information
____Leave only call back name and number
____Okay to fax to home

____Written communication
____ Okay to mail to my home
____ Okay to mail to work/office
____ Okay to fax to office

____Work Telephone #_____
____Okay to leave detailed information
____Leave only call back name and number

____ Cell Phone #_____
____ Okay to leave detailed information
____ Leave only call back name and number

Patient signature: X_____ Date _____

Print patient name: _____ Date of birth _____

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Date	**Disclosure to whom address or fax #**	**Description/ purpose of disclosure**	**By whom disclosed**

LASER TOUCH MEDICAL CLINIC

PERSONAL INFORMATION
INFORMACION PERSONAL

PATIENT: _____ **BIRTH DATE:** _____ **AGE** _____
Last name/ Apellido First Name/Nombre

DRIVER LIC. / I.D # _____ **SOCIAL SEC:** _____ **MARITAL STATUS: M S W D**
de LICENCIA / I.D # SEGURO SOCIAL ESTADO CIVIL: C S V D

HOME ADDRESS: _____ **CITY:** _____
DIRECCION DE CASA CIUDAD

STATE: _____ **ZIP:** _____ **EMAIL:** _____
ESTADO CODIGO POSTAL CORREO ELECTRONICO

BILLING ADDRESS: _____
DIRECCION DE CORREO

HOME PHONE: _____ **WORK PHONE:** _____ **CELL PHONE:** _____
NUMERO DE CASA NUMERO DE TRABAJO NUMERO DE CELLULAR

EMPLOYER: _____ **OCCUPATION:** _____
TRABAJO OCUPACION

WORK ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____
NUMERO DE TRABAJO CIUDAD ESTADO CODIGO POSTAL

SPOUSE / PARENT NAME: _____ **SPOUSE / PARENT PHONE #:** _____
NOMBRE DEL PADRE / DEL ESPOSO(A) NUMERO DEL PADRE / EPOSO(A)

IN CASE OF EMERGENGY NOTIFY (OTHERTHAN SPOUSE) _____
EN CASO DE EMERGENCIA NOTIFICAR A (APARTE DEL ESPOSO(A)

ADDRESS: _____ **PHONE:** _____
DIRECCION NUMERO DE TELEFONO

REFERRED BY: MAIL: _____ **MAGAZINE:** _____ **RADIO:** _____ **OTHER:** _____
REFERIDO POR: CORREO REVISTA RADIO OTRO

INTERNET: _____ **FRIEND (NAME):** _____
INTERNET AMIGA(O)

SERVICES OR INFORMATION INTERESTED / SERVICIOS O INFORMACION INTERESADOS:

☐ **BOTOX**

☐ **MIGRAINE HEADACHES**
DOLORES DE MIGRANA

☐ **SWEATING HANDS OR UNDERARMS**
MANOS SUDOROSAS O AXILLAS

☐ **DERMAL FILLERS**
RELLENOS

☐ **THREADING**

☐ **LASER HAIR REMOVAL**
RMOBER EL BELLO

☐ **SKIN CARE**
QUIDADO DE LA PIEL

☐ **ACNE**

☐ **SUN DAMAGE**
MANCHAS DEL SOL

☐ **STRETCH MARKS**
ESTRIAS

☐ **OPEN PORES**
PORAS ABIERTAS

☐ **PEELS**
PEELES FACIALES

☐ **VEIN TREATMENT**
TRATAMIENTO PARA VENAS

AUTHORIZATION

I hereby authorize the above medical Doctor to release any information acquired in the course of my examination and treatment. I will not challenge such credit, debit or financing card payments once the services are provided. The practice encourages complete post-op care and follow-up interaction to address any issues that might arise and that this non credit card challenge agreement is irrevocable. I understand that for any outstanding balance on my account, there will be a $40 monthly late charge fee as well as a $15 statement fee.

PATIENT'S SIGNATURE _____ **DATE:** _____