

PATIENT INFORMATION

Date _____ Email _____
Patient's Name _____
Responsible Party: _____ Relationship: _____
Street _____ Apt.# _____
City _____ State _____ ZIP _____
Home Phone () _____ Cell Phone () _____ Work Phone () _____
Date of Birth _____ Age _____ Gender: Male Female
Soc. Sec. # _____ / _____ / _____ Driver's License # _____
Employer _____
Which Doctor will you be seeing today? _____

INSURANCE INFORMATION

Do You have insurance? YES NO Type: PPO _____ Medi Care _____ Other _____
Insurance Co. _____ Policy/Group No. _____

IF DIFFERENT FROM PATIENT

Name of Primary Insurance Policy Holder _____
Insured's SS# _____ / _____ / _____ Date of Birth _____

SECONDARY INSURANCE INFORMATION

Do you have secondary insurance? YES NO
Insurance Co. _____ Policy/Group No. _____

NEAREST RELATIVE NOT LIVING WITH YOU

Name _____ Relationship: _____
Street _____ Phone # _____
City _____ State _____ ZIP _____

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE- I authorize the release of any medical information necessary to process any claim incurred. I authorize payment of medical benefits from either government or private insurance companies, to my physician for any services provided. I understand that if the physician is not contracted with the above listed insurance company, this office will be billing as a courtesy and that I am responsible for any unpaid charges. Office visits not cancelled 24 hours in advance may be subject to a \$25.00 fee.

SIGNED: _____ DATE: _____

As a courtesy and service to our patients, we bill your insurance company free of charge. We will bill any deductibles or co-payments to your credit card directly.

Visa Mastercard Card Number _____ Exp. Date _____

Signature _____

January 1, 2009

PATIENT 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 our "Privacy Officer".

WHO WILL FOLLOW THIS NOTICE:

This notice describes our office's practices including that of

- any health care professional authorized to enter information to your medical chart
- all departments and units of the medical office, including the billing office
- all employees, staff and other 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 our 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 office, whether made by office personnel or your 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 the medical information.

We are required by law to:

- make sure that medical information that identifies you is kept in private;
- give you this notice of legal duties and privacy practices with respect to medical information about you; and
- 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, medical assistants, technicians or other personnel who are involved in taking care of you at our office. For example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow a healing process. We also may disclose a medical information about you to people outside the office who may be involved in your medical care after you leave our office, such as family member, clergy, or others we use to provide services that are part of your care.

➤ **For Payment.** We may use medical information about you so that the treatment and the services you receive at our 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 laboratory tests you receive at our 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 a prior approval or to determine whether your plan will cover the treatment.

➤ **For Health Care Operations.** We may use medical information about you for the office operations. These uses and disclosures are necessary to run the 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 disclose information to doctors, medical assistants, technicians, and other office personnel for review and learning purposes.

Subject to certain restrictions, we may also disclose medical information to other entities for their own health care operations. For example, we may release information to your health plan in order for them to run quality-related activities and performance measures.

- **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 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 Involved in Your Care or Payment for Your Care.** We may release medical information about you to a friend or a family member who is involved in your medical care. We may also give information to someone who helps pay for your care. 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.

- **As Required by Law.** We will disclose medical information about you when required to do so by federal, state or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose medical information about you when necessary to prevent 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:

➤ **Workers' Compensation.** We may release medical information about you for workers' compensation or similar programs. These programs provides 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:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- 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;
- to notify the appropriate government authority if we believe a patient has been a 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 law. 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 law suit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request 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:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct; and
- in emergency circumstances to report a crime, the location of the crime or victims; or the identity, description or location of the person who committed the crime.

➤ **Coroners, Medical Examiners and Funeral Directors.** We may use and disclose 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 office to funeral directors as necessary to carry out their duties.

➤ **National Security and Intelligence Activities.** We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

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 right to inspect and copy medical information that may be used to make a decision about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to our "Privacy Officer". If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the 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 office.

To request the amendment, your request must be made in writing and submitted to our "Privacy Officer". 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:

- has not created by us, unless the person or entity that created the information is no longer available to make an amendment;
- is not part of the medical information kept by or for the office;
- is not part of the information which you would be permitted to inspect and copy;
or
- is 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.

To request this list or accounting of disclosures, you must submit your request in writing to our "Privacy Officer". Your request must state a time period which may not be longer than six years and may not include dates before February 26, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional 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.

➤ **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to our "Privacy Officer". In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

➤ **Right to Request Confidential Communications.** You have right to request that we communicate with you about your medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to our

"Privacy Officer". 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.

➤ **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.

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 about you as well as any information we receive in the future. We will post the copy of the current notice in the office. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register at or are admitted to the office for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with the office, contact "Privacy Officer" at (949) 581 - 2002. All complaints must be submitted in writing.

You will not be penalized for filing the 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.

This is prepared by the office of:
Alireza Etemadi, M.D.

ACKNOWLEDGE AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a copy of the Notice of Privacy Practices for (Dr.Etemadi's) Medical Practice at 24881 Alicia Pkwy Unit N, Laguna Hills, CA 92653. As it is currently in effect. I have read and understand the information presented in the notice. I understand that I am entitled to receive a copy at the address above. I also understand that Dr.Etemadi reserves the right to change the notice. If any future changes are made to the notice, on my next visit following implementation of such changes, I will be provided a copy of the new notice in effect.

Patient Name _____

Patient Signature _____

Date _____

Restrictions on Patient Information: _____

Special Contact Requirement: _____

For office use only

Release of Medical Records

To: _____

Name of doctor or facility: _____

Phone: _____

Fax: _____

* * *

Please forward a copy of records on the following patient:

Name of patient: _____

DOB:

Patient's signature:

to the office of:

**A. Etemadi, M.D.
24881 Alicia Parkway
Suite N
Laguna Hills, CA 92653**

**Tel: (949) 581-2002
Fax: (949) 581-2221**

Thank you for your prompt attention to this request.

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)

By: _____
Patient's or Patient 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.