Institute for Progressive Medicine

4 Hughes, Suite #175 Irvine, CA 92618 Tel: (949) 600-5100 Fax: (949)600-5101
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Medical Doctor New Patient Packet

PLEASE BRING COMPLETED FORMS TO YOUR FIRST APPOINTMENT
(Please Print Clearly)

Today's Date: ___/___/___ Driv. Lic. # _____

Name: _____ (First, Middle Initial, Last)

Primary Reason for Visit: _____

Birth Date: ____/____/_____ Age: _____ □ Female □ Male Race: ___ Ethnicity: ____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Primary Telephone Number: (_____) _____-_____ □ home □ cell

Secondary Telephone Number: (_____) _____-_____ □ home □ cell

Occupation: _____ Employer: _____

Employer Telephone: (_____) _____-_____

Marital Status: □ Single □ Married □ Divorced □ Separated □ Widowed

Spouse/Partner Name: _____ Spouse/Partner Birth Date: ___/___/_____

Payment must be made at the time of service. We only accept Medicare (provided you have not assigned your benefits to an HMO). We cannot accept HMO, EPO, Medi-Cal or private PPO Insurance for office visits and procedures.

Who is financially responsible for this bill? _____
I will be paying today with: □ Cash □ Check □ Visa/MC □ Medicare PPO (covered services)

Who may we contact in the case of an emergency?

Name:_____ Tel: (_____) _____-_____ Relationship: _____

If you are a minor (under 18) or dependent, please provide us with your guardian information:

Name of Guardian: _____ Tel: (_____) _____-_____

I hereby consent to have my information released to the following individual. This consent will remain in effect until otherwise notified by me in writing.

□ Medical Information □ Billing Information □ Do NOT release any of my information

Name: _____ Relationship: _____

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I certify the information above is true and correct to the best of my knowledge. I will notify IPM of any changes in the status of the above information.

Signature: _____ Date: _____

Parent signature (if minor) _____ Date: _____

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Notice of privacy – Introduction
THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

At Institute for Progressive medicine (hereafter known as IPM), we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information as defined by federal regulations.

Understanding Your Health Record/Information
Each time you visit IPM, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- □ Basis for planning your care and treatment
- □ Means of communication among the many health professionals who contribute to your care
- □ Legal document describing the care you received
- □ Means by which you or a third-party payer can verify that services billed were actually provided
- □ A tool in educating health professionals
- □ A source of information for public health officials for improving the health of this state and the nation
- □ A source of data for our planning
- □ A tool with which we can assess and continually work to improve the care we render

Understanding what is in your health record and how your health information is used, helps you to ensure its accuracy. It will help you understand who, what, when, where and why others may access your health information. It will also help you make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your record is the physical property of IPM, the information belongs to you. You have the right to:

- □ Obtain a paper copy of this Notice of Information Practices upon request
- □ Inspect and copy your health record as provided for in 45 CFR 164.524
- □ Amend your health record as provided in 45CFR 164.528
- □ Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- □ Request communications of your health information by alternative means or at alternative locations
- □ Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- □ Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities
IPM is required to:

- □ Maintain the privacy of your health information
- □ Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- □ Abide by the terms of this notice
- □ Notify you if we are unable to agree to a request restriction
- □ Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied to us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization

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Referral Information

How did you hear about us? Please choose the referral type and fill in the information below.

☐ Healthcare Practitioner (Name): _____

☐ Friend or Family (Name): _____

May we mention your name when sending a thank you to the person who referred you to IPM? ☐ Yes ☐ No

☐ Website/Search Engine: _____

☐ Print Media/Mailer (Name): _____

☐ Other (Please specify): _____

Patient Contact Information

Staff at IPM may contact you by mail, email, text or telephone to relay important information about your health such as appointment reminders, lab results, physician recommendations and prescription information.

STATEMENT OF PATIENT AWARENESS AND RESPONSIBILITY

- I am aware that any therapy, no matter how well designed and carried out, may fail to alleviate my symptoms and improve my health.
- I agree to make every effort to pursue the program mutually agreed upon with my physician.
- I expect to be informed of those therapies most relevant to my condition, both conventional and alternative, realizing that I have the choice to accept, refuse or terminate them at any point.
- I understand that unforeseen difficulties may arise in the course of my treatment.
- I am responsible to seek professional medical attention from a medical or naturopathic doctor employed at the Institute for Progressive Medicine, or another facility for any worsening of my condition, including consideration of hospitalization, invasive procedures or treatment in the emergency room.
- I am aware that many medical conditions require additional treatment and that follow-up visits are often necessary.
- I am aware that I will not be told to avoid seeing other physicians. I understand that I may be referred to another physician for treatment and that other options of medical care are available to me.

I have received a copy of IPM's Notice of Health Information Practices.

_____

Patient Name (Please print)

_____

Patient Signature **Date**

_____

Witness **Date**

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IPM Office Policy

We recognize and appreciate that health care can involve a major financial commitment. We aim to provide you with effective services and treatments. As a patient of the Institute for Progressive Medicine, you are responsible for the total charges incurred for each visit or any balances not paid by your insurance company to your practitioner. Charges for cash services are to be paid at the time of each visit. Payment is due upon receipt of a statement including charges for deductible, co-pay, or non-covered services. **If your insurance does not remit payment within sixty (60) days, the balance will be due and payable by you.** All patients are required to sign a copy of the standard arbitration form included in this packet before they may see a doctor or receive any services.

We accept Visa, MasterCard, personal checks and cash as forms of payment. There will be a $35.00 charge for all returned checks. **We are contracted providers for Medicare only. We do not accept Medi-cal, HMO, EPO or other private insurance.** You will be required to sign a waiver if you wish to be seen and are covered under Medi-Cal and/or an HMO. **At this time, we are unable to accept any insurance (including Medicare) for visits with a naturopathic doctor (N.D.).**

If you have a private insurance our office staff can provide you with the necessary paperwork (super-bill, procedure and diagnosis codes) you will need to submit for reimbursement to your insurance. Please remember that you have the primary relationship with your insurance company and you are responsible for the total amount owed at the time of your visit. **We are unable to submit a bill for you if we are not a contracted provider for your insurance.**

All appointments made with a doctor or IV nurse are confirmed via telephone two days in advance. Doctors' appointments not canceled with **AT LEAST 24 HOURS NOTICE** will be charged a **$50.00** missed appointment fee. Appointments with the IV nurse that are missed without prior notice given to reception will be charged a **$25.00** missed appointment fee. This charge is directly payable by you and cannot be submitted to your insurance. **We make every effort to see all scheduled appointments; however, we reserve the right to reschedule your appointment if you arrive more than 15 minutes after your scheduled appointment time**.
Phone consultations are not billable to Medicare and payment is required at the time of the scheduled appointment.

Payment for all supplements, IVs, and non-covered treatments (e.g. acupuncture, prolotherapy, etc.) is due at the time of service. Most insurance companies do not cover these services. You have the right to refuse any service recommended by our staff.

Mail order supplements are sent via UPS. Payment must be received before any items can be shipped to you. I have read, understand, and agree to the above stated policies of The Institute for Progressive Medicine.

Print name: _____

Signature: _____ Date:____/____/____

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MEDICARE BILLING INFORMATION

Medicare subscriber #: _____-_____-_____ Effective Date: ____/____/____

Medicare Insurance □ Primary □ Secondary If secondary, list primary insurance information here:

Insurance Name: _____ Name of Insured: _____

Group number: _____Subscriber number: _____

Birth Date of Insured: ____/____/____ Relationship to Patient: _____

Is your Medicare connected with an HMO? □ Yes □ No

Do you have Medi-cal/Medicaid as your secondary insurance? □ Yes □ No

In order to bill Medicare, we must have a copy of your driver's license, Medicare and secondary (if any) insurance cards. Please be prepared to give your card(s) to the receptionist. If you do not have your Medicare card with you, please ask reception to assist you in calling Medicare at 1-800-MEDICARE (1-800-633-4227) to verify your Medicare coverage.

I request that payment of authorized Medicare benefits be made on my behalf to the Institute for Progressive Medicine for any services furnished to me by a physician practicing as part of that group. I authorize the holder of any medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Signature: _____Date: _____

*** PRESCRIPTION MEDICATION POLICY ***

Prescription medication may be recommended and prescribed by a physician at the Institute for Progressive Medicine. All prescription medications present a potential risk of side effects which may or may not be noticeable to the patient. Side effects may be compounded or worsened when using multiple medications. For this reason, their use must be monitored by a physician. Our policy on prescription refills exists to comply with federal drug regulations and to protect the health of our patients.

- No patient will receive a prescription refill unless he or she has been seen in-person by a physician at the Institute for Progressive Medicine within the last 12 months. If you have not been seen by a physician at IPM within this time, you will be required to be seen in-person by an IPM physician before a refill can be granted by our staff.

- There may be cases where a physician requires a patient to be seen in-person before a refill can be given, even if it has been lass than 12 months since the last office visit.

- When requesting a refill, please do not call our office. Instead, request that your pharmacy fax a prescription refill request to us at 949-600-5101. Allow up to 72 hours for our medical staff to respond to refill requests from your pharmacy.

I have read, understood, and agree to abide by the above prescription medication policy at IPM.

_____ _____

Patient Signature **Date**

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Laboratory Billing Information

Our doctors may order laboratory or other diagnostic testing for you. Some laboratory testing is performed in our private laboratory and other tests must be sent to an outside laboratory for processing. It is your choice whether or not to receive laboratory testing recommended by your doctor.

Although we do not bill insurance other than Medicare PPO for office visits, as a courtesy to our patients we will bill most PPO insurances (some exclusions apply) for in-house laboratory testing ordered by your doctor at the Institute for Progressive Medicine. We cannot accept HMO, EPO, Medi-Cal or Medicaid insurance plans for laboratory testing or any other service, visit or procedure at the Institute for Progressive Medicine.

Some specialized outside laboratory testing is payable by the patient directly to the company performing the testing, unless specific provisions are made by the laboratory to accept insurance. A minimal sample processing fee may apply for outside laboratory tests.

If you would like us to bill insurance for in-house laboratory testing, please fill in the following information:

_____
Name of Insurance

_____
Name of Insured if different from patient

_____ _____
Group Number subscriber Member ID Number

_____ _____
Date of Birth of Insured Relation to Patient

More on Insurance Billing

There are many great insurance companies, each with a variety of different plans serving the patients in our practice. It would be an impossible task for our staff to know which labs and services are covered or deemed by the insurance company to be medically necessary for each patient at the time of services.

We feel confident that we provide services during your visit that are appropriate and important for your age and/or condition. Your insurance company might not always agree. They may deny coverage of certain labs or services are medically unnecessary or because your specific policy may not provide coverage for certain services.

It is the patient's responsibility to understand their individual insurance policy and coverage. If you are unsure about coverage for a particular test or procedure, please contact your insurance company directly.

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Medical Questionnaire

Height: _____ Weight: _____

Current Medications:

Name of prescription:	Strength and Dosage:	How often per day
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Nutritional Supplements and Over the Counter Medications:

Name of prescription:	Strength and Dosage:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Drug Allergies: please check or list all drugs and the type of reaction:

□ I am not allergic to any medications
□ Penicillin Reaction_____ □ Codeine Reaction_____
□ Sulfa Reaction_____ □ Other Reaction_____
_____
_____

Medical problems: Have you had (or do you have now) any of the following medical problems:

□ High Blood Pressure □ Breast Cancer □ Asthma □ Kidney Stones
□ Heart Disease □ Colon Cancer □ Emphysema □ Urinary Tract Infection
□ Heart Attack □ Other Cancer □ Tuberculosis □ Other Kidney Disease
□ Stroke □ Abnormal PAP □ Sickle Cell □ Seizure Disorder
□ Diabetes □ Hepatitis or Jaundice □ Anemia □ Received Blood Transfusion
□ Thyroid Disease □ Liver/Pancreas Disease □ Arthritis □ Sexually Transmitted Disease
□ Positive HIV or AIDS □ Other (Describe): _____

Would you like to be tested for HIV? □ Yes □ No

Smoking and Alcohol History:

Do you smoke now? □ Yes □ No Have you smoked in the past? □ Yes □ No
For how many years did you smoke? _____ When did you quit: _____
Do you use other tobacco products: □ Yes □ No
How much alcohol do you drink: □ None □ 1-7 Drinks/week □ 8-14 Drinks/week
□ More than 14/week □ Specify: _____

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Past surgery: have you had any of the following operations, and the year:

☐ Appendix _____ year ☐ Gall Bladder_____ year ☐ Thyroid_____ year
☐ Hernia ____ year ☐ Heart _____ year ☐ Lung_____ year
☐ Hysterectomy ____ year ☐ Gall Bladder_____ year ☐ Tonsils_____ year
☐ Spine/joint ____ year ☐ other: _____
_____

Hospitalizations, Illnesses, Surgeries:

Year: Reason:
1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____
5. _____ _____

Family Health

Please give the following information about your immediate family: Relationship

Relationship	Age if living	Age at death	State of health or cause of death
Father			
Mother			
Brother/Sister			
Spouse			
Children			

Other diseases in your family:

☐ Stroke ☐ Kidney Disease ☐ Asthma ☐ Diabetes ☐ Thyroid ☐ Heart Disease
☐ Anemia ☐ Bleeding problems ☐ Leukemia or Lymphoma ☐ Hypertension
☐ Mental Disorder ☐ Other cancer _____

_____
_____
_____
_____

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Nutrition and Diet

Please answer the following questions in the space provided:

1. How many meals do you eat each day? _____

2. Do you diet frequently? □ Yes □ No

3. Do you exercise? □ Yes □ No

If so, what type of exercise do you do?_____

4. How many hours per night do you sleep? _____

5. What types of foods do you eat? List a typical day below:

_____

_____

_____

_____

_____

Immunizations:

Tetanus: _____ year Pneumonia: □ Yes □ No Chicken Pox: □ Yes□ No

Influenza: _____year Hepatitis A: □ Yes □ No Hepatitis B: □ Yes □ No

TB skin test: _____Year TB test positive? □ Yes □ No

□ Other

If you were born after 1957, have you received a second measles vaccination? □ Yes □ No

Do you have any additional information not mentioned above? _____

_____

_____

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Current (or recent past) Symptoms

General	
Weight loss:	□ Yes □ No
Weight gain:	□ Yes □ No
Loss of appetite:	□ Yes □ No
Fever:	□ Yes □ No
Night sweats:	□ Yes □ No
Weakness and fatigue:	□ Yes □ No
Sensitivity to heat or cold:	□ Yes □ No

Skin	
Rashes/itching:	□ Yes □ No
Nail fungus:	□ Yes □ No
Moles that have changed color or size:	□ Yes □ No
Bruise easily:	□ Yes □ No
Changes in hair or nails:	□ Yes □ No
Changes in color or pigmentation:	□ Yes □ No

Eyes	
Wear glasses or contact:	□ Yes □ No
Blurred vision:	□ Yes □ No
Visual disturbances or double vision:	□ Yes □ No
Cataracts or Glaucoma:	□ Yes □ No
Eye pain/Inflammation or discharge:	□ Yes □ No

Ears and Nose	
Nosebleeds:	□ Yes □ No
Nasal congestion/drainage:	□ Yes □ No
Sinus infection:	□ Yes □ No
Loss of smell:	□ Yes □ No
Frequent colds:	□ Yes □ No
Ringing in the ear:	□ Yes □ No

Allergies	
Hay fever or allergies (Year round):	□ Yes □ No
Hives:	□ Yes □ No
Taken allergy shot now or in the past:	□ Yes □ No
Drug reaction:	□ Yes □ No

Mouth & Throat	
Dental problems/Dentures/Tooth pain:	□ Yes □ No
Mouth sores:	□ Yes □ No
Sore throat or Hoarseness:	□ Yes □ No
Difficulty swallowing:	□ Yes □ No
Bleeding gums:	□ Yes □ No
Change in taste:	□ Yes □ No

Respiratory	
Persistent cough:	□ Yes □ No
Cough productive of sputum:	□ Yes □ No
Coughing up blood:	□ Yes □ No
Asthma or wheezing:	□ Yes □ No
Exposure to tuberculosis:	□ Yes □ No
Sleep Apnea:	□ Yes □ No
Snoring:	□ Yes □ No
Awaken Tired:	□ Yes □ No

Shortness of Breath	
At rest:	□ Yes □ No
With exercise, climbing hill or stairs:	□ Yes □ No
Wake up at night short of breath:	□ Yes □ No
Sleep on more than one pillow to prevent shortness of breath:	□ Yes □ No

Heart	
Heart palpitations:	□ Yes □ No
High blood pressure:	□ Yes □ No
Swelling on your feet or ankles:	□ Yes □ No
Pain in leg or buttock when walking:	□ Yes □ No
Chest pain or discomfort: At rest:	□ Yes □ No
At exertion:	□ Yes □ No
Chest pain:	□ Yes □ No
Wheezing:	□ Yes □ No
Coughing blood:	□ Yes □ No
Sputum production:	□ Yes □ No
Blueness of skin:	□ Yes □ No

Endocrine	
Goiter:	□ Yes □ No
Thyroid problem/Medication:	□ Yes □ No

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Gastrointestinal

Indigestion or heartburn:	□ Yes □ No
Frequent use of antacids or acid:	□ Yes □ No
Abnormal bloating:	□ Yes □ No
Abdominal pain:	□ Yes □ No
Stomach ulcer:	□ Yes □ No
Nausea or vomiting:	□ Yes □ No
Vomiting blood:	□ Yes □ No
Gallstones:	□ Yes □ No
Hemorrhoids or rectal pain:	□ Yes □ No
Constipation:	□ Yes □ No
Diarrhea frequently or persistently:	□ Yes □ No
Blood with bowel movement:	□ Yes □ No
Black or tar-like stools:	□ Yes □ No
Change in bowel habits:	□ Yes □ No
Frequent use of laxatives:	
Previous jaundice:	□ Yes □ No
Difficulty swallowing:	□ Yes □ No
Change in appetite:	□ Yes □ No

Genitourinary

Discomfort/burning/straining with urine	☐ Yes ☐ No
Nocturia (urination at night) How many times at night?	□ Yes □ No
Difficulty starting or stopping urine:	□ Yes □ No
Kidney stones:	□ Yes □ No
Dark color or cloudy urine:	□ Yes □ No
Leaking bladder:	□ Yes □ No
Loss of libido:	□ Yes □ No
Pain with intercourse:	□ Yes □ No
Testicular pain or swelling:	□ Yes □ No
Gonorrhea:	□ Yes □ No
Syphilis:	□ Yes □ No

Neurologic

Common headache:	□ Yes □ No
Frequent or severe headache:	□ Yes □ No
Seizures or epilepsy:	□ Yes □ No
Numbness or weakness in arm or leg:	□ Yes □ No
Fatigue:	□ Yes □ No
Memory loss:	□ Yes □ No

Muscle Joints

Do you have arthritis or joint pain:	□ Yes □ No
Swollen or red joints:	□ Yes □ No
Gout:	□ Yes □ No
Neck or back pain:	□ Yes □ No
Muscle cramps/weakness:	□ Yes □ No
Deformity of joints:	□ Yes □ No

Blood/Lymphatic

Anemia:	□ Yes □ No
Transfusions:	□ Yes □ No
Bleeding tendency:	□ Yes □ No
Clotting problems:	□ Yes □ No
Lymph node enlargements or pain:	□ Yes □ No

Mental Health

Marital problems:	□ Yes □ No
Difficulty sleeping:	□ Yes □ No
Feeling sad or depressed:	□ Yes □ No
Feeling nervous or anxious:	□ Yes □ No
Suicidal thoughts:	□ Yes □ No
Are you seeing a therapist:	□ Yes □ No

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Women Only

Age menses started: _____

Date of last period: _____

Number of pregnancies: _____

Births _____

Miscarriages: _____

Abortions: _____

Complications of pregnancy ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

High blood pressure ☐ Yes ☐ No

C-section ☐ Yes ☐ No

Toxemia: ☐ Yes ☐ No

Other: _____

Do you examine your breasts regularly:	□ Yes □ No
Have you ever taken birth control pills:	□ Yes □ No
Have you noticed any breast lumps:	□ Yes □ No
Vaginal discharge at present time:	□ Yes □ No
Vaginal discomfort at present time:	□ Yes □ No
Irregular period:	□ Yes □ No
Bleeding when not your period:	
Pain with intercourse:	□ Yes □ No
Hot flashes:	□ Yes □ No

Men Only

History of prostate trouble:	☐ Yes ☐ No
Problems with erection/sexual difficulty:	☐ Yes ☐ No
Penile discharge:	☐ Yes ☐ No
Do you examine your testicles frequently:	☐ Yes ☐ No

MY SIGNATURE BELOW CONSTITUTES CONSENT TO MEDICAL SERVICES:
I consent to medical evaluation and treatment by The Institute for Progressive Medicine. I understand that the Institute for Progressive Medicine may recommend various methods to help me regain my health and those methods will be discussed.

_____

Patient Name (Please print) **Patient Signature** **Date**

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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 right 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 shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, 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.
Filing by Physician 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 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 by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision**: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.
I understand that I have the right to receive a copy of this 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 Duly (Date)
Authorized Representative Signature

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

By: _____
Signature of Translator (if applicable) (Date)

_____
Print Name of Translator

By:_____
Patient's Signature (Date)

_____
Print Patient's Name

By:_____
Patient's Representative's Signature (if applicable) (Date)

_____
Print Name and Relationship to Patient