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

** IMPORTANT - PLEASE BRING COMPLETED FORMS TO YOUR FIRST APPOINTMENT **

Full Legal Name_____

Nickname_____

Primary Reason for Visit_____

How did you hear about us? _____

Birth Date_____/____/_____ Age_____ □ Female □ Male Race_____ Ethnicity_____

Mailing Address_____

City _____State_____ Zip _____

Email Address_____

Primary phone (_____) _____-_____ □ home □ cell □ work

Secondary phone (_____) _____-_____ □ home □ cell □ work

Employer phone (_____) _____-_____

Occupation_____ Employer_____

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

Spouse/Partner Name_____ Spouse/Partner Birth Date____/____/____

Who may we contact in the case of an emergency?

Name_____Phone(_____) _____-_____ Relationship_____

(Minors under 18) Name of Guardian_____ Tel (_____) _____-_____

Check below if you agree to share personal information with a named individual:

☐ I consent to have my personal medical and billing information shared with the person listed below.

Name _____Relationship _____

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.

IPM does not accept any medical insurance plans for services. We currently accept cash, check, most major credit cards, and CareCredit as valid forms of payment. Payment is due at the time of service.

I certify the information above is true and correct to the best of my knowledge and 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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Patient Medical History

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 supplement	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 (past and present)

□ High Blood Pressure	□ Colon Cancer	□ Kidney Stones	□ Hepatitis or Jaundice
□ Heart Disease	□ Breast Cancer	□ Urinary Tract Infection	□ Liver/Pancreas Disease
□ Heart Attack	□ Other Cancer	□ Other Kidney Disease	□Anemia
□ Stroke	□ Asthma	□ Received Blood Transfusion	□ Psychiatric Disorder
□ Diabetes	□ Emphysema	□ Abnormal PAP	□ Seizure disorder
□ Thyroid Disease	□ Tuberculosis	□ Positive for HIV or AIDS	□ Other
□ Arthritis	□ Sleep Apnea	□ Sexually Transmitted Disease	

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

Tobacco, Alcohol and drug 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 _____

Do you or have you ever used drug(s) recreationally? □ Yes (Current) □ Yes (Past) □ No

If yes, please list drug(s) and frequency _____

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Past surgery

☐ 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 familial relationships

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
☐ Anemia ☐ Bleeding problems ☐ Leukemia or Lymphoma ☐ Hypertension ☐ Heart Disease
☐ 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

Breakfast_____

_____

Lunch _____

_____

Dinner_____

_____

Snacks_____

_____

Do you Drink Coffee? If so how often? _____

Do you consume soft drinks? If so how often? _____

Immunizations (Please complete to the best of your ability)

Tetanus	_____ Year	Pneumonia	_____ Year	Chicken Pox	_____ Year
Influenza	_____Year	Hepatitis A	_____ Year	Hepatitis B	_____ Year
TB	_____Year	TB test positive?	□ Yes □ No	Measels	_____Year

Other _____

What are your top three health goals?

_____

_____

_____

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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	□ 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

Shortness of Breath

Shortness of breath at rest	□ Yes □ No
Shortness of breath 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
Chest pain or discomfort 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
Diabetes Type I or II (Circle which)	□ Yes □ No
Prediabetes	□ 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	□ Yes □ No
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
Leaky 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
Work Stress	□ Yes □ No
Family Stress	□ Yes □ No
Financial Stress	□ 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	□ Yes □ No
Abortions	□ Yes □ No
Complications of pregnancy	□ Yes □ No
Diabetes during pregnancy	□ Yes □ No
High blood pressure during pregnancy	□ Yes □ No
C-section	□ Yes □ No
Toxemia	□ Yes □ No
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	□ Yes □ No
Pain with intercourse	□ Yes □ No
Hot flashes	□ Yes □ No
Other	

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
Other	

Do you have any additional information you would like the doctor to know? (Please write below)

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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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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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 read, understand and agree to **IPM's Notice of Health Information Practices and Statement of Awareness and Responsibility** above.

Print name: _____

Signature: _____ 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 cost-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. Charges for cash services are to be paid at the time of each visit. All patients are required to complete the following forms:

- IPM New Patient Packet
- IPM Physician-Patient Arbitration Agreement
- IPM Patient Private Contract

The above documents must be completed and signed before a patient may see a doctor or receive any service at IPM.

IPM currently accepts cash, check, most major credit cards, and Care Credit as valid forms of payment. There will be a $35.00 charge for any returned checks. **IPM does not accept medical insurance plans for services rendered at our facility. If you have any questions about our payment policy, please contact reception.**

If you have a private insurance our office staff may provide you with the necessary paperwork (super-bill, procedure and diagnosis codes) that you may submit for reimbursement to your insurance. Please remember that most insurance companies do not cover integrative or alternative medical services. You have the primary relationship with your insurance company and you are responsible for the total amount owed at the time of your visit.

Unfortunately, due to Medicare regulations, IPM is unable to provide superbills or billing assistance for reimbursement for patients who have Medicare or Medicare Advantage plans.

Appointments made with a doctor at IPM are confirmed via telephone or text message two days in advance of your scheduled appointment. Doctors' appointments not canceled with **AT LEAST 24 HOURS NOTICE** will be charged a **$50.00** missed appointment fee.

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, or if any emergency or unforeseen circumstances arise.

Payment for all services is due at the time of service. You have the right to refuse any treatment or service recommended by our doctors or staff for any reason.

I have read, understand and agree to the **IPM Office Policy** above.

Print name: _____

Signature: _____ Date:____/____/____

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IPM 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.

- Under certain circumstances our physicians may require a patient to be seen in-person before a refill can be given; even if it has been 6 months or less 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.

Laboratory Billing Information

Our doctors may order laboratory or other diagnostic testing for you. Most testing will be sent to an outside laboratory for processing and billing. It is your choice to receive laboratory testing recommended by your doctor. The fee for collection of samples at IPM to be sent to an outside laboratory is $25.

Outside laboratories are usually contracted with most major insurance plans, so they may bill your insurance for you. Please make sure you provide your current insurance information to our staff so that it can be forwarded to the lab for billing purposes.

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.

I have read, understood and agree to the **IPM Prescription Medication and Laboratory Billing Policy.**

_____ _____

Patient Signature Date

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IPM 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

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IPM Patient Private Contract

This contract is made between physicians at Institute for Progressive Medicine, A Professional Medical Corporation (referred to as "IPM Physicians") and any patient seeking treatment at IPM (referred to as "Patient"). If as a patient you have any questions about this contract, please contact IPM reception.

_____ _____

Patient Full Name (please print) Date of Birth

_____ _____

Telephone E-mail Address

- Patient has been informed that IPM Physicians have voluntarily opted out of the Medicare program effective January 1, 2019 for a period of at least two years and are not excluded from participating in Medicare Part B under Sections 1128, 1156 or 1892 or any other section of the Social Security Act. This contract is valid from the date signed and is effective for the entire duration of the opt-out period.

- Patient or his or her legal representative, accepts full responsibility for payment of charges for all services furnished by IPM Physicians. He or she further understands that Medicare limits do not apply to what IPM Physicians may charge for items or services furnished at IPM.

- Patient or his or her legal representative agrees not to submit a claim to Medicare or to ask IPM Physicians to submit a claim to Medicare.

- Patient or his or her legal representative understands that Medicare will not pay for any items or services furnished by IPM Physicians.

- Patient enters into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from a physician and or practitioner who has not opted out of Medicare. This contract does not prevent Patient from seeking Medicare-covered services furnished by other physicians or practitioners who have not opted out of Medicare.

- Patient or his or her legal representative understands that Medigap plans, Medicare Advantage programs and other supplemental insurance plans may not pay for items and services not paid for by Medicare.

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- Patient or his or her legal representative acknowledges that he or she is not entering into this contract during a time when Patient is requiring emergency or urgent care services.

- Patient agrees to reimburse IPM Physicians for any costs and reasonable attorney's fees that may result from violation of this contract by Patient and his or her legal representatives.

- Patient or Patient's legal representative has had the opportunity to read, understand and ask questions regarding this contract before signing.

- Patient or his or her legal representative acknowledges that a copy of this contract has been made available to him or her before items or services are furnished under the terms of this contract. This contract supersedes (replaces) any previous agreements between Patient and IPM Physicians regarding Medicare.

- IPM Physicians will retain this original contract for the duration of the opt-out period and will supply a copy of this contract to Centers for Medicare Services (CMS) upon request.

_____ _____
Provider Signature Date

_____ _____
Provider Signature Date

_____ _____
Patient or Legal Representative Signature Date

_____ _____
Witness Date