New Patient Packet

Name:_____ Date of Birth:_____

Gender: ☐ Male ☐ Female ☐ Other:_____ SSN: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Referring Physician: _____ Phone:_____

Self Referred: ☐ YES ☐ NO **How Did You Hear About Us?:** ☐ Family/Friend ☐ Google ☐ Social Media ☐ Yelp

Primary Care Physician: _____ Phone:_____

Pharmacy Information: _____ Phone: _____

Address: _____

Insurance Information:

Primary Insurance: _____ Member ID:_____

Secondary Insurance: _____ Member ID: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Assignment of Benefits

I request that payment of authorized insurance or Medical Benefits be made either to my or on my behalf to Pedes Orange County *or* Broad Reach Specialty Surgery for any provided services.

I authorize the release of any medical or other information necessary to determine these benefits or the benefits payable for related services to Pedes Orange County *or* Broad Reach Specialty Surgery by my insurance carrier or my insurance company or other entity if requested.

I understand that I am financially responsible to Pedes Orange County *or* Broad Reach Specialty Surgery for any charges not covered by my insurance to the extent permitted by state and federal law. It is my responsibility to notify the organization of any changes in my health care coverage. In some cases, exact insurance benefits cannot be determined until the insurance company received the claim. I am responsible for the entire bill or balance of the bill as determined by Pedes Orange County *or* Broad Reach Specialty Surgery and/or my health care insurer if the submitted claims or any part of them are denied for payment. I understand that by signing this form, I am accepting financial responsibility as explained above for all payments for services received.

In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered service. Co-insurance and the deductible are based on the charge determination of the Medicare carrier.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. This assignment will remain in full effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

I understand that I am financially responsible for all charges, whether or not paid by my insurance.

Disclosure of Financial Relationship

Federal law requires that your physician disclose to you any financial relationship he or she may have in another healthcare entity to which you may be referred, so that you may address any concern you may have directly with your physician.

Your physician may have a financial interest in Pedes Orange County *or* Broad Reach Specialty Surgery.

You are free to receive the consultation or services that your physician has deemed appropriate at either this clinic or any other clinic offering similar services. In the event you do not wish to be referred to this clinic, please notify your physician.

In-Office Procedure Cancellation Policy

Please read carefully and ask reception to answer any question you may have.

Pedes Orange County *or* Broad Reach Specialty Surgery values your time. We know your schedule can change and sometimes at the last minute. A lot can happen in the days, weeks, or months that have passed since your appointment was originally set.

It is out longstanding policy to call you or your designated point of contact 48 hours (two business days) prior to your visit. For example, if you have an appointment on a Monday we will calling to confirm on the previous Thursday. And if you have an appointment on a Friday we will call you that Wednesday.

Additionally, if you have an in-office procedure, we will need to confirm your appointment no later than 1:00pm the previous business day. If we are unable to reach you or your designated point of contact for an in-office procedure, we will cancel that appointment and attempt to reschedule.

Our cancellation policy for in-office procedures helps ensure that all of our patients are seen promptly at their appointment time. We encourage our patients to notify us as soon as possible when scheduling conflicts arise so we can arrange a more convenient appointment time.

Designated Point of Contact: _____ Phone: _____

Relationship: _____

Acknowledgements:

Your signature below acknowledge the receipt and confirms full understanding of the following documents/policies:

- Assignment of Benefits
- Disclosure of Financial Relationships
- In-Office Procedure Cancellation Policy
- Patient Rights & Responsibilities
- Privacy Practices
- Conditions of Admissions

Please let our team know if you would like to receive paper copies of any of the above listed documents.

_____

Patient or Authorized Representative Signature Date

_____

Witness Signature Date

Physician – Patient Arbitration Agreement

Agreement To Arbitrate

It is understood that any dispute as a medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompletely 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 such dispute decided in a court of law before a jury, and instead or accepting the use of arbitration.

All Claims Must Be Arbitrated

It is the intention of the parties that this agreement bin 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 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 physicians' partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims of 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.

Procedures And Applicable Law

A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (part 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 part'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 reason or entity which would otherwise be a proper additional party in a court action, an 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 judgement or summary adjudication in accordance with the Code of Civil Procedure. Discover shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

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.

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.

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 or Authorized Representative Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and should 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 trail. See Agreement to Arbitrate of this contract.

Patient or Authorized Representative:	Pedes Orange County Provider or Authorized Representative
_____	_____
Signature	Signature
_____	_____
Print	Print

Date _____ Date _____

Authorization for use or disclosure of health information

Completion of this document authorizes the disclosure and use of health information about you. Failure to provide all information requested may invalidate the authorization.

Name:_____ Date of Birth:_____

I hereby authorize **Pedes Orange County, Inc *or* Broad Reach Specialty Surgery** to release my information to:

_____

Persons/Organizations authorized to receive the information

_____

Address (Street, City, State, and Zip Code) Phone Fax

- ☐ **Primary Care Provider:** _____
- ☐ **Referring Provider:** _____

AND

I hereby authorize _____ to release my information to:

- ☐ **Pedes Orange County, Inc – 1400 Reynold Ave Suite 110, Irvine, CA 92416 | Phone: 949.387.4724 | Fax: 949.209.0407**
- ☐ **Broad Reach Specialty Surgery – 1400 Reynold Ave Suite 110, Irvine, CA 92416 | Phone: 949.387.4724 | Fax: 949.209.0407**

The following information:

All health information pertaining to my medical history, mental or physical condition and treatment received; OR

Only the following records or types of health information:

_____

Purpose of requested use or disclosure:

Patient request; OR

Other: _____

Expiration:

This authorization expired on this date: _____

My Rights:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.
- I may revoke this authorization at any time, but I must do so in writing and submit it to 1400 Reynold Ave Suite 110, Irvine, CA 92416 | Phone: 949.387.4724 | Fax: 949.209.0407

_____

Patient or Authorized Representative Signature Date