Pacific Hyperbaric Oxygen Therapy

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PLEASE PRINT CLEARLY

TODAY'S DATE: _____ REASON FOR TODAY'S VISIT: _____

PATIENT INFO

NAME: _____
First Middle Initial Last

SEX: M○ F○ BIRTH DATE: _____ AGE_____ SOCIAL SECURITY #: _____

MARITAL STATUS

○*SINGLE* ○*MARRIED* ○*SEPARATED* ○*DIVORCED* ○*WIDOWED* ○*PARTNERED*

ADDRESS: _____ APT.#_____
CITY_____STATE_____ZIP_____
PHONE #: _____CELL #: _____
EMAIL ADDRESS: _____

RESPONSIBLE PARTY OTHER THAN PATIENT _____ RELATIONSHIP: _____
SOCIAL SECURITY#: _____

EMPLOYER

NAME_____PHONE_____
OCCUPATION_____

I WANT MY HEALTH INFORMATION RELEASED TO THE FOLLOWING PEOPLE IN THE EVENT OF EMERGENCY: _____

EMERGENCY CONTACT:

NAME: _____PHONE #: _____RELATIONSHIP: _____

Are you, or think you may be pregnant? Yes ○ No ○

HOW DID YOU HEAR ABOUT US?_____
PRIMARY CARE PHYSICIAN?_____PHONE# _____
PREFERRED PHARMACY: _____PHONE_____

Medical History:

CURRENT MEDICATION LIST:

_____
_____
_____
_____

- ○ Diabetes
- ○ Asthma
- ○ Heart Disease
- ○ Migraine Headaches
- ○ Pacemaker
- ○ Stroke
- ○ Emphysema
- ○ Epilepsy
- ○ Cancer
- ○ Multiple Sclerosis
- ○ Pneumonia

HEALTH HABITS

- ○ Tobacco (How much/day? _____)
- ○ Caffeine (How much/day? _____)
- ○ Alcohol (How much/day? _____)

Check off what applies:

CHECK CURRENT SYMPTOMS

EAR, NOSE, THROAT

- ○ Congestion
- ○ Loss of hearing
- ○ Deviated Septum
- ○ Sinus problems
- ○ Bleeding
- ○ Frequent Wax
- ○ Ringing in ears
- ○ Hearing Aid(s)
- ○ Drainage

Lungs

- ○Asthma
- ○Cough
- ○Emphysema
- ○Shortness of Breath
- ○Cough up blood
- ○Pneumothorax(Collapsed Lung)

CARDIOVASCULAR

- □Irregular Heartbeat
- □High/Low blood pressure
- □Poor circulation
- □Chest pain
- □Varicose veins

Head

- ○ Headaches
- ○ False Teeth
- ○ Contacts

To the best of my knowledge, the information provided herein is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

SIGNATURE: _____**DATE:**_____

PRINT NAME: _____**RELATIONSHIP TO PATIENT:**_____

CONSENT FOR HEALTHCARE MESSAGES:

I _____, DOB: _____give permission to the physician's and their staff at Pacific Hyperbaric Oxygen Therapy to leave messages regarding my health care in the following ways when I am not available:

○ May **ONLY** leave information with me, personally. If you check this box, no other selection should be marked, please skip to the **CONTACT INFORMATION** section below.

○ May leave **appointment reminders** on my answering machine/voicemail.

○ May leave **general questions/information** on my answering machine/voicemail

○ May leave **appointment reminders** with....

- May leave **lab results** with…
- May leave **general questions/information** with…
- I prefer that **ALL healthcare messages** be left with…

NAME: _____ RELATIONSHIP: _____

CONTACT INFORMATION:

Preferred Method of Contact:_____ Home○ Cell○ Work○

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____DATE: _____

PAYMENT RESPONSIBILITY ACKNOWLEDGEMENT:

Please initial next to each item below to acknowledge that you have read and understand our office policy regarding patient payment responsibility.

_____ For patients with no insurance coverage, payment is due at the time of service. We accept cash, MasterCard, and Visa.

_____ We will bill your insurance carrier for all covered services if you are covered by a plan that we contract with as participating providers. You are required to pay all co-pays at the time of service.

_____ For amounts due after insurance has processed the claim (if you haven't met your deductible, co-insurance, or non-covered services), we will send you a statement in the mail.

IT IS THE RESPONSIBILITY OF THE PATIENT TO NOTIFY OUR OFFICE OF ANY CHANGE IN INSURANCE, MAILING ADDRESS, OR OTHER CONTACT INFORMATION. Your signature below along with initialing each line above signifies that you have read and understand your responsibilities to Ocean Front Urgent & Family Care

PATIENT SIGNATURE: _____ DATE: _____

PATIENT NAME (PRINTED): _____ DATE: _____

WITNESS SIGNATURE: _____DATE: _____

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 free from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and 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 rote 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 jointer in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and jointer any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provision 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 Procedures. 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 sign below. 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.

SIGNATURE: _____PRINT NAME: _____Date: _____

INSURANCE CONSENT:

I certify that I have insurance coverage with the supplied insurance company and assign directly to Dr. Rahimi & Dr Yeroomian from Ocean Front Urgent Care all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.** The above named doctor(s) may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Ocean Front Urgent Care for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.

SIGNATURE: _____Print Name: _____Date: _____

MINOR CONSENT:

I do hereby request and authorize the doctor and practice staff to perform necessary services for the minor child named above including but not limited to lab, x-rays, sutures, minor surgery, and treatment which are ordered by the doctor.

SIGNATURE: _____Print Name: _____

Relation:_____Date _____