ZENA

MEDICAL

359 SAN MIGUEL DRIVE SUITE 300 NEWPORT BEACH CA 92660

PLEASE PRINT & COMPLETE ALL PAGES

□ New Patient □ Info Update

Name:_____
Last First MI

Home Address:_____
Street City State/Zip Code

Home #: _____-_____-_____ Cell #: _____-_____-_____ Work #: _____-_____-_____

Social Security #: _____ Date of Birth: _____ Age:_____

Sex: □ M □ F Marital Status: □ Single □ Married □ Divorced □ Widow Driver's License #: _____

Email: _____

Primary Insurance Co. Name_____Phone_____

Insurance Address:_____ ID#_____Group#_____

Full Name of Subscriber:_____SSN Subscriber:_____DOB of Subscriber:_____

Patient's relationship to subscriber: □ Self □ Spouse □ Child □Other:_____

Are you allergic to latex? □ Yes □ No

Are you allergic to any medication? □ Yes □ No Known Allergies
If yes, please specify: _____

Have you ever had cold sores? □ Yes □ No

Name of responsible party for minor: _____ Relationship: _____ _Phone #:_____

Name of spouse or closest relative: _____ Relationship: _____ Phone #:_____

Name of primary care physician: _____ Phone#:_____

Preferred Pharmacy Phone Number: _____

Referred By: _____

Patient Privacy Policy Consent

This consent will apply to all health care providers employed by and acting for the benefit of this office who conducts, plan and direct treatment and follow up and may be involved in treatment, directly or indirectly. In the course of providing services to you, this office will create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for service and to conduct day-to-day health care operations. The notice of privacy rights describes the uses and disclosures in detail. The use and disclosures of your health information may include care and services, follow-up care from another health professional, disclosure of your information for billing purposes or processing claims for obtaining payment, or submission of claims to a third- party or insurer. You have the right to restrict the use of disclosure made for purposes of treatment or healthcare operations, this is office is not obligated to agree to these restrictions. If this office does agree, however, the restrictions are binding. You may revoke this consent in writing at any time, except to the extent that this office has taken action relying on this consent.

I have read this and understand it. I consent to the use and disclosure of my personal health information for purposes of treatment, payment, and health care operations.

_____ _____ _____

Patient Signature **Printed Name** **Date**

Medical History

Name:_____ Height:_____ Weight:_____ Date:_____

Medical Conditions: (Please indicate with an "X" all that apply)

Skin	Cardiovascular	Hematologic/Metabolic	Eye, Ear, Nose
□ Basal cell skin cancer	□ Heart attack	□ HIV/AIDS/OTHER STDS	□ Blurry vision
□ Squamous cell skin cancer	□ Irregular heart beat	□ Hepatitis C	□ Dry eyes
□ Melanoma	□ Chest pain/tightness	□ Anemia	□ Glaucoma
□ Psoriasis	□ Heart murmur	□ Bleeding disorders	□ Ear disease
□ Eczema	□ Shortness of breath	□ Autoimmune disease	□ Nasal allergies
□ Acne	□ High/Low blood pressure	□ Thyroid disease	□ Nasal obstruction
□ Scarring/keloids	□ Pacemaker	□ Diabetes	□ Nose bleeding
□ Other_____	□ Stent or artificial valve	□ Kidney disease	□ Sinus disease

Gastrointestinal	Musculoskeletal	Pulmonary	Neurologic/Psychiatric
□ Gastritis	□ Arthritis	□Asthma	□ Seizures
□ Ulcers	□ Fibromyalgia	□ COPD	□ Headaches
□ Colitis	□ Arthritis	□ Pneumonia	□ Depression
□ Diverticulitis	□Artificial joints	□ Tuberculosis	□ Schizophrenia/Bipolar

Do you use:

Alcohol □ Yes □ No Frequency _____
Tobacco □ Yes □ No Frequency _____
Aspirin □ Yes □ No Frequency _____

Are you:

□ Pregnant
□ Trying to conceive
□ Breastfeeding

Family History (Indicate any conditions of immediate family members- mother, father, siblings, children)

□ Heart disease	□ Hypertension	□ Stroke	□ Diabetes
□ Cancer (type)	□ Autoimmune disease	□ Eczema	□ Psoriasis
□ Melanoma	□ Non-melanoma skin cancer	□ Asthma	□ Seasonal allergies/hay fever

Surgical/Procedure History (list all surgeries including cosmetic and laser procedures)

Date	Type	Physician	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you or anyone in your family had problems associated with surgery?

□ Bleeding □ Lidocaine allergy □ Other_____
□ General Anesthesia □ Poor scarring

Hospitalizations (Other than surgery)

Date	Reason/Illness	Physician	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications
(include vitamins, diet pills, birth control, herbal supplements, etc.)

Name	Strength/Dose
_____	_____
_____	_____
_____	_____

Allergies

Medication	Reaction
_____	_____
_____	_____
_____	_____

Physician –Patient/Client 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 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 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/client 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/client" 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, associated, 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/client 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 court action, shall 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 party) 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 such intervention and joinder any existing court of action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law application 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 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 arbitration agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this arbitration agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this arbitration agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial: _____

Patient 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.

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.

_____ _____ _____

Patient Signature **Printed Name** **Date**

Patient Privacy Policy Consent

This consent will apply to all healthcare providers employed by and acting for the benefit of this office who conduct, plan and direct treatment and follow-up and may be involved in treatment, directly or indirectly. In the course of providing services to you, this office will create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services and to conduct day-to-day health care operations. The Notice of Privacy Practices describes the uses and disclosures in detail. The use and disclosures of your health information may include care and services, follow-up care from another health professional, disclosure of your information for billing purposes or processing claims for obtaining payment, or submission of claims to a third-party or insurer. You have the right to restrict the use of disclosure made for purposes of treatment or health care operations, but this office is not obligated to agree to these restrictions. If this office does agree, however, the restrictions are binding. You may revoke this consent in writing at any time, except to the extent that this office has taken action relying on this consent.

I have read this document and understand it. I consent to the use and disclosure of my personal health information for purposes of treatment, payment and health care operations. I have received a copy of the Notice of Privacy Practices from this office.

_____ _____ _____

Patient signature or legally authorized individual | Print name if signed on behalf of the patient | Relationship - parent, legal guardian name

Please initial and provide any additional information as required to enable us to appropriately use and disclose your protected health information for the following:

I agree to be contacted for appointments, biopsy/lab results, or follow up information regarding my care by:

□ Phone Preferred number _____

□ Ok to leave message/voicemail

□ Email

□ Text

□ **Discuss my personal health information with the following**: _____ _____ _____

Name | Relationship | Phone Number

_____ _____ _____

Name | Relationship | Phone Number

_____ _____ _____

Name | Relationship | Phone Number

These consents will remain in effect until revoked by me in writing.

_____ _____ _____

Patient Signature | **Printed Name** | **Date**

Consent for Use of Photographs

I consent for medical photographs to be taken of me or my child (or for person whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching at Zena Medical, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the staff at Zena Medical at 949-200-8222.

☐ I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes at Zena Medical and to be used in my medical record.

Patient Signature _____ Date_____

☐ I agree to the use of my images for teaching purposes AND to be used for my medical record but NOT FOR medical publication.

Patient Signature _____ Date_____

☐ I agree to the use of my image for medical records ONLY.

Patient Signature _____ Date_____

Financial Policy

Payment is expected as services are rendered. We accept cash, Visa, MasterCard, Discover, American Express, and personal checks. Please read and initial whichever policy that applies to you below:

- **Cash and out-of-network PPO patients:** If you are a cash patient or if your physician is not a contracted provider for your insurance company, we will collect payment in full at the end of your visit. Initial visits are charged a standard consultation fee plus additional fees for any procedures performed at the time of your visit. Feel free to discuss these charges with your doctor prior to the procedure. We will provide a form for you to submit to your insurance company for direct reimbursement. You will be mailed a standard insurance form, which is acceptable to most PPO insurance companies.

  _____ **Initials**

- **Medicare patients:** We will bill Medicare for you and Medicare will forward the claim to your supplemental insurance for processing. If there is any balance on your account, you will receive an invoice from us.

  _____ **Initials**

All patient refunds will be kept as a credit on the patient's account toward their next visit unless a refund request is initiated by the patient. Refunds are up to the discretion of the office manager, and the following criteria must be met prior to issuing a patient refund: there are no outstanding insurance claims on the patient's account, and there are no outstanding balances on the patient's account.

All returned checks will be subject to a $25.00 fee per occurrence. Cancellations made with less than 24 hours notice will be subject to a $50-$150 cancellation fee.

I understand that I will be expected to pay for all applicable fees for the day of service. I understand that I am responsible for any balances not covered by insurance. I will assume responsibility of notifying this office of any changes in insurance coverage. I authorize the office of Leur Medicine Inc. to release to any company providing me with medical insurance any information, including the diagnosis and the records of all treatments and/or examinations provided to me by my physician for the purpose of billing (if applicable).

I have read, understand, and agree to the above policies.

_____ _____ _____

Patient Signature **Printed Name** **Date**

MEDICARE RECIPIENTS ONLY- I request that payment be made directly to Leur Medicine Inc.

_____

Medicare Patient Signature or legally authorized individual