Acuity Eye Group

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Patient Registration Form

Patient Information			
Name:		DOB (M-D-Y): - -	
Address:			
City:	State:	Zip Code:	SSN:
Home Phone:	Cell Phone:		Work Phone:
Sex: [ ] Male [ ]Female [ ]Other	Marital Status:		
Email Address:			
Doctor / Referral Information			
Primary Care Physician (PCP):		Phone:	
Referring Physician (if not PCP)		Phone:	
Facility Information			
Skilled Nursing Facility [ ]Yes [ ]No	Hospice [ ]Yes [ ] No		
Facility Name:			
Facility Address:			
Medical Decision Making & Financially Responsible Party (*If not patient*)			
Guardian: [ ] Power of Attorney: [ ] Other: [ ] Please Specify: *Please provide documentation to verify relationship to patient.*			
Name:			
Address:			
DOB (M-D-Y): - -	Phone:		SSN:
Is the person listed above financially responsible for the patient? [ ] Yes [ ] No If no, please provide information below.			
Name:		DOB (M-D-Y) - -	
Address:		Phone:	
Emergency Contact Information (*If different from person mentioned above*)			
Name:	Relationship:		Phone:

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS DECLARATION:

I hereby authorize release of any medical information necessary to process my insurance claim and ASSIGN to the DOCTOR all payments from MEDICARE and/or other Insurance provider(s) for services rendered. I understand and agree to the above conditions.

____________________________________ __________________

Signature of Patient or Patient Representative Date

____

Printed Patient Representative Name and Relationship to Patient

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MEDICATIONS, ALLERGIES, SURGERIES	
Drug Allergies? [ ] YES [ ] NO	Surgeries? [ ] YES [ ] NO
If YES to Drug Allergies, list all medications and reactions in the space provided below. (EX: Penicillin, Sulfa Drugs, NSAIDs, etc.)	If YES to Surgeries, list all surgeries below. (EG: Tonsillectomy, Appendectomy, Cataract, etc.)

PAST MEDICAL HISTORY

Have you ever been hospitalized? [ ] YES, please specify date and reason below. [ ] NO

Date	Reason

Have you been diagnosed with any of the following conditions? (Check any that apply)

- ☐ Anemia
- ☐ Angina
- ☐ Asthma
- ☐ Cancer (specify below)
- ☐ Cataracts
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy (seizures)
- ☐ Goiter
- ☐ Heart murmur
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hypothyroidism
- ☐ Jaundice
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Leukemia
- ☐ Pneumonia
- ☐ Psoriasis
- ☐ Pulmonary Embolism
- ☐ Rheumatic Fever
- ☐ Stomach or Peptic Ulcer
- ☐ Stroke
- ☐ Tuberculosis

Other Medical Conditions:

SOCIAL HISTORY

(Check any that apply)

- ☐ Smoking, ______ packs per day, for ______ years.
- ☐ Alcohol
- ☐ Illicit Drugs, specify: _______________, _______________, _______________, _______________

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GENERAL PROBLEM REVIEW

In the past month, have you had any of the following problems? (Check any that apply)

General
- [ ] Recent Weight Gain
- [ ] Recent Weight Loss
- [ ] Fatigue
- [ ] Weakness
- [ ] Fever
- [ ] Night Sweats

Muscle/Joints/Bones
- [ ] Numbness
- [ ] Joint pain
- [ ] Muscle weakness
- [ ] Joint swelling

Eyes
- [ ] Pain
- [ ] Redness
- [ ] Loss of Vision
- [ ] Double/Blurred Vision
- [ ] Dryness

Throat
- [ ] Frequent sore throats
- [ ] Hoarseness
- [ ] Difficulty in swallowing
- [ ] Pain in jaw

Heart and Lungs
- [ ] Chest pain
- [ ] Palpitations
- [ ] Shortness of breath
- [ ] Fainting
- [ ] Swollen legs/feet
- [ ] Cough

Skin
- [ ] Redness
- [ ] Rash
- [ ] Nodules/Bumps
- [ ] Hair loss
- [ ] Color changes of hands or feet

Stomach and Intestines
- [ ] Nausea
- [ ] Heartburn
- [ ] Stomach pain
- [ ] Vomiting
- [ ] Yellow Jaundice
- [ ] Constipation
- [ ] Persistent diarrhea
- [ ] Blood in stools
- [ ] Black stools

Nervous System
- [ ] Headaches
- [ ] Dizziness
- [ ] Fainting/Loss of Consciousness
- [ ] Numbness or Tingling Memory Loss

Ears
- [ ] Ringing in ears
- [ ] Loss of hearing

Blood
- [ ] Anemia
- [ ] Clots

Kidney/Genital/Bladder
- [ ] Frequent/Painful urination
- [ ] Blood in urine
- [ ] Impotence
- [ ] Incontinence
- [ ] Infections

Psychiatric
- [ ] Depression
- [ ] Anxiety
- [ ] Mood swings
- [ ] Insomnia
- [ ] Hallucinations
- [ ] Disorientation

FAMILY HISTORY

Has a member of your family been diagnosed with any of the following problems?

Father
- [ ] Glaucoma
- [ ] Cataract
- [ ] Macular Degeneration
- [ ] Diabetes
- [ ] Hypertension
- [ ] Cancer
- [ ] Arthritis
- [ ] Heart Disease
- [ ] Other: ____________

Mother
- [ ] Glaucoma
- [ ] Cataract
- [ ] Macular Degeneration
- [ ] Diabetes
- [ ] Hypertension
- [ ] Cancer
- [ ] Arthritis
- [ ] Heart Disease
- [ ] Other: ____________

Brother
- [ ] Glaucoma
- [ ] Cataract
- [ ] Macular Degeneration
- [ ] Diabetes
- [ ] Hypertension
- [ ] Cancer
- [ ] Arthritis
- [ ] Heart Disease
- [ ] Other: ____________

Sister
- [ ] Glaucoma
- [ ] Cataract
- [ ] Macular Degeneration
- [ ] Diabetes
- [ ] Hypertension
- [ ] Cancer
- [ ] Arthritis
- [ ] Heart Disease
- [ ] Other: ____________

Daughter
- [ ] Glaucoma
- [ ] Cataract
- [ ] Macular Degeneration
- [ ] Diabetes
- [ ] Hypertension
- [ ] Cancer
- [ ] Arthritis
- [ ] Heart Disease
- [ ] Other: ____________

Son
- [ ] Glaucoma
- [ ] Cataract
- [ ] Macular Degeneration
- [ ] Diabetes
- [ ] Hypertension
- [ ] Cancer
- [ ] Arthritis
- [ ] Heart Disease
- [ ] Other: ____________

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INFORMATION REGARDING DILATING EYE DROPS

Dilating drops are used to dilate or enlarge the pupils of the eye to allow the ophthalmologist to get a better view of the inside of your eye.

Dilating drops frequently blur vision for a length of time which varies from person to person and may make bright lights bothersome. It is not possible for your ophthalmologist to predict how much your vision will be affected. Because driving may be difficult immediately after an examination, it's best if you make arrangements not to drive yourself.

Adverse reactions, such as acute angle-closure glaucoma, may be triggered from the dilating drops. This is extremely rare and treatable with immediate medical attention.

I hereby authorize Dr. ____________________ and/or such assistants as may be designated by him/her to administer dilating eye drops. The eye drops are necessary to diagnose my condition.

____ _____________
Patient (or person authorized to sign for patient) Date

____ _____________
Witness Date

Print patient Name: ____

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DISCLOSURE OF PHYSICIAN OWNERSHIP

This notice explains how this organization is owned and operated. Please carefully review the information contained in this notice. Your eye care provider is part of an organization dedicated to providing comprehensive eye care services from finding the perfect frames to renowned specialists. Our organization is owned by physicians who prioritize your health and managed by professionals who coordinate to provide the highest quality care and outcomes.

If you would like to be seen by a provider who is not part of this organization, please ask the front desk or your insurance provider for a list of eye care specialists in your area.

The organization Acuity Eye Care includes Acuity Optical, Retina Institute of California Medical Group, California Clinic Management and the ambulatory surgery centers listed below.

1. San Gabriel Ambulatory Surgery Center L.P.; Renaissance ASC, LLC; Trinity Surgical Solutions, Inc; Orange ASC; and Premiere ASC, Inc meet the definition of “physician-owned ambulatory surgery center” under 42 CFR §416.
   The ambulatory surgery center is owned in part by the following physicians:
   - Tom Chang, M.D.
   - Mike Samuel, M.D.
   - Mike Davis, M.D.
   - Anthony Culotta, M.D.
   - Reid Wainess, M.D.
   - Lily Lee, M.D.
   - Kevin Suk, M.D.
   - Josh Morrison-Reyes, M.D.
   - Jessica Boeckman, M.D.
   - Brian Chen, M.D.
2. You have the right to choose the provider of your health care services. Although we believe that the following ambulatory surgery centers will be able to meet your needs, you have the option to use a facility other than these ambulatory surgery centers. You will not be treated differently by your physician if you choose to use a different facility; however, your physician may not be able to perform your procedures at an alternative facility if he does not maintain privileges at such facility.

If you have any questions concerning this notice, please feel free to ask your physician or any Acuity Eye Group team member.

Signing below means that you have received and understand this notice.

____ _______________

Signature Date

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Payment Policy

Thank you for choosing us as your eye care provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. *Knowing your insurance benefits is your responsibility.* Please contact your insurance company with any questions you may have regarding your coverage.

2**. Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance**. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.

7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise

negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency. If you are not willing to work on a payment plan to address an outstanding unpaid balance of over $500, you may be discharged from this practice. If this is to occur, you will be notified by mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. **Missed appointments**. Our policy is to charge for missed appointments not canceled or rescheduled within 24 hours prior to the appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____________________________________ _____________
Signature of patient or responsible party Date

Acuity Eye Group
Our Vision is Your Vision™

Acuity Eye Group's Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: 3/1/2023

Summary

This is a summary of how we may use and disclose your protected health information and your rights and choices when it comes to your information. We will explain these in more detail on the following pages.

Acuity Eye Group:

Your clinic or surgery center may have previously been known as a different name. Acuity Eye Group is organized as an Affiliated Covered Entity for complying with privacy rules.

This notice applies to all of the entities, which may have been known formerly or currently known to you as: Retina Institute of California Medical Group d/b/a Acuity Eye Group; California Clinic Management, LLC; Trilogy Eye Medical Group d/b/a Acuity Eye Group; Friendly Eye Medical Group; West Coast Eye Care; Orange Ambulatory Surgery Center, LLC; Renaissance Ambulatory Surgery Center, LLC; Trinity Surgical Solutions, Inc; Premiere Ambulatory Surgery Center, Inc; San Gabriel Anesthesia Associates, P.C.; San Gabriel Ambulatory Surgery Center, L.P. ; Lily Lee MD, Inc

If you are unsure if this notice applies to you, please contact compliance@acuityeyegroup.com

Our Uses and Disclosures

We may use and disclose your information as we:

- Treat you.
- Bill for services.
- Run our organization.
- Do research.
- Comply with the law.
- Respond to organ and tissue donation requests.
- Work with a medical examiner or funeral director.
- Address workers' compensation, law enforcement, or other government requests.
- Respond to lawsuits and legal actions.

Your Choices

You have some choices about how we use and share information as we:

- Communicate with you.
- Tell family and friends about your health care.
- Advertise our services.

Your Rights

You have the right to:

- Get a copy of your paper or electronic protected health information.
- Correct your protected health information.
- Ask us to limit the information we share, in some cases.
- Get a list of those with whom we've shared your information.
- Request confidential communication.
- Get a copy of this privacy notice.
- Choose someone to act for you.

Purpose

Acuity Eye Group (AEG or We) are committed to protecting your privacy. We are also legally required to maintain the privacy of your protected health information (PHI) under the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws. We follow state privacy laws when they are stricter or more protective of your PHI than federal law.
As part of our commitment and legal compliance, we are providing you with this Notice of Privacy Practices (Notice). This Notice describes:

- Our legal duties and privacy practices regarding your PHI, including our duty to notify you following a data breach of your unsecured PHI.
- Our permitted uses and disclosures of your PHI.
- Your rights regarding your PHI

Contact

If you have any questions about this Notice, please contact compliance@acuityeyegroup.com

PHI Defined

Your PHI:

- Is health information about you:
  - which someone may use to identify you; and
  - which we keep or transmit in electronic, oral, or written form.
- Includes information such as your:
  - name.
  - contact information.
  - past, present, or future physical or mental health or medical conditions.
  - payment for health care products or services; or
  - prescriptions.
- Excludes employment records that your employer may hold.

Scope

We create a record of the care and health services you receive, to provide your care, and to comply with certain legal requirements. This Notice applies to all the PHI that we generate.

We follow the duties and privacy practices that this Notice describes and any changes once they take effect.

Changes to this Notice
We can change the terms of this Notice, and the changes will apply to all information we have about you. The new notice will be available on request, in our office, and on our website. We will also send you a copy of the revised notice.

Data Breach Notification
We will promptly notify you if a data breach occurs that may have compromised the privacy or security of your PHI. We will notify you within the legally required time frame after we discover the breach. Most of the time, we will notify you in writing, by first-class mail, or we may email you if you have provided us with your current email address and you have previously agreed to receive notices electronically. In some circumstances, our business associates, which are described in more detail below, may provide the notification. In limited circumstances when we have insufficient or out-of- date contact information, we may provide notice in a legally acceptable alternative form.

Uses and Disclosures of Your PHI
The law permits or requires us to use or disclose your PHI for various reasons, which we explain in this Notice. We have included some examples, but we have not listed every permissible use or disclosure. When using or disclosing PHI or requesting your PHI from another source, we will make reasonable efforts to limit our use, disclosure, or request about your PHI to the minimum we need to accomplish our intended purpose.

Uses and Disclosures for Treatment, Payment, or Health Care Operations

- Treatment. We may use or disclose your PHI and share it with other professionals who are treating you, including doctors, nurses, technicians, medical students, or hospital personnel involved in your care. For example, we might disclose information about your overall health condition to physicians who are treating you for a specific injury or condition.
- Payment. We may use and disclose your PHI to bill and get payment from health plans or others. For example, we share your PHI with your health insurance plan so it will pay for the services you receive.
- Health Care Operations. We may use and disclose your PHI to run our practice and improve your care. For example, we may use your PHI to manage the services you receive or to monitor the quality of our health care services.

Other Uses and Disclosures
We may share your information in other ways, usually for public health or research purposes or to contribute to the public good. We must meet conditions in the law before we can share your information for these reasons:

- **Our Business Associates.** We may use and disclose your PHI to outside persons or entities that perform services on our behalf, such as auditing, legal, or transcription (**Business Associates**). The law requires our business associates and their subcontractors to protect your PHI in the same way we do. We also contractually require these parties to use and disclose your PHI only as permitted and to appropriately safeguard your PHI.
- **Legal Compliance**. For example, we will share your PHI if the Department of Health and Human Services requires it when investigating our compliance with privacy laws.
- **Public Health and Safety Activities.** For example, we may share your PHI to:
    - report injuries, births, and deaths.
    - prevent disease.
    - report adverse reactions to medications or medical device product defects.
    - report suspected child neglect or abuse, or domestic violence; or
    - avert a serious threat to public health or safety.
- **Responding to Legal Actions.** For example, we may share your PHI to respond to:
    - a court or administrative order or subpoena.
    - discovery request; or
    - another lawful process.
- **Research.** For example, we may share your PHI for some types of health research that do not require your authorization, such as if an institutional review board (IRB) has waived the written authorization requirement. If the research does require your approval, we will only share your information if you agree to share your information with the research study.
- **Quality Assessment:** We strive to provide the best care to our patient population. To better understand the needs of our diverse community and improve the coordination and delivery of care, we may conduct quality assessment and improvement activities. These include outcomes evaluation and development of clinical guidelines, population- based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination.
- **Medical Examiners or Funeral Directors.** For example, we may share PHI with coroners, medical examiners, or funeral directors when an individual dies.
- **Organ or Tissue Donation.** For example, we may share your PHI to arrange an authorized organ or tissue donation from you or a transplant for you.
- **Workers' Compensation, Law Enforcement, or Other Government Requests.** For example, we may use and disclose your PHI for:
    - workers' compensation claims.
    - health oversight activities by federal or state agencies.
    - law enforcement purposes or with a law enforcement official; or
    - specialized government functions, such as military and veterans' activities, national security and intelligence, presidential protective services, or medical suitability.

- **Marketing or Sale of Health information**. Most uses and sharing of your health information for marketing purposes or any sale of your health information are strictly limited and require your written authorization. You may cancel your authorization, in writing, at any time, but it will not affect information that we already used and disclosed based on the earlier authorization.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, please contact compliance@acuityeyegroup.com and we will make reasonable efforts to follow your instructions. We may share your information if we believe it is in your best interest, according to our best judgment, and:

- If you are unable to tell us your preference, for example, if you are unconscious.
- When needed to lessen a serious and imminent threat to health or safety.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

You have the right to:

- **Inspect and Obtain a Copy of Your PHI.** You have the right to see or obtain an electronic or paper copy of the PHI that we maintain about you (right to request access). Some clarifications about your access rights:
    - We may require you to make access requests in writing by submitting a completed form that is signed and dated by you or your legal representative.
    - You may request that we provide a copy of your PHI to a family member, another person, or a designated entity. We require that you submit these requests in writing with your signature, and/submit an electronically signed form, and clearly identify the designated person and where to send the PHI.
    - You may request that we direct a copy of your PHI to a third party of your choice on a standing, regular basis. We require that you submit these requests by submitting a completed form that is signed and dated by you or your legal representative.
    - if you request a copy of your PHI, we will generally decide to provide or deny access within 15 days, however, if we cannot act within 15 days, we will give you a reason for the delay in writing and when you can expect us to act on your request; and
    - We may deny your request for access in certain limited circumstances, however, if we deny your access request, we will provide a written denial with the basis for our decision and explain your rights.
- **Make Amendments**. You may ask us to correct or amend PHI that we maintain about you that you think is incorrect or inaccurate. For these requests:
    - You must submit requests in writing/electronically specify the inaccurate or incorrect PHI and provide a reason that supports your request.

- We will generally decide to grant or deny your request within 15 days. If we cannot act within 15 days, we will give you a reason for the delay in writing and include when you can expect us to complete our decision, which will be no longer than an additional 30 days. We will only ask for an extension once in response to a request.
- We may deny your request for an amendment if you ask us to amend PHI that is not part of our record, that we did not create, that is not part of a designated record set, or that is accurate and complete.
- If we deny your request, we will tell you why in writing. You will have the right to submit a written statement disagreeing with the denial and, if you opt not to submit this statement, you may request that we provide your original request for amendment and the denial with any future disclosures of PHI subject to the amendment. However, we may prepare a written rebuttal to any individual's statement of disagreement; and we will append the material created or submitted in accordance with this paragraph to your designated record.

- **Request Additional Restrictions.** You have the right to ask us to limit what we use or share about your PHI (right to request restrictions). You can contact us and request us not to use or share certain PHI for treatment, payment, or operations or with certain persons involved in your care. We require that you submit this request in writing. For these requests:
  - We are not required to agree.
  - we may say "no" if it would affect your care; but
  - We will agree not to disclose information to a health plan for purposes of payment or health care operations if the requested restriction concerns a health care item or service for which you or another person, other than the health plan, paid in full out-of-pocket, unless it is otherwise required by law.
- **Request an Accounting of Disclosures.** You have the right to request an accounting of certain PHI disclosures that we have made. For these requests:
  - We may ask for an additional 15 days during this 30-day period, but if we do, we will only do it once, provide a written statement of why, and indicate the date by which we intend to send the response.
  - We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures, such as any you asked us to make; and
  - We will provide one accounting a year for free.
- **Request Confidential Communications.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or at a specific address. For these requests:
  - you must specify how or where you wish to be contacted; and
  - We will accommodate reasonable requests.
- **Choose Someone to Act for You**. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI. We will confirm the person has this authority and can act for you before we take any action.

- **Make Complaints.** You have the right to complain if you feel we have violated your rights. We will not retaliate against you for filing a complaint. You may either file a complaint:

    - directly with us by contacting compliance@acuityeyegroup.com. All complaints must be submitted in writing; or with the Office for Civil Rights at the US Department of Health and Human Services. Send a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775; or visit www.hhs.gov/ocr/privacy/hipaa/complaints/

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Acknowledgement of Receipt

I,__________________________, (individual's name), acknowledge that on ___________(date), I received a copy of Acuity Eye Group's Notice of Privacy Practices and I read and understood it. I understand that:

- I have certain rights to privacy regarding my PHI.
- AEG can and will use my PHI for the purposes of my treatment, payment, and health care operations.
- The Notice explains in more detail how AEG may use and share my PHI for other purposes.
- I have the rights regarding my PHI listed in the Notice.
- AEG has the right to change the Notice from time to time and I can obtain a current copy of the Notice by contacting compliance@acuityeyegroup.com

___________________________________ _____________

Patient Signature or Patient Representative Date

Date of Birth: ___________________ Relationship to Patient:__________________

Consent for Receiving Electronic Communication

_________ [Initial here] I consent to be contacted by text, email, other electronic communication by AEG for appointment reminders or other AEG services using the phone number and email in my medical record.

FOR OFFICE USE ONLY:

Good Faith Effort to Obtain Acknowledgement ☐*Check this box here if patient signed above*

I attempted to obtain the patient's or the patient's representative's signature on the HIPAA Notice of Privacy Practices Acknowledgement Form, but was unable to do so as document below:

Reason: ____

Name:____Date:_____________

Signature: ____

NOTICE AND ACKNOWLEDGMENT OF RECEIPT AND UNDERSTANDING

Patient Notice about CMS Open Payments

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals.

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page can be found at https://openpaymentsdata.cms.gov

Patient Notice about Medical Board of California

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to www.mbc.ca.gov , email: licensecheck@mbc.ca.gov , or call (800) 633-2322.

____ ______________
Patient (or person authorized to sign for patient) Date

Print Patient Name: ____

PHYSICIANS – 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 be 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 binds 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 parties, 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 fee from the patient 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 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 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 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 any other applicable statutory of 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 the joinder in this arbitration of any persons or entity which would otherwise be a proper additional party in a court action, and 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. Discovery shall be conducted pursuant to the 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 assessed 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 at any time for the condition.

Article 6: Retroactive Effect: If the patient intends this agreement to cover services rendered before the date it is signed (Including, but not limited to, emergency treatment) the patient should initial directly below and this agreement will be considered effective as of the date of the first medical services:

_________ Patient's or Patient Representative's 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. 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 TO COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

_______________________________________ _____________

Signature of Patient or Patient Representative Date

____

Printed Patient Name

____ _____________

Signature of Physician or Authorized Representative Date

____

Printed Patient Representative Name and Relationship to Patient (if Present)