Justin Paquette, M.D.
8670 Wilshire Blvd Suite 200
Beverly Hills, CA 90211
(310) 870-7123 Fax (310) 652-2501

Date Of Service: ___________

PATIENT INTAKE FORMS

PATIENT INFORMATION					
First name and last name:	Date of Birth:	SSN #:	Cell Phone No:	Home Phone No:	Sex:
Street Address	City, State, Zip	E-mail Address:	Marital Status:		
Date of Injury:	Emergency contact:	Relation:	Phone number:	Email address of contact:	
Currently Working?:	Date last worked:	****Referred by:**	**Phone No:**		

EMPLOYER		
Employer at time of injury:	Street Address:	City, State, Zip:
Phone No:	Contact Person / Ext. :	Fax No:
Current Employer:	Street Address:	City, State, Zip:
Phone No:	Contact Person / Ext. :	Fax No:

APPLICANT ATTORNEY (WORKER'S COMP AND PERSONAL INJURY)			
Attorney / Law Firm:	Street Address, Suite No:	City, State, Zip:	
Office Phone No:	Fax No:	Cell Phone No:	E-Mail Address:

DEFENSE ATTORNEY (WORKER'S COMP AND PERSONAL INJURY)			
Attorney / Law Firm:	Street Address, Suite No:	City, State, Zip:	
Office Phone No:	Fax No:	Cell Phone No:	E-Mail Address:

INSURANCE		
Insurance Company:	Phone No:	Fax No:
Adjuster (WC PATIENTS ONLY):	Phone No / Ext. (WC PATIENTS ONLY):	Fax No (WC PATIENTS ONLY):
Street Address:	City, State, Zip:	E-mail Address:
File No (WC PATIENTS ONLY):	Claim #/ID #:	WCAB #/Group #:

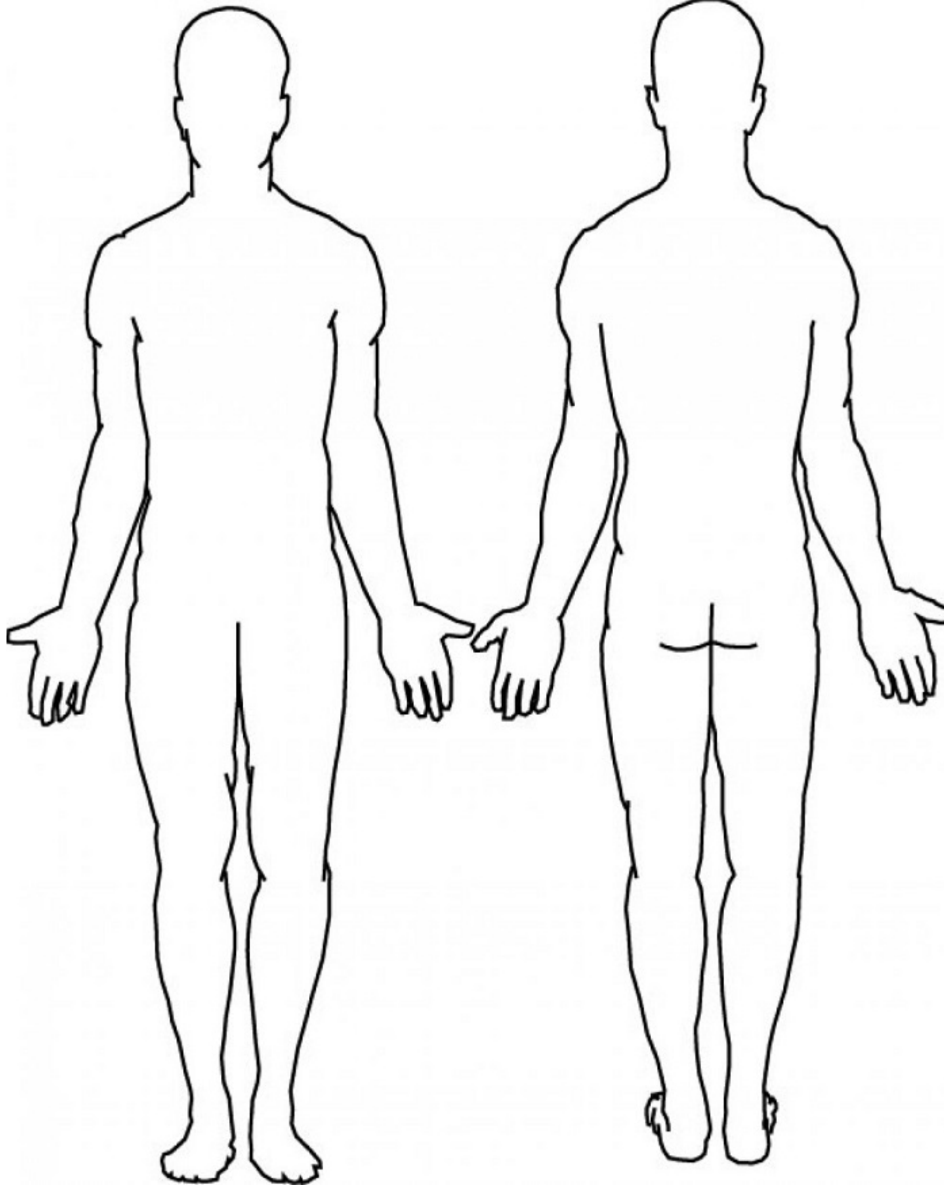
PATIENT PAIN DRAWING

Patient: ______________________________ Date: ______________________

Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. (this page to be done in office)

ACHE	NUMBNESS	PINS & NEEDLES	BURNING	STABBING
^^^^^^^^^^^^^^	= = = = = =	OOOOOOOOOOOOOOOO	xxxxxxxxxxxxx	////////////////////////////

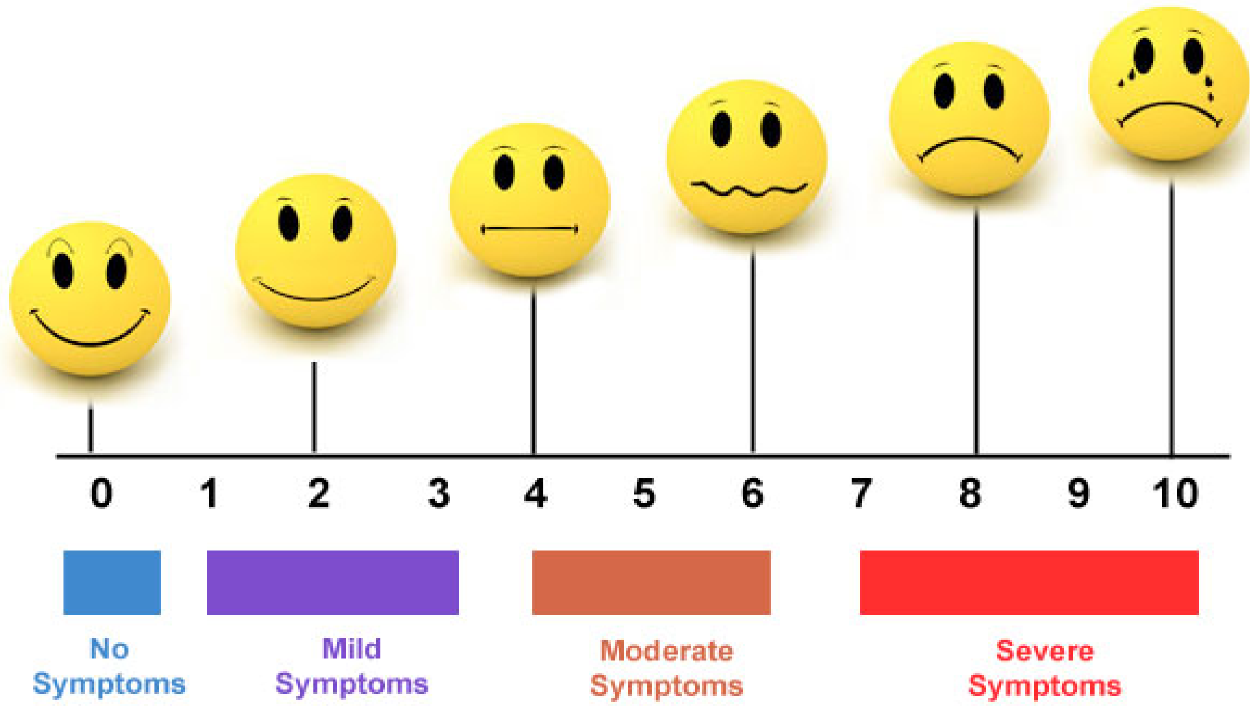
FRONT **BACK**



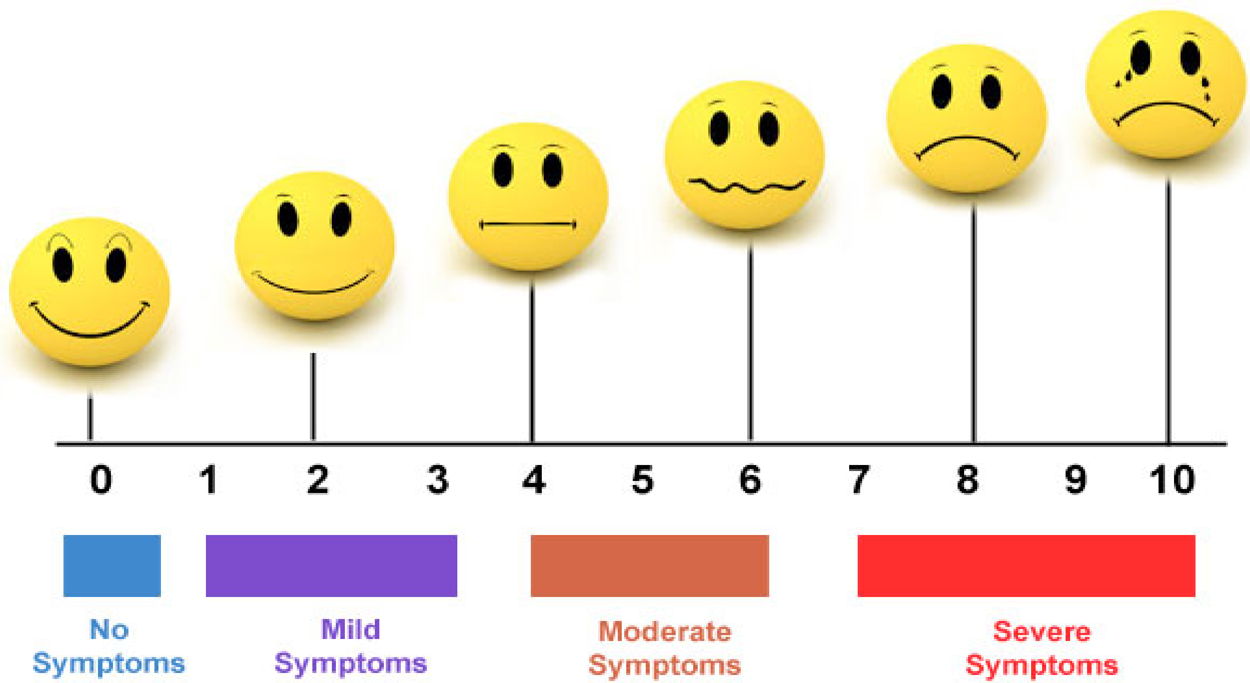
What bothers you more (i.e. pain, numbness, etc.)?

- Back ______ % vs. Neck ______ % = 100%
- Back ______ % vs. Leg(s) ______ % = 100%
- Neck ______ % vs. Arm(s) ______ % = 100%

PAIN SCALE AT REST (PLEASE CIRCLE A NUMBER)



PAIN SCALE WITH ACTIVITIES (PLEASE CIRCLE A NUMBER)



The Paquette Spine Institute

8670 Wilshire Blvd., Suite 200
Beverly Hills, CA 90211
TELEPHONE NO: (310) 870-7123 FAX NO: (310) 652-2501

CURRENT MEDICAL HISTORY SHEET

NAME:____**AGE:**____________
HEIGHT:________**WEIGHT:**________ **RT HANDED: [ ] LT HANDED: [ ] BOTH: [ ]**

GENERAL MEDICAL DR: NAME: ____

ADDRESS: ____

TELEPHONE: ____

CHIEF COMPLAINT:____

HISTORY OF PRESENT ILLNESS
How long have you had this ____

Have you had any treatment for it: No Yes...Please list: _______________________________________

Do you have medication for this problem? No Yes Does it help? NO Yes

Please check: Have you had: X-rays MRI CT Scan Bone Scan Nerve studies

Other:____

For which body parts?____

Have you had: Chiropractic Physical Therapy Acupuncture Other: ______________________

PLEASE DESCRIBE WITH YOUR OWN WORDS HOW THE INJURY HAPPENNED AND ANY TREATMENT THAT YOU HAD RECEIVED TO DATE.

____

____

____

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If you need additional space please notify us

The Paquette Spine Institute

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AUTOMOBILE INJURY HISTORY

NAME:____________________________________ DATE OF ACCIDENT:_______________ APPROXIMATE TIME:_______________

WHERE DID ACCIDENT HAPPEN?:____

DESCRIBE ACCIDENT IN YOUR OWN WORDS:____

____

____

WHAT WAS YOUR POSITION IN CAR?: ☐ DRIVER ☐ PASSENGER.

IF PASSENGER, WERE YOU SITTING IN:
☐ FRONT? ☐ RIGHT REAR? ☐ LEFT REAR? ☐ MIDDLE SEAT?

DID YOUR VEHICLE STRIKE ANOTHER VEHICLE?: ☐ YES ☐ NO

WAS YOUR CAR STRUCK BY ANOTHER VEHICLE?: ☐ YES ☐ NO

WAS THE IMPACT FROM: ☐ THE FRONT? ☐ THE RIGHT SIDE? ☐ THE LEFT SIDE? ☐ THE REAR?

AT THE TIME OF IMPACT, WERE YOU: ☐ LOOKING STRAIGHT AHEAD? ☐ LOOKING RIGHT? ☐ LOOKING LEFT?

WERE BOTH HANDS ON THE STEERING WHEEL?: ☐ YES ☐ NO

WAS YOUR FOOT ON THE BRAKE?: ☐ YES ☐ NO

WERE YOU BRACED FOR IMPACT?: ☐ YES ☐ NO

WHERE IN THE CAR WERE YOU AFTER THE ACCIDENT?:____

WERE YOU WEARING A SEATBELT?: ☐ YES ☐ NO

DID YOU STRIKE ANYTHING IN THE VEHICLE AT TIME OF IMPACT?: ☐ YES ☐ NO

IF YES, SPECIFY:

☐ STEERING WHEEL ☐ DASHBOARD ☐ WINDHIELD ☐ SIDE DOOR ☐ ARM REST ☐ SIDE WINDOW

PLEASE STATE PART OF BODY: ☐ CHEST ☐ CHIN ☐ KNEE ☐ SHOULDER ☐ HAND ☐ HEAD

IMMEDIATELY FOLLOWING THE ACCIDENT, HOW DID YOU FEEL?____

____

WERE YOU UNCONSCIOUS?: ☐ YES ☐ NO IN A DAZE?: ☐ YES ☐ NO

DID YOU GO TO THE HOSPITAL?: ☐ YES ☐ NO

IF YOU WENT TO THE HOSPITAL, WHEN? AT TIME OF ACCIDENT?: ☐ YES ☐ NO

HOW DID YOU GET TO HOSPITAL?: AMBULANCE?: ☐ YES ☐ NO PRIVATE TRANSPORTATION?: ☐ YES ☐ NO

DID THE AMBULANCE ATTENDANTS PLACE YOU IN A NECK COLLAR?: ☐ YES ☐ NO SPLINTS?: ☐ YES ☐ NO

BRACE?: ☐ YES ☐ NO

History continued……..

NAME OF HOSPITAL:____

ATTENDED BY DR.:__________________________ WERE YOU X-RAYED AT THE HOSPITAL?: ☐ YES ☐ NO

IF SO, WHAT WAS THE DIAGNOSIS?:____

WERE YOU ADMITTED TO THE HOSPITAL?: ☐ YES ☐ NO

HOW LONG DID YOU STAY?:____

WHAT TREATMENT DID YOU RECEIVE?:____

____

____

DESCRIBE SYMPTOMS FROM THE DAY FOLLOWING ACCIDENT TO TODAY'S DATE:________________

____

____

____

WHAT RECOMMENDATIONS WERE MADE? SEE YOUR OWN DOCTOR?: ☐ YES ☐ NO

SEE SPECIALIST DR.?: ☐ YES ☐ NO PHYSICAL THERAPY?: ☐ YES ☐ NO

BEFORE THE INJURY WERE YOU CAPABLE OF WORKING ON AN EQUAL BASIS WITH OTHERS YOUR AGE?:

☐ YES ☐ NO

ARE YOUR WORK ACTIVITIES RESTRICTED AS A RESULT OF THIS ACCIDENT?: ☐ YES ☐ NO

ARE YOUR HOME ACTIVITIES RESTRICTED AS A RESULT OF THIS ACCIDENT?: ☐ YES ☐ NO

IF YES GIVE PERCENTAGE OF RESTRICTION:____________

DO YOU HAVE A COPY OF POLICE REPORT?: ☐ YES ☐ NO. IF YES, PLEASE BRING A COPY TO OUR OFFICE.

SIGNATURE____

PLEASE LIST ALL THE PRESCRIPTION MEDICATIONS YOU TAKE NOW:

1.____ 2. ____

3.____ 4. ____

5.____ 6. ____

7.____ 8. ____

PLEASE LIST ANY OVER-THE-COUNTER MEDICATIONS: VITAMINS; HERBAL COMPOUNDS ETC. YOU TAKE:

____

ARE YOU ALLERGIC TO ANY MEDICATIONS: [ ] NONE KNOWN

YES
(LIST):____

DO YOU HAVE ANY ALLERGIES TO FOODS OR OTHER SUBSTANCES:
[ ] NONE KNOWN

YES (LIST):
____

PLEASE LIST THE NAMES AND TELEPHONE NUMBERS OF ALL YOUR TREATING PHYSICIANS:

1.____ 2. ____

3.____ 4. ____

5.____ 6. ____

PREVIOUS INJURIES: (Any and all Motor vehicle injuries, work Injuries, personal injuries i.e. slip and fall that involve injury to your spine) **Yes** **NO**
Please state date of injury, treatment and approximate recovery from 0 to 100%
Injury#1______________________________Treatment:___________________Recovered? 0-100%_____
Injury#2______________________________Treatment:___________________Recovered? 0-100%_____
Injury#3______________________________Treatment:___________________Recovered? 0-100%_____
Injury#4______________________________Treatment:___________________Recovered? 0-100%_____

PAST MEDICAL HISTORY
PLEASE MARK THE CONDITIONS YOU HAVE: [ ] NONE

[ ] ARTHRITIS [ ] CARDIOVASCULAR DISEASE [ ] DEPRESSION [ ] DIABETES

[ ] EMPHYSEMA [ ] GASTRIC ULCER [ ] HIGH BLOOD PRESSURE [ ] KIDNEY DISEASE

LIST SIGNIFICANT ILLNESS YOU HAVE HAD IN THE PAST [ ] NONE [ ] LIST (strokes, seizures, etc.):

____

PAST SURGICAL HISTORY

[ ] NONE [ ] LIST (all surgeries with dates) HAVE YOU EVER HAD A BLOOD TRANSFUSION: [ ] YES [ ] NO

____

____

____

____

____

____

SOCIAL HISTORY:

DO YOU DRINK ALCOHOLIC BEVERAGES: [ ] SOCIALLY [ ] DAILY HOW MANY DRINKS:____________

DO YOU SMOKE: [ ] NEVER [ ] QUIT_____YEARS AGO [ ] YES SINCE ________PACKS DAILY_______

OTHER?____

PLEASE NOTE ANY OTHER SIGNIFICANT FAMILY OR SOCIAL EVENT:____

FAMILY HISTORY:

IS YOUR MOTHER LIVING: YES, AGE:______ IN GOOD HEALTH NO, CAUSE OF DEATH?__________________________________

IS YOUR FATHER LIVING: YES, AGE:_______IN GOOD HEALTH NO, CAUSE OF DEATH?__________________________________

SIBLINGS: BROTHER(S)______LIVING ______DECEASED: CAUSE____

SISTER(S) ______LIVING______DECEASED: CAUSE:____

ANY SIGNIFICANT FAMILY ILLNESSES: YES [ ] NO [ ]

____

____

OTHER CONCERNS:

____

____

____

____

____

____

Justin D. Paquette, MD
Neurosurgical Spine Surgeon

CONSENT TO MEDICAL OR SURGICAL CARE AND TREATMENT

Patient Name: Date of Surgery:

I authorize Dr. Justin Paquette and such physicians, assistants, or other personnel of the hospital or medical facility chosen by him, or that you have previously seen, to perform the following (IN MEDICAL TERMS KNOWN AS):

____

____

____

And/or to do any other procedures that in their judgment may be advisable to my well being, including such procedures that are considered medically advisable to remedy conditions discovered during the above procedure. Preoperative evaluations will need to be obtained by a medical physician.

NOTE TO PATIENT: There are inherent risks involved in any surgical procedure or treatment programs. It is not possible to guarantee or give assurance of a successful result. It is important that you clearly understand and agree to the planned surgery or treatment. Medicine and surgery are generally safe and helpful. However, medical or surgical procedures of any type involve the taking of risks, ranging from minor to serious (including the risk of death). It is important to be aware of the following possible risks before receiving the treatment you and your physician are planning.

GENERAL RISKS AND COMPLICATIONS: I am satisfied with my understanding of the more common risks and complications of the treatment or procedure. These risks include, but are not necessarily limited to: bleeding, infection, pain, injury to the nerves and blood vessels with subsequent dysfunction, thrombophlebitis and blood clot formation, stiffness in the extremity and decreased range of motion, weakness in the extremity and possible paralysis, injury to other adjacent body organs, wound healing problems, adverse drug and anesthesia reactions, and even death. Such medically unrelated conditions as heart attack, lung failure, liver failure, stroke, and gallstones may occur in association with the operation. If a metallic implant or other type of orthopaedic device is used, there may be untoward reaction to that substance. On occasion the orthopaedic hardware may fail, loosen, or dislocate, or may need to be removed. I fully understand that my condition may become worse as a result of the operation because of any one of the conditions mentioned above. I also understand that if I have cosmetic implants of any type, Dr. Paquette and his associates cannot assume responsibility for damage, dislodgement or rupture of cosmetic implants during surgery.

Initial _______

INSURANCE: I understand any insurance coverage I have is a contract between the insurance company and myself. I accept full responsibility for verification of coverage of any involved personnel in my care. Dr. Paquette does not act as the agent for any arrangements, nor is he responsible for any other providers or their fees. I understand any or all amounts not covered by my insurance carrier are my full responsibility unless otherwise arranged in written contract. Insurance is billed as a courtesy to the patient.

SPECIFIC RISKS AND COMPLICATIONS: I am satisfied with my understanding of the specific risks and complications of this procedure and treatment, as reviewed with me by my treating physician.

ALTERNATIVE METHODS OF TREATMENT: I am satisfied with my understanding of alternative procedures or treatment and their possible benefits and risks. This would include rest modification in my activity level, appropriate bracing of the injured area, the use of anti-inflammatory medication, and physiotherapy.

ALTERNATIVE SURGERY: I understand that other forms of surgery may be available. The procedure planned, the reasons and surgical alternatives have been reviewed in full and I understand them. I realize that if one procedure does not result in the desired result, further or different surgeries may be necessary.

NO TREATMENT: I am satisfied with my understanding of the possible consequences, outcomes, or risks if no treatment is rendered.

SECOND OPINION: I have been offered the opportunity to seek a second opinion concerning the proposed treatment procedure. This may be obtained if desired.

ADDITIONAL OR DIFFERENT PROCEDURES DURING CARE AND TREATMENT:
I understand that conditions may arise which are unforeseen at this time and that it may be necessary and advisable to perform operations and procedures different from, or in addition to, the procedure described. I authorize and consent to the performance of such additional or different operations and procedures as are considered necessary and advisable.

OTHER SERVICES: I consent to the performance of pathology and radiology services as needed and I further authorize the disposal of any severed tissue or member in accordance with customary hospital or medical facility practice.

Initial _______

PHOTOGRAPHY: I consent to the photographing, filming, or videotaping of the treatment or procedure for educational or diagnostic use.

OBSERVERS: I consent to an observer viewing my case. I understand that he/she will not be involved in the surgical procedure.

NO GUARANTEES: I fully understand that there are risks involved in any procedure or treatment and it is not possible to guarantee or give assurance of a successful result.

OTHER QUESTIONS: I am satisfied with my understanding of the nature of the procedure or treatments, and all of my additional questions about the treatment or procedure have been answered.

DATE: ______________ TIME: ______________ AM / PM

SIGNATURE: ____

WITNESS: ____

TRANSLATED (IF APPLICABLE): _____________________________________

PHYSICIAN: _________Justin D. Paquette, M.D.___________________________

If you have any questions or concerns regarding this consent form, please contact: Gloria Agabra at the following (310) 870-7123

Justin Paquette, M.D.
8670 Wilshire Blvd, Ste. 200 ● Beverly Hills, CA 90211
Tel: (310) 870-7123● Fax: (310) 652-2501

MEDICAL INFORMATION RELEASE ONLY

I hereby authorize Dr. Paquette to furnish information to insurance carriers concerning this injuries/illness.

Patient's signature: ___________________________________ Date: ____/____/_______

If the patient is a minor or incompetent, the parent or guardian should sign below, and in addition, the minor or incompetent patient should sign above, if at all possible.

Parent's or Guardian 's signature: ________________________Date:____/____/_______

MEDICAL INFORMATION RELEASE ASSIGNMENTS OR BENEFITS

I hereby authorize Dr. Paquette to furnish information to insurance carriers concerning this injuries/illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered and all major medical benefits.
I understand that I am financially responsible for charges not covered by this authorization, and/or the balance not paid by insurance.

Patient's signature: ____________________________________ Date: ____/____/______

If the patient is a minor or incompetent, the parent or guardian should sign below, and in addition, the minor or incompetent patient should sign above, if at all possible.

Parent's or Guardian's signature: _______________________ Date: ____/____/_______

MEDICAL INFORMATION RELEASE RESEARCH AND PUBLICATION

☐ I hereby authorize Dr. Paquette to use my medical information (including photographs) for the purposes of research studies and possible publication. I understand that my identity will be kept anonymous.

→ ☐ I hereby give permission for my photograph to be used unaltered.

→ ☐ I hereby authorize that any photograph used be altered to conceal my facial identity.

☐ I hereby authorize Dr. Paquette to use my medical information only (no photographs) for the purposes of research studies and possible publication. I understand that my identity will be kept anonymous.

Patient's signature: ____________________________________ Date: ____/____/______
If the patient is a minor or incompetent, the parent or guardian should sign below, and in addition, the minor or incompetent patient should sign above, if at all possible.

Parent's or Guardian's signature: _______________________ Date: ____/____/_______

Name of the patient: _________________________________ Date: ____/____/_______

A copy of this authorization shall be as valid as the original

Justin Paquette, M.D.
8670 Wilshire Blvd, Ste. 200 ● Beverly Hills, CA 90211
Tel: (310) 870-7123● Fax: (310) 652-2501

NOTICE OF PRIVACY PRACTICES

To our patients

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Justin Paquette, M.D. is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances
The following circumstances may require us to use or disclose your health information

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
2. You can request a restriction in our use of disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care, such as family members and friends. We are not required to agree to your request. However, if you do agree, we are bound by our agreement except when otherwise required by law, emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing **to Gloria Agabra, Office Manager/Privacy Officer or you may call (310) 870-7123** for further information.

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Justin Paquette, M.D. at 8670 Wilshire Blvd. Ste. 200, Beverly Hills, CA 90211. You must provide us with a reason that supports your request for amendment.

5. Right to a copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, contact our front desk receptionist.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, **contact Gloria Agabra, Office Manager/Privacy Officer at (310) 870-7123**. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Justin Paquette, M.D. will obtain your written authorization for uses or disclosures that are not identified by this notice or our health information privacy policies, please contact Justin Paquette, M.D. at 8670 Wilshire Blvd., Suite 200, Beverly Hills, CA, 90211

I hereby acknowledge that I have been presented with a copy of Justin Paquette, M.D. Notice of Privacy Practices.

Name of the patient: ______________________________________

Date: ____/____/_______

Signature: _______________________________

Justin Paquette, M.D.

<u>Statement of Patient Financial Responsibility</u>

Justin Paquette, M.D. is dedicated to providing the highest quality orthopaedic medical care for our patients. As a professional courtesy, our staff will bill your insurance carrier for you at no extra cost.

In the event the insurance carrier may not reimburse part or all of the professional and/or treatment claims of our patients, the patient will then become responsible for any remaining unpaid portion.

We will submit bills and attempt to obtain reimbursement from your insurance carrier for up to 90 days from the date of service. After 90 days, the patient will be required to remit payment for any remaining balance regarding services rendered but not yet paid.

When necessary, patients (the client) may also contact their insurance companies on their own behalf to urge compliance of payment and with the principles of general fairness and equity.

We will do our best to determine eligibility and coverage information from the insurance carriers but ultimately, it is the patient's responsibility to know what his/her benefits are.

Should you have any further questions or concerns, our finance department would be happy to speak with you.

I have read and understand, and will agree to comply with, the above stated financial policy.

I understand that I am financially responsible for the balance of any professional or treatment sessions for which payment has for any reason been denied by my insurance carrier. This includes treatment sessions not covered by my insurance company upon medical review, or treatments that may no longer be covered by insurance as a result of denied status.

__________________________________ __________________

(Patient's Signature) (Date)

____

(Please Print Name)

J U S T I N   P A Q U E T T E ,   M . D .
8 6 7 0   W I L S H I R E   B L V D . ,   S U I T E   2 0 0
B E V E R L Y   H I L L S ,   C A   9 0 2 1 1
O F F I C E   (3 1 0)   8 7 0 - 7 1 2 3 F A X   (3 1 0)   6 5 2 - 2 5 0 1

Authorization for release and/or disclosure of medical information

Medical Information Request from:	Please send medical information to:
___________________________	___________________________
Name of provider or facility	Name of provider or facility
___________________________	___________________________
Address	Address
____________ ____________	____________ ____________
Telephone Fax	Telephone Fax

I hereby authorize ___________________to release and/or disclose the medical information as indicated below to the health provider or facility indicated above.

Release and/or Disclose records and information regarding:

___________________________	______-______-______
Name of patient	Date of birth
___________________________	(______)____________________
Address	Telephone #

Duration: This authorization shall become effective immediately and shall remain in effect until revoked in writing by the undersign.

Revocation: The authorization may be revoked in writing by the undersign at any time before the release of any information from the disclosing party. Written revocation will not affect any action taken in reliance on the authorization before the revocation was received.

Redisclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Records requested:
☐ Medical records…☐ Complete chart…Or From ___________To__________
☐ X-Rays ☐ M.R.I. ☐ Other_________________ ☐ Report ☐ Films

A copy of this authorization is as valid as the original.

____   __________________
Signature of patient or representative of the patient   **Date**

I have the right to receive a copy of this authorization. The copy is for me to keep.

HEALTHCARE LIEN

Justin Paquette, M.D.
8670 Wilshire Blvd. Suite 200 Beverly Hills, California 90211

Patient Name: ____________________________________ DOB: ________/________/_________

Patient SSN: _________-________-__________

Date of Injury: _________/________/_________

Patient authorizes Provider(s) to furnish his/her Attorney and insurance carrier with a full report of examination, diagnosis, course of treatment, prognosis, and any other relevant information concerning his/her care and treatment for the aforementioned injury. Patient further authorizes his/her Attorney and insurance company to furnish Provider(s) with information concerning the merits, viability and status of Patient's injury claim.

Patient hereby gives this Lien to Provider against all proceeds (whether by settlement, judgment or award, including all Med-Pay advances), derived from Patient's injury claim to secure payment of all fees owed Provider(s) by Patient for treatment furnished Patient for the aforementioned injury. This Lien, regardless of when executed, shall apply retroactively to all care and treatment furnished Patient by Provider(s) arising out of aforementioned injury.

Patient understands and agrees that this Lien attaches against all proceeds derived from Patient's injury claim as soon as the proceeds are received, by either Patient or his/her Attorney. Patient authorizes and directs his/her Attorney and insurance carrier to withhold from any settlement, judgment or award all funds necessary to fully and completely satisfy this Lien.

Patient further authorizes and directs his/her Attorney to honor this Lien and make full payment thereon as soon as possible and prior to and in advance of distributing any of the proceeds derived from Patient's injury claim to Attorney or Patient. It is understood and agreed that payment shall be tendered without regard to setoff, unresolved claims against other third parties, or apportionment or pro-rata distributions to other healthcare providers.

Patient and Attorney understand that this Lien is offered for the protection of Provider and in consideration for Provider agreeing to await payment for services rendered to Patient. Patient understands and agrees that payment of Provider's fees is not contingent on Patient's receipt of a favorable settlement, judgment or award and that he/she remains directly and fully responsible to Provider for all services rendered him/her. Patient agrees that if no suit on the injury claim is filed by Attorney within the statutory period provided therefore, that all Providers' fees shall become due and payable immediately upon expiration of the statutory period.

Attorney and Patient hereby agree to immediately notify Provider(s) in the event Patient retains new or different legal counsel. Patient directs his/her new counsel to execute a new copy of this Lien and otherwise honor the terms thereof.

Attorney agrees that his/her status as trustee for those funds recovered on Patient's behalf will change from trustee to debtor if Attorney: (1) does not directly and fully and completely pay Provider for services furnished Patient that is subject to this Lien (absent a written agreement signed by Provider accepting a compromised amount in lieu of full payment; (2) releases/forwards the funds from Patient's settlement, judgment or award from his/her trust account prior to satisfaction of this Lien; or (3) refuses to withhold that amount owed Provider from the funds obtained on Patient's behalf by way of settlement, judgment or award.

Patient, Attorney and Provider agree that if enforcement of this Lien, or any portion thereof, is required, all disputes for less than $5,000 will be submitted to Small Claims Court for resolution while all disputes in amount in excess thereof will be submitted to binding arbitration with any award therefrom confirmed by a court of competent jurisdiction. Patient, Attorney and Provider further agree that if enforcement of this Lien, or any portion thereof, is required, that the prevailing party shall be entitled to recover Attorney's fees, arbitration fees and costs, jointly and severely, from the non-prevailing part(ies).

I/we have read and fully understand this lien and agree to be bound by its terms.

Dated: ____________________________ ____
(Patient Signature)

Dated: ____________________________ ____
(Attorney Name)

____
(Attorney Signature)

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 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 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 or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, 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 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, 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 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 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 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 initial below:

Effective as of the date of 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 OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: ____________________ __________
Physician's or Authorized Representative's Signature (Date)

____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: ____________________ __________
Patient's or Patient Representative's Signature (Date)

By: ____________________
Print Patient's Name

____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

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