Medical History

Name: _____ D.O.B. _____

Home Phone#: _____ _____Mobile Phone#: _____

Email Address (Required): _____

Referring Dr.: _____Weight: _____ Height: _____Sex: Male Female

List of Current Medications: _____

YES NO ***Please answer the following:***

☐ ☐ Have you or any blood relative had a reaction to local or general anesthetic?
If yes, please describe: _____
_____

☐ ☐ Do you have a history of alcohol or drug dependency?

☐ ☐ Allergies to any drugs? If yes, please describe: _____
_____

List drug allergy reactions: _____

☐ ☐ Latex allergies/sensitivities? If yes, please describe: _____

☐ ☐ Previous surgeries? If yes, indicate procedure and year performed:
_____
_____

☐ ☐ Major illnesses or conditions? If yes, please describe:
_____
_____

☐ ☐ Smoker? Packs per day?_____ ___ Quit? When? _____

☐ ☐ Do you use Alcoholic beverages? ☐Occasionally If daily, how much?_____

☐ ☐ Could you be pregnant? Last menstrual period? _____ ☐ Not Applicable

☐ ☐ Have you ever been diagnosed with an irregular heart beat?
If yes, date of diagnosis:_____

Check here if you have had any of the following:

☐Glasses ☐Contacts ☐Dentures: ☐Upper ☐Lower ☐Partials: ☐Upper ☐Lower
☐High Blood Pressure
☐Heart Attack, Date(s):_____
☐Congestive Heart Failure ☐Heart Murmur
☐Open Heart Surgery, Dates(s):_____ ☐Angioplasty/Stent,Date(s):_____
☐Chest Pain, when and duration?_____
☐Pacemaker, Date(s):_____ ☐Seizures ☐Dizziness/Black Out ☐Utilize C pap
☐Stroke, Date(s):_____
☐Sleep Apnea, Diagnosis Date:_____ ☐Blood Transfusion, Date(s): _____
☐Hepatitis, Type:_____ ☐Liver Disease
☐Diabetes (please check those that apply): ☐Insulin Dependent ☐Oral Medication ☐Diet Control
☐Asthma ☐Emphysema ☐Tuberculosis ☐Recent Head Cold, Date:_____
☐Other Respiratory Conditions:_____
☐Arthritis ☐Joint Replacement Surgery, which joint(s):_____
☐Kidney Disease ☐Kidney Stones ☐Bladder Problems ☐Prostate Problems
☐Stomach Ulcers ☐History of Indigestion/Heartburn/Reflux ☐History of Post-Operative Nausea
☐ A blood relative has had above complication – Relation: _____
Please list relative complications: _____
Patient Signature: _____ Date:_____

STANISLAUS
ORTHOPAEDIC
AND SPORTS MEDICINE CLINIC

John J. Casey Jr., M.D.
Jonathan L. Cohen, M.D.
William L. Pistel, D.O.
Mohamed A. Ibrahim, M.D., FACS
Marc A. Trzeciak, D.O.
Adam P. Warren., M.D., M.P.H.
Michael P. Wolterbeek, D.P.M.
Pedram Vaezi, D.C., Q.M.E.

Financial Policy

Effective: 01.01.2014

PPO/ HMO's - We will submit claims directly on your behalf to your respective insurance courier. The patient/ guardian are responsible for any copays or patient responsibility on the day of the visit. Referrals are the responsibility of the patient/ guardian to obtain from their primary care physician **PRIOR** to their appointment in this office. **IF REFERRALS ARE NOT OBTAINED, THE PATIENT/GUARDIAN IS FULLY RESPONSIBLE FOR CHARGES INCURRED OR THE OFFICE VISIT WILL BE CANCELED.** We are limited by HMO's to provide treatment only for what is authorized. If you choose to have treatment for additional problems not authorized by your plan, you will be financially responsible for the charges.

Workers Comp. - Your workers compensation carrier must authorize all visits in advance. All services are to be paid by workers comp. In the event the workers comp carrier should deny a claim, the patient will be responsible for the bill.

Office Visit Cash Pay – A consultation fee of $300.00 will be collected on the day of the patients initial office visit. A $100.00 office fee will be due and payable for any office visits thereafter, this charge would not include any additional services outside the office visit such as: casting, injections, medications, etc.

X-Ray Cash Pay: **An X-ray fee of $75.00 will be collected for each occurrence within our office.**

Cancelled/ No Show Appointments – If the patient fails to notify office within 48 hours of the patients visit, a cancellation charge of $35.00 will be applied to your account.

Returned Check - In the event of insufficient funds a returned check fee of $25.00 will be added to your account balance along with the payment amount which was on the check.

***** IT IS THE REPSONSIBILITY OF THE PATIENT/ GUARDIAN TO INFORM OUR OFFICE OF ANY CHANGES IN THEIR INSURANCE COVERAGE AND BILLING INFORMATION.***

Important Information Regarding HIPPA

In general, the HIPPA rule gives individuals the right to request a restriction on uses and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Note: USES AND DISCLOSURES MAY BE PERMITTED IN THE CASE OF AN EMERGENCY

Please list any other persons you wish Stanislaus Orthopaedics to release information to

Name: _____ Contact Number: _____

Relationship: _____

By signing the following, I certify that I have read and fully understand all paragraphs of the foregoing and any questions that I have had have been answered.

_____ _____	_____	_____
Patients Name (please print)	Patient's Signature	Date
_____	_____	_____
Name of Patient's Personal Representative (please print)	Signature of Patients Personal Representative	Relationship to Patient

STANISLAUS
ORTHOPAEDIC
AND SPORTS MEDICINE CLINIC

John J. Casey Jr., M.D.
Jonathan L. Cohen, M.D.
William L. Pistel, D.O.
Mohamed A. Ibrahim, M.D., FACS
Marc A. Trzeciak, D.O.
Adam P. Warren., M.D., M.P.H.
Michael P. Wolterbeek, D.P.M.
Pedram Vaezi, D.C., Q.M.E.

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 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 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 the 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.

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 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 counseling 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, nor 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 dispute with this arbitration, including, but not limited to, Code of Civil Procedure Section 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 Date: date of first medical services.

_____
Patient 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.

_____ _____
Physicians or Authorized Representative's Signature Date

_____ _____
Print or Stamp Name of Physician, Medical Group Date

_____ _____
Print Patient's Name Date

_____ _____
Patient/Representative's Signature Date

_____
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 the Patient's medical records.