

PATIENT POLICY FORM



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We understand that medical information about you and your health is personal. As the custodians of the information in your medical record, we are committed to protecting the privacy of your information as required by law, professional accreditation standards and our internal policies and procedures.

Attached is a copy of our Notice of Privacy Practices. This notice explains your rights, our legal duties and our privacy practices. It also describes how medical information about you may be used and disclosed and who can get access to this information. Please review it carefully.

We ask that you sign and return this cover letter to us for our records. Your signature only acknowledges that we have provided you a copy of our Notice of Privacy Practices as required by law. The law also requires us to document the fact that we have distributed the notice by collecting and retaining these signed acknowledgements.

I hereby acknowledge receipt of the Notice of Privacy Practices:

Name of Patient _____ **Date** _____

Patient or Representative's Signature

If Representative, Print Name and Relationship

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician 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 333.2. 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 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 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)

By: _____
Patient or Patient Representative's Signature (Date)

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

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.

PATIENT INTAKE FORM



DATE: _____ EMAIL: _____

PATIENT'S FULL NAME: _____

DOB: _____

ADDRESS: _____ CITY/STATE/ZIP _____

HOME #: _____ WORK #: _____ CELL #: _____

INSURANCE INFORMATION

POLICY HOLDER'S NAME _____ RELATIONSHIP _____

ADDRESS: _____ CITY/STATE/ZIP _____

PRIMARY CARE PHYSICIAN'S NAME _____ PHONE # _____

I AUTHORIZE THIS OFFICE TO RELEASE TO MY INSURANCE CARRIER ANY INFORMATION THEY MAY REQUIRE TO PROCESS MY CLAIMS.

I HEREBY ASSIGN MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO HB URGENT CARE, BARRY SCHWARTZ, MD. I AM FINANCIALLY RESPONSIBLE FOR NON-COVERED SERVICES, COPAYS, AND DEDUCTIBLES (HOWEVER, HB URGENT CARE WILL ACCEPT INSURANCE PAYMENT AS PAYMENT IN FULL FOR OFFICE VISIT CHARGES RELATED TO COVID-19 EVALUATION AND TESTING)

SIGNED _____ DATE _____

CONSENT FOR TREATMENT

I HEREBY CONSENT FOR HUNTINGTON BEACH URGENT CARE, ITS DOCTORS, PHYSICIAN ASSISTANTS, NURSE PRACTITIONERS AND STAFF TO EVALUATE AND TREAT MY MEDICAL CONDITION. I AUTHORIZE HBUC TO EMAIL AND/OR LEAVE A VOICEMAIL WITH COVID-19 RESULTS ON PHONE NUMBER PROVIDED.

SIGNED _____ DATE _____