# Registration Form

## Basic Information

Name:_____ Date of Birth: _____/_____/_____
Last First Middle Initial Month Date Year

Street address: _____

City: _____ State: _____ Zip code: _____

Home phone: (_____)_____ Mobile phone: (_____)_____

Email Address: _____

Pharmacy:_____
Name Address

## Demographic Information

Sex assigned at birth: ☐M ☐F Gender identity: _____
Pronouns: ☐She/her ☐Him/his ☐They/them

Marital Status:
☐Married ☐Separated ☐Widowed ☐Divorced ☐Single ☐Partnered for ___ years ☐Minor

Occupation: _____

Patient Employer/School: _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____

Contact Relation: _____ Contact number: (_____)_____

I certify that I, and/or my dependent(s), have insurance coverage with:

_____
**Name of insurance company(ies)**

I assign directly to Dr. Presser Belkin all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment services and determining insurance benefits or benefits payable for related services.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Parent, Guardian, or Personal Representative Relationship to Patient

# Medical History Form

**Name: _____ Date of birth: ____/____/_____ Age: _____**

Name of referring physician: _____

Other physicians involved in your care: _____
(Who require a copy of this visit)

Reason you are seeing the doctor today: _____

_____

## Past Family History

Mother: □Alive □Deceased
Cause of death if applicable: _____
Father: □Alive □Deceased
Cause of death if applicable: _____
Siblings: □Alive □Deceased
Cause of death if applicable: _____

## Past Social History

Birth place: _____
Residence: _____
Number of children: _____
Have you ever smoked? □Yes □No
If so, how many years did you smoke? _____
How many packs per day? _____
If you quit, when did you quit? _____
Do you drink alcohol? □Yes □No
Approximately how many drinks per week? _____
Any other substance use? □Yes □No
Please specify: _____

## Other Exposures

Occupation: _____
Occupational exposures: _____
Pets and animal exposure: _____
Travel history in the past 6 months: _____

**Past Medical History**

**Past Surgical History**

**Allergies**

☐ X-Ray Contrast
☐ Latex
☐ Medications
Please specify: _____
_____
☐ Other
Please specify: _____
_____

**Immunizations**

Pneumonia vaccine:
☐Yes ☐No

Shingles vaccine:
☐Yes ☐No

Flu vaccine for this year:
☐Yes ☐No

**Current Medications**

| *Name* | *Dose* | *Frequency* |
|---|---|---|

**Review of symptoms** (please check all that apply)**:**

*Constitutional*

- ☐ Fevers
- ☐ Chills
- ☐ Weight loss/weight gain
- ☐ Night sweats

*Skin*

- ☐ Rashes
- ☐ Lesions
- ☐ Ulcers
- ☐ Jaundice/discoloration

*Eyes*

- ☐ Dry eyes
- ☐ Double vision
- ☐ Visual loss

*Head, Ears, Nose, Mouth, Throat*

- ☐ Headaches
- ☐ Dizziness
- ☐ Lightheadedness or vertigo
- ☐ Sore throat
- ☐ Thrush
- ☐ Hoarseness of voice
- ☐ Nasal discharge
- ☐ Nasal polyps
- ☐ Nasal obstruction
- ☐ Nasal epitasis
- ☐ Sinus congestion

*Respiration*

- ☐ Shortness of breath
- ☐ Asthma
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Valley fever
- ☐ Cough
- ☐ COPD
- ☐ Coughing of blood
- ☐ Pneumonia
- ☐ Wheezing
- ☐ Tuberculosis
- ☐ Sputum production
- ☐ Snoring

*Lymphatics*

- ☐ Lymph node enlargement

*Cardiovascular*

- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Chest pain
- ☐ Hypertension
- ☐ Heart attack

*Gastrointestinal*

- ☐ Heart burn (GERD)
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Blood in stool

*Musculoskeletal*

- ☐ Color changes to fingers
- ☐ Muscle pains
- ☐ Joint pains
- ☐ Leg swelling

*Genitourinary*

- ☐ Painful urination
- ☐ Blood in urine
- ☐ Genital discharge

*Neurologic and Psychiatric*

- ☐ Difficulty walking
- ☐ Numbness
- ☐ Difficulty speaking
- ☐ New onset seizures
- ☐ Anxiety
- ☐ Depression

# Notice of Privacy Practices

## Acknowledgment of Receipt

By signing this form, you acknowledge receipt of the *Notice of Privacy Practices of* ***Liza Presser Belkin MD, Inc*** and/or acknowledge that the *Notice of Privacy Practices of Liza Presser Belkin MD, Inc* is available upon your request. Our *Notice of Privacy Practices* provides information about how we may use and disclose your protected health information. We encourage you to read in full.

Our *Notice of Privacy Practices* is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our organization at **805-569-3377** or finding it online at **http://drpresserbelkin.com/**

I acknowledge receipt of the *Notice of Privacy Practices* of ***Liza Presser Belkin MD, Inc.***

**Signature:**_____ **Date:**_____
Patient, Parent, Guardian, or Personal Representative

## Inability to Obtain Acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Signature of provider representative:_____ Date:_____

# Patient Care Financial Agreement

The purpose of this agreement is to give you a clear understanding of our policy concerning payment for appointments that are not cancelled within 24 hours in advance and for patients who have "no showed" for their appointment.

When an appointment is made for a skin test, follow-up, or any other procedure at Dr. Liza Presser Belkin's office, our professional time, treatment rooms, and equipment are solely dedicated for your use and treatment. This allows you, our valued patient, to receive the care and expertise you deserve in an environment designed especially for your needs. Last minute cancellations and "no-shows" make it difficult and even impossible to make the best use of Dr. Presser Belkin's time.

We appreciate the time we are able to spend with you. We diligently strive to be prepared and on time for your appointment so that you can receive the maximum benefit during your time at our office.

**As such, we charge a $150 fee if we do not get cancellation notice within 24 hours of your appointed time.**

To avoid the $150 penalty, we ask that you please notify us with at least 24 hour advanced notice if you are unable to make your scheduled appointment.

We thank you for your time and cooperation.

**I hereby authorize this office to charge my account a fee of $150.00 should I fail to notify the office at least 24 hours in advance in the event that I am unable to attend my scheduled appointment.**

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative Date

_____

Name of Patient, Parent, Guardian, or Personal Representative

# 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 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 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.

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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:**_____ _____

**Patient's or Patient Representative's Signature** **Date**

**By:**_____

**Print Patient's Name**

_____

If Representative, Print Name and Relationship to Patient

By:_____ _____

Physician or Authorized Representative Date