

**PETER S. LORMAN, M.D. • DONALD B. STRIPLIN, M.D. • JOSEPH C. PECK, M.D.  
CHARLES D. TUREK, M.D. • JUAN C. FRISANCHO, M.D.**

**INFORMATION REQUIRED FOR CASE HISTORY FILE**

DATE \_\_\_\_\_  
PATIENT'S NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTH DATE \_\_\_\_\_  
STREET \_\_\_\_\_ PHONE \_\_\_\_\_ SEX \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_  
CITY \_\_\_\_\_ ZIP \_\_\_\_\_ MARITAL STATUS M S W D  
OCCUPATION \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_ REFERRED BY \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_  
DRIVERS LICENSE # \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
IN CASE OF EMERGENCY PLEASE NOTIFY \_\_\_\_\_ PHONE \_\_\_\_\_

**BILLING INFORMATION**

NAME OF RESPONSIBLE PARTY \_\_\_\_\_  
(PLEASE CIRCLE ONE) SELF, MOTHER, FATHER, SPOUSE, EMPLOYER  
ADDRESS (if different from patient's) \_\_\_\_\_  
PHONE \_\_\_\_\_ DRIVERS LICENSE # \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

**INSURANCE INFORMATION**

DO YOU HAVE PRIVATE OR GROUP INSURANCE? YES \_\_\_ NO \_\_\_  
NAME OF YOU INSURANCE COMPANY: PRIMARY \_\_\_\_\_  
(PLEASE CIRCLE ONE) SELF, MOTHER, FATHER, SPOUSE, EMPLOYER  
GROUP# \_\_\_\_\_ CERTIFICATE # \_\_\_\_\_  
SECONDARY \_\_\_\_\_  
(PLEASE CIRCLE ONE) SELF, MOTHER, FATHER, SPOUSE, EMPLOYER  
GROUP# \_\_\_\_\_ CERTIFICATE # \_\_\_\_\_

**PLEASE PRESENT YOUR INSURANCE CARD AT THE FRONT DESK.**

**GENERAL HISTORY**

WERE YOU INJURED **ON THE JOB**? YES \_\_\_ NO \_\_\_ / **AUTO ACCIDENT**? YES \_\_\_ NO \_\_\_ / **PERSONAL INJURY**? YES \_\_\_ NO \_\_\_  
TYPE OF PROBLEM, OR PART INJURED \_\_\_\_\_ RIGHT OR LEFT  
DATE OF ONSET OF COMPLAINT, OR DAT OF INJURY \_\_\_\_\_ DATE OF LAST WORK \_\_\_\_\_  
IF INJURY OR ACCIDENT, WHERE DID IT OCCUR? \_\_\_\_\_  
HAS ANY OTHER M.D. TREATED YOU FOR THIS CONDITION? YES \_\_\_ NO \_\_\_  
NAME OF PHYSICIAN \_\_\_\_\_ ADDRESS \_\_\_\_\_  
**ARE YOU ALLERGIC TO ANY MEDICATION? PLEASE LIST** \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE** (consent for treatment and for acceptance of financial responsibility)  
(Parent or legal guardian must sign if the patient is a minor.)

**ASSIGNMENT OF BENEFITS**

*I hereby authorize the above doctors to furnish to my insurance company all information which my insurance company may request concerning my illness or injury. I hereby assign the above doctors all payments to which I am entitled for Medical and/or Surgical expenses. I understand I am financially responsible to the above doctors for charges not covered by this assignment. A photostat of this assignment is as valid as the original.*

**SIGNED** \_\_\_\_\_  
(SIGNATURE OF POLICY HOLDER)

**PETER S. LORMAN, M.D., DONALD B. STRIPLIN, M.D.  
JOSEPH C. PECK, M.D.  
CHARLES D. TUREK, M.D., JUAN C. FRISANCHO, M.D.**

**To provide you with the best possible medical care, please be as complete as possible in detailing all of your medical history.**

**CURRENT MEDICAL PROBLEMS**

**PAST (RESOLVED) MEDICAL PROBLEMS**

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**SURGERIES (PLEASE LIST ALL)**

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**CURRENT MEDICATION & DOSAGES**

**ALLERGIES TO MEDICATIONS**

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# ELIGIBILITY WAIVER FORM

PLEASE COMPLETE ALL BOXES AND BLANK SPACES. THANK YOU

SUBSCRIBER INFORMATION		
SUBSCRIBER LAST NAME	FIRST	M.I.
PATIENT LAST NAME	FIRST	M.I.
SUBSCRIBER I.D.#	GROUP #	HEALTHPLAN

I, \_\_\_\_\_, understand that I am eligible for \_\_\_\_\_  
(NAME OF PATIENT) (HEALTH PLAN)

benefits on or as of \_\_\_\_\_ through my \_\_\_\_\_  
(EFFECTIVE DATE) (OWN, SPOUSE'S, PARENT'S)

employment at \_\_\_\_\_ . I understand that \_\_\_\_\_  
(NAME OF EMPLOYER) (NAME OF GROUP)

is my selected group under which I am covered. I am aware that if the above is not true, I (or the person financially responsible for me) am responsible for all charges related to services provided to me. I agree that if the above is not true, I (or the person financially responsible for me) will pay in full all such charges.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE
X	

# 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 report 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 services 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 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. However, following the assertion of any claim against the physician, 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 thereafter. 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.

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 judgement or summary adjudication in accordance with the Code of Civil Procedure.

**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: \_\_\_\_\_ (Date)  
Physician's or Duly Authorized Representative's Signature

**Peter S. Lorman, MD • Donald B. Striplin, MD • Joseph C. Peck, MD  
Charles D. Turek, MD • Juan C. Frisancho, MD**

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

By: \_\_\_\_\_ (Date)  
Patient's Signature

\_\_\_\_\_  
Print Patient's Name

By: \_\_\_\_\_ (Date)  
Signature of Translator (if applicable)

\_\_\_\_\_  
Print Name of Translator

By: \_\_\_\_\_ (Date)  
Patient's Representative's Signature

\_\_\_\_\_  
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.

## **NOTICE OF HEALTH INFORMATION PRACTICES**

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

### *Introduction*

At Drs. Lorman, Striplin, Peck, Turek, and Frisancho we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 01-01-04, and applies to all protected health information as defined by federal regulations.

### **Understanding Your Health Record/Information**

Each time you visit Drs. Lorman, Striplin, Peck, Turek, and Frisancho, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

### **Your Health Information Rights**

Although your health record is the physical property of Drs. Lorman, Striplin, Peck, Turek, and Frisancho, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

## **Our Responsibilities**

Drs. Lorman, Striplin, Peck, Turek, and Frisancho are required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

## **For More Information or to Report a Problem**

If you have questions and would like additional information, you may contact the practice's Privacy Officer, Stacey D. at 310-257-1500.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

### *Office for Civil Rights*

U. S. Department of Health and Human Services 200 Independence Avenue, S.W.  
Room 509F, HHH Building  
Washington, D.C. 20201

## **Examples of Disclosures for Treatment, Payment and Health Operations**

### *We will use your health information for treatment.*

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

### *We will use your health information for payment.*

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

### *We will use your health information for regular health operations.*

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in

your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

*Business associates:* There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

*Notification:* We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

*Communication with family:* Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

*Funeral directors:* We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

*Marketing:* We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

*Food and Drug Administration (FDA):* We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

*Workers compensation:* We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

*Public health:* As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

*Correctional institution:* Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

*Law enforcement:* We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Notice of Privacy Policies Revision Number \_\_\_\_\_.