# PATIENT REGISTRATION

LAST NAME:_____FIRST NAME:_____MI:____

ADDRESS:_____CITY:_____ZIP:____

HOME #:_____CELL#:_____WORK #:_____

E-mail #_____Fax #:_____

## GUARANTOR'S INFO
## COMPLETE IF PATIENT IS MINOR OR A DEPENDENT

**Last Name:**_____**First Name:**_____**MI:**_____

**Billing Address : if different than Patient Address, Complete Third Party Billing Bellow**

_____

## EMERGENCY CONTACT INFORMATION

**NAME:**_____**PHONE#:**_____

## ARE YOU INTERESTED IN LEARNING ABOUT OUR COSMETIC PROCEDURES/PRODUCTS

**YES:**_____**NO:**_____

Patient or Guarantor's Name:_____Date:_____

Patient or Guarantor's Signature:_____Date:_____

# Office Policies and Agreement

Malak P. Zacca Shammas, M.D

This Agreement is Between: FIRST NAME LAST NAME

And ENTITY: Malak P. Zacca Shammas, M.D

Notice of Privacy Practices

- By signing this agreement you acknowledge that you have been presented with ENTITY Notice of Privacy Practices, which is attached with agreement and also posted in reception area.

How We May Communicate with You

- We may contact you regarding appointments, test results and other matters related to your healthcare, at any of the Addresses, Fax, and/or Phone numbers that you have provided on the Registration Form.
- You hereby agree to notify us of any change of address or other contact information as soon as possible.

Policy for Communicating Test Results to You

- As a patient, I agree to actively participate and communicate with this office to obtain my test results.
- As a patient, I agree to call this office 5-7 working days after I have completed a test. We encourage this policy to ensure that we have indeed received your test results.
- After review, your doctor may recommend an "Office Visit" or a "Phone Visit" to review results & plans with you.
- We may communicate with you via email regarding appointments and results (e.g. Yahoo, Gmail, etc).
- If we receive abnormal test results ordered by another physician, we believe that physician should counsel you directly about those results. However, you may request additional counseling from your ENTITY Physician by scheduling an Office Visit.

Responsibilities as a Patient

- Ask questions when you don't understand any part of your medical care.
- Cooperate with the planned treatment program or explain why cooperation is not possible.
- Communicate with us any special needs you may have, or if you need anything while waiting.

- Keep scheduled appointments or call to cancel on time (see cancellation policy).
- Update personal information and insurance information whenever there is a change.
- Update your doctor with any new medical condition & complete Medication List with each visit

Proof of Identity

- Patients are required to show proof of identity (e.g. Drivers License, Passport...etc)

Patient Name: LAST NAME, FIRST NAME.

Patient/Guarantor's Signature: _____ Date: _____

**No Show & Cancellation Policy**

- Please call our office 24 hours prior to a scheduled appointment if you need to change or cancel
- We reserve the right to charge $50 fee if a follow up appt no cancel or miss within 24hrs _____
- If a New Patient or a Physical appointment does not cancel or miss within 24 hrs, we reserve the right to charge $150 _____
- For New Patient Appointment Credit Card is requested at the time of making the Appointment to reserve it _____

**Medical Renewal**

As a patient, I understand that my medication renewal is subject to my physician's periodic review of my health status to assess need and to monitor therapy

As a patient, I must maintain my status as an Active patient by visiting the physician at least once a year in order to be eligible for any prescription (s) renewal

The physician may require evaluating you in the office prior to authorizing prescription renewal

As a patient, I agree to promptly make follow up **OFFICE VISIT** I am notified of this requirement.

**Doctor-Patient Relationship:**

The patient or the doctor can terminate this agreement without providing an explanation
If you choose to terminate, please send us a letter stating that you no longer wish to be a patient

If you send us a termination letter, we will honor your courtesy by giving you a copy of your medical records without charge
If the Doctor decides to terminate, he/she will provide you in writing with at least 15 days of emergency treatment & prescriptions and the final date that he/she will be available for you
Upon receiving a termination letter, you should act promptly to find another doctor
Arbitration Agreement is part of this agreement and requires your signature

Release of Medical Information to and by ENTITY

I hereby authorize any prior or present treating physician, hospital or other health institution, to release all of my medical Information for the purpose of Treatment and Healthcare Operations, by any means of communication to **MALAK P. ZACCA-SHAMMAS, M.D.** (ENTITY) and authorize ENTITY to use and disclose protected health information (PHI) to carry treatment, Payment, and Healthcare Operations.

Patient Name: _____

Patient/ Guarantor's Signature: _____ Date: _____

Copying Policy

- You can request a copy of your entire file or part of your records on a CD for a Flat Fee of $25, plus postage (Priority Mail or similar). Preparing a Paper Copy may cost more.
- There is no fee for a one time copying of pertinent records to another physician upon written request

Policy for Patients Less than 18 Years of Age

- Proof of Identity of the child should be provided at the time of the first visit (school ID, birth certificate, etc.)
- Child must be accompanied by a parent or guardians during each visit and for all tests and procedures performed in or out of the office
- If the Parent is the subscriber to insurance and is requesting that our office submit insurance claims, then the subscriber must also provide proof of identity.

Pregnancy and Medications

- As a patient, should I become pregnant, I agree to promptly notify this office, and any other treating physician, If I am taking any medications that this medical practice has prescribed
- I also agree to discuss with my physician(s) if I am planning to become pregnant
- As a male patient, I agree to notify my physician(s) if I am planning to have a child with my partner.

Fees for Additional Services ("Personal Services", Generally not Covered by Insurance)

- Telephone Visits: Pre-arranged just like any other appointment. May be requested by patient but requires physician's approval. Fee will be based on elapsed time, or may be set prior to the visit. Secure payment in advance is required. Ask for details when ready to make one. Costs are generally between $50-$100.
- Report Preparation: Payment is due when the report is ready. Advance payment or a method of payment guarantee is required. Examples of Reports:
  - School, Immigration, Airlines, Health Clubs…etc
  - Life & Health Insurance, Disability Reports, Medical-Legal reports…etc
- Obtaining Prior Authorization for Specific Test or Treatment: You may request this when there are circumstances that require additional information to be provided to your Insurance carrier to obtain an authorization. AN example is entering an appeal process for a denied test or treatment. The physician will charge a fee based on the amount of time that is required to support your case.

Elements of Cost Associated with Procedures & Services

- Physician's fee, Anesthesia fee, Facility fee, Pathology fee, Fee for Personal Services
- Imaging Services (Professional fee for doctor who interprets the results plus…Technical/or facility fee)
- Other Testing Fees: Lab fee, an interpretation fee, draw fee & processing fee may also apply.

ENTITY and Insurance Companies

- Our office has NO Agreement with any HMO or IPA plan. Patients covered under these plans will be required to pay directly for the service that they receive
- As a patient, I am required to be familiar with my insurance coverage and its policies and Know my co-pay, co-insurance, deductable, total out of pocket expense, effective date of coverage, pre-existing conditions—AND whether I am receiving service from a contracted or out-of-net-work physician or healthcare provider/facility

Patient Name: LAST NAME, FIRST NAME

Patient/Guarantor's Signature: _____ Date: _____

TREATMENT AUTHORIZATION:

- I hereby authorize the physician and/or assistant at ENTITY to administer such treatment and medication as may be deemed necessary administer such treatment and medication as may be deemed necessary or advisable in the treatment and diagnosis of my condition. I give this authorization voluntarily and I hereby acknowledge that no guarantees have been made to me as to the result of treatments and examinations.
- If the patient a minor or legally incapacitated, the PARENT and/or Legal Guardian agree that he/she/ has the legal authority to authorize ENTITY to evaluate and treat the patient

FINANCIAL OBLIGATIONS & ASSIGNMENT BENEFITS

- I agree to pay for all medical services, insurance deductibles, co-payments, co-insurance or any prior unpaid balance at the Time of Service.
- As a patient, I understand that I am financially responsible for all charges whether or not they are paid by Insurance.
- I agree to pay any balance upon receipt of my First Statement.
- I understand that this ENTITY requires Advance Payment for certain in-office or out-patient services
- I hereby authorize my Insurance Company to pay Malak Shammas, M.D. Directly
- If I receive a check from my insurance, I agree to immediately endorse the back of the check to Malak Shammas, M.D. & send it to medical office at 9400 Brighton Way, #410, Beverly Hills, Ca, 90210.
- I hereby authorize the release of all necessary information to secure the payment of benefits
- If for any reason any portion of the bill is not paid by my insurance within thirty days the claim was submitted, I agree to contact my insurance company and make arrangements for prompt payment.
- Late fees and other charges may apply if payments are not received in a timely manner.
- A copy of this agreement is deemed as valid as the original.

**I HAVE REVIEWED ABOVE POLICIES & AGREEMENT AND HEREBY AGREE TO COMPLY WITH <u>ENTITY POLICIES</u>**

Patient Name: _____

Patient/Guarantor's Signature: _____ Date:_____

**NOTICE OF PRIVACY PRACTICES: HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

My signature below indicates that I have been provided with a copy of this Notice of Privacy Practices.

Signature of Patient_____ Date_____

## Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, 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;
- tool in educating heath professionals;
- source of data for medical research;
- source of information for public health officials charged with improving the health of the nation;
- source of data for facility planning and tool with which we can assess and work to improve the care we render and the outcomes we achieve.

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. We reserve the right to change this Notice in the future.

## Your Health Information Rights:

Although *your health record is the physical property of the healthcare practitioner or facility that compiled it,* the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522
- obtain a paper copy of this Notice
- inspect and obtain a copy your health record as provided for in 45 CFR 164.524. You must submit your request in writing, and we are entitled to charge a copying fee for this service.
- ask us to amend your health record as provided in 45 CFR 164.528. Your signature and explanation are required.
- obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

If you have questions or would like additional information, you may contact the Director of Health Information Management at (444) 111-1111. If you believe your privacy rights have been violated, please discuss it with your doctor in this office. You can file a complaint with the Director of Health Information Management or with the Secretary of Health and Human Services. There will be no penalty for filing a complaint

## Our Commitment

We are committed to maintain the privacy of your health information, as required by law. We will not use or disclose your health information without your authorization, except as described in this notice.

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

We will use your health information for treatment within our practice. With your consent, we will also provide your outside physician or a subsequent healthcare provider with copies of various reports that should assist him/her in treating you as well.

We will use your health information for payment. For example, to obtain insurance benefits for you, forms may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We may use your health information in an effort to continually improve the quality and effectiveness of the healthcare and services we provide.

Laboratory and Outside Medical Services: We may disclose your health information to other providers so that they can perform the job we've asked them to do, and so that they can bill you or your third party payer for services rendered. So that your health information is protected, however, we require these providers 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 judgement, 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.

Other: We may disclose health information to funeral directors, organ procurement organizations, correctional institutions, public health authorities, workers compensation programs, law enforcement, and/or the Food and Drug Administration consistent with applicable law to carry out their duties.

Legal Proceedings: Your health record may be subpoenaed through the legal system.

Public Health and Safety: We may provide medical information about you if required by law, or to prevent serious threat to public health and safety.

Research: We may disclose information to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

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 workforce 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.

# 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 any action in any court by the physician to collect any fee from the patient shall not waive the right to complete 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 rate share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or apr 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: **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:_____ _____ By:_____ _____
Physician's or Authorized Representative's Signature Date Patient's or Patient Representative's Signature Date

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