# Patient Information

**PERSONAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Full Name: |  |  |  |
|  | *Last* | *First* | *M.I.* |

|  |  |  |
| --- | --- | --- |
| Mailing Address: |  |  |
|  | *(Street Address, City, State, and ZIP)* |  |

|  |  |  |
| --- | --- | --- |
| Physical Address: |  |  |
|  | *(Street Address, City, State, and ZIP)* |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Phone: |  | Secondary Phone: |  |

|  |  |
| --- | --- |
| Email |  |
| SSN or Gov’t ID: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Birth Date: |  | Marital Status: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Age: |  | Weight: | |  |
| Gender: |  | | Height: |  |
| Spouse’s Name: |  | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| Spouse’s Employer: |  | Spouse’s Work Phone: |  |

Preferred Pharmacy\* (name & location):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT’S EMERGENCY CONTACT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  | Phone: | |  |
| Relationship: |  | | Address: |  |

**CONSENT FOR TREATMENT**

**I hereby authorize directly to Dr. Patricia Schechter, D.O. Family Practice Group for surgical and/or medical services rendered. I shall be personally liable for any unpaid balance to the doctor. I authorize all medical and pharmacy records to be released to Dr. Patricia Schechter, D.O. Family Practice Group. I hereby authorize Dr. Patricia Schechter, D.O. Family Group Practice to release any medical records to my insurance carrier or its representatives.**

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |
|  |  |  |  |

**PATIENT’S ADDITIONAL INFORMATION- For Purposes of Grant Funding**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Marital Status: |  | Household Size: | |  |
| Housing Status: |  | |

**JOB INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Employer: |  | Occupation: | |  | |
| Email: |  | | Phone: |  | |
| Physical Address: |  | | | |  |
|  | *(Street Address, City, State and Zip)* | | | |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Employment Status: |  | Type of Business: |  |

**PRIMARY INSURANCE**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Type of Primary Insurance: |  | Policy Number: | |  | |
| Insurance Name: |  | Effective Date: | |  | |
| Group Number: |  | | Expiration Date: |  | |
| Physical Address: |  | | | |  |
|  | *(Street Address, City, State and Zip)* | | | |  |

**SECONDARY INSURANCE (if applicable)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Type of Primary Insurance: |  | Policy Number: | |  | |
| Insurance Name: |  | Effective Date: | |  | |
| Group Number: |  | | Expiration Date: |  | |
| Physical Address: |  | | | |  |
|  | *(Street Address, City, State and Zip)* | | | |  |

**MEDICAL HISTORY**

**Surgeries: -Circle and state DATE when procedure occurred-**

Appendectomy Artificial Joint Blood Transfusion

Breast Implant/Enhancement Breast Surgery Carpal Tunnel Surgery

Chemotherapy/Radiation Colonoscopy C-Section

Cyst Removal Eye Surgery Gall Bladder Surgery

Gastric Bypass Heart Valve/Pacemaker Hemorrhoid Surgery

Hernia Repair Hysterectomy Knee Surgery

Tonsillectomy Tubal Ligation Wisdom Teeth Removal

**OTHER SURGERIES**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Personal Medical History**- **Circle and Explain**

ADHD Alcoholism Anemia

Arthritis Asthma/Emphysema Bleeding Tendency

Cancer Depression Diabetes or Gestational-pregnancy-Diabetes

Eczema Eye Disease (Cataract/Glaucoma) Ear/ Nose/ Throat Problems

Hypertension Headaches/Migraines Heart Disease

High Blood Pressure High Cholesterol Kidney/Bladder Disease

MI (Heart Attack)-less than age 50 Psychiatric Illness Seizures

Sexual Disease-Chlamydia/Herpes/Etc Skin Disease or rashes Stomach Problems: gastritis, ulcer, etc

Stroke Substance Abuse Thyroid / Adrenal Disease

Tuberculosis

EXPLANATION:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever been hospitalized or under medical care for a long time? (if yes, for what reason?)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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List any allergies (foods/medications/etc)

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**Childhood Diseases** -**Circle if any apply**

Measles

Mumps

Chickenpox

Diabetes

**Gynecological Medical History (Female Only)**

How old when periods first began? (age)\_\_\_\_\_\_\_\_\_\_\_\_\_ How long do periods last? (days)\_\_\_\_\_\_\_\_\_\_

LMP:\_\_\_\_\_\_\_\_\_\_\_\_ How many children?\_\_\_\_\_\_\_\_\_\_\_\_ How many pregnancies?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many miscarriages/abortions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Menopause started? (date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you pregnant or breastfeeding?\_\_\_\_\_\_\_\_ Are you taking birth control pills or shots?\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have difficult periods?\_\_\_\_\_\_\_\_\_\_\_\_\_Do you have pain with intercourse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last pap?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had an abnormal pap?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last mammogram?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_More than 1 sexual partner recently?\_\_\_\_\_\_\_\_

Have you had a hysterectomy? (Full or partial?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family Medical History**- **Circle and state which family member- and specify maternal or paternal**

Alcoholism Alzheimer’s Disease Arthritis

Asthma ADHD Bleeding Tendency

Cancer Depression Diabetes

Eczema Headaches/Migraines Heart Problems

High Cholesterol Hypertension MI (Heart Attack)-less than age 50

Seizures Stroke Substance Abuse

Suicide Tuberculosis Unknown Cause of Death

**Explanation of above, or any extra information you would like the doctor to know:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Social History**

Alcohol Use -Drinks per **DAY/** per **WEEK \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Caffeine Intake- **Type/** Drinks per **DAY/** per **WEEK \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Prescription Drug Abuse (if yes, name the drug)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Use?\_\_\_\_\_\_\_(if yes, how many packs a **day/** a **week**?)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational Drug Use?\_\_\_\_\_\_\_\_\_(if yes, name type and frequency)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sexual Satisfaction?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercising Regularly?\_\_\_\_\_\_\_\_How many times per week?\_\_\_\_\_\_What kind of exercise?\_\_\_\_\_\_\_\_\_\_\_\_

Disability?\_\_\_\_\_\_\_\_\_\_(if yes, then explain)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Living Situation:

Alone?\_\_\_\_\_\_ with children?\_\_\_\_\_with parents?\_\_\_\_\_\_with roommates?\_\_\_\_\_with partner/spouse?\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other diseases or medical conditions NOT listed on this form? Explain

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you able to perform acts of daily living (ADL)? If no, please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a religious, cultural, physical, or other factors that might influence your care? Please explain.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**MEDICATION INFORMATION**

**Please list all medications with strength & dosage and supplements you are currently taking and name of doctor who prescribed them.**

**MEDICATION PRESCRIBING DOCTOR STRENGTH**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**MEDICATION** ALLERGIES  **REACTION**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear Patient,

Please be informed that you are responsible for any charges exceeding your insurance coverage. Remember that it is your responsibility to check if your insurance company covers the service before services are rendered.

Thank you,

Dr. Patricia Schechter

Please sign below indicating agreement to the responsibility of charges exceeding your insurance coverage.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name (Printed)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDITIONAL OFFICE FEES**

Please be aware of the fees for items preformed for you by the staff.

These items are costs your insurance may not cover.

* Refills without appointments $45
* Prior authorizations for medications and procedures $35
* Copies $0.25/page
* No show/ Failure to cancel appointment within 24 hours $75

(\*Arriving 10 or more minutes late to your appointment qualifies as a “No Show”)

* Patient assistance program forms $45

Additional Fees for Forms are posted in the waiting room.

Please sign this form to indicate your knowledge of the fees.

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

A copy of *NOTICE OF PRIVACY RIGHTS* is posted in the waiting room, hard copy available upon request and is available online.

NOTICE:

By signing this form, you are stating you have received the *NOTICE OF PRIVACY RIGHTS*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Representative Signature/ Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name (if Representative, Print Name & Relationship to Patient)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please provide the names and contact information of whom we can discuss your medical information.

Release of Information:

**I authorize Dr. Schechter’s office to release medical information to the following people**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Relationship to patient Address Phone**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Relationship to patient Address Phone**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name and Relationship to patient Address Phone**

* **All Immediate Family**
* **Do not release to anyone but me**

:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Representative Signature/ Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Patient Name (if Representative, Print Name & Relationship to Patient)

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 contact 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 30 days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within 30 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, 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 contact. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issue 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 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 with this arbitration agreement 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 the 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 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 rating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days of the 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 first medical services: *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient’s or Patient’s Representative’s Initials*

If any provision of this 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 the arbitration agreement. By my signature below, 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 or Representative's Signature Date**

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Print or Stamp Name of Physician, Medical Group Print Patient’s Name