Mark Suski, MD, FACS

Cosmetic and Reconstructive Plastic Surgery
227 West Janss Road, Suite 205
Thousand Oaks, CA 91360
(805) 494-3330

Patient Information

Patients Name: Last:		First:	MI:
Current address:			
City:	State:		ZIP Code:
Male ☐ Female ☐	Marital Status:		Birthdate:
Social Security Number:			
Primary Care Physician:			Mobile Number:
Occupation:	Employer:		Home Phone:
Email:	Referred By:		Business Phone:
Reason for Referral:			
Pharmacy:			

In Case of Emergency

Name of a relative or friend:			
Address:			
City:	State:	ZIP Code:	Phone:
Relationship:			

The above information is true is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Mark Suski, MD or insurance company to release any information required to process my claims.

Patient/Guardian Signature _____ Date _____

Patient, Family, and Social Information

Do you smoke? Yes ☐ No ☐ Quit ☐	If yes, how long?	Packs per day?	If quit, how long ago?
Do you drink alcohol? Yes ☐ No ☐ Quit ☐	If yes, drinks per day?	If quit, how long ago?	
Do you have any history of substance abuse or IV drug use? Yes ☐ No ☐			
Have you completed a "Durable Power of Attorney for Healthcare" also known as an "Advanced Directive" or a "Living Will" Yes ☐ No ☐ (If yes, please provide a copy for your medical record in our office)			

Family History

Father: Living ☐ Deceased ☐	If Deceased, at what age?	Cause of death?	
Mother: Living ☐ Deceased ☐	If Deceased, at what age?	Cause of death?	
Brother(s) Number Living ____ Number Deceased ____	If Deceased, at what age?	Cause of death?	
Sister(s) Number Living ____ Number Deceased ____	If Deceased, at what age?	Cause of death?	
Children Number Living ____ Number Deceased ____	If Deceased, at what age?	Cause of death?	

Medical and Surgical History

Medical History – List all serious conditions for which you have been treated by a doctor. Examples include, but are not limited to, anemia, diabetes, cancer, heart trouble, kidney disease, epilepsy, high blood pressure, and hypercholesterolernia:

Condition	Date	Treating Physician

Surgical History – List all operations below, and any significant complication related to the operations:

Operation	Date	Significant Complications

Diagnostic Test – List any recent diagnostic test, including angiograms or x-rays:

Name of Test / X-ray	Date	Where Performed

Medications – List all your medications

Medications	Dosage	Frequency

Review of Systems – Please Check any conditions or symptoms you have experienced:

☐ Diabetes –
If yes, controlled by ☐Insulin / ☐Medication / ☐Diet
☐ Pacemaker –
If yes, date placed or revised _____
☐ Weight loss
☐ Fatigue
☐ Fever
☐ Poor healing
☐ Difficulty Urinating
☐ Bladder Infection

☐ Bruise/bleed easily
☐ Blurred vision
☐ Decreased hearing
☐ Sore throat
☐ Cough
☐ Wheezing
☐ Chest Pain
☐ Palpitations
☐ Rapid heart beat
☐ Shortness of breath

☐ Swelling in Feet/Legs
☐ Abdominal pain
☐ Blood in stools
☐ Constipation
☐ Diarrhea
☐ Vomiting blood
☐ Back pain
☐ Joint pain
☐ Dizziness/ Fainting
☐ Headaches

☐ Stroke/CV/TIA
☐ Blood Clots
☐ Pain/weakness in arms/legs
☐ Numbness/tingling

☐ Other _____

☐ Other _____

☐ Other _____

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HIPAA Privacy Rule of Patient Authorization Agreement
Authorization for the Disclosure of Protected Health information (PHI) for Treatment, Payment, or Healthcare Operations

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintain health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.
I understand that this information serves as:

- A basis for planning my care and treatment;
- A means of communication among health professionals who may contribute to my healthcare;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand I can review and obtain a copy of the **Notice of Privacy Practices (Notice)** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my PHI to another covered entity. I have the right to review the Notice prior to signing this authorization. I authorize the disclosure of my PHI as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement
Consent to the Use and Disclosure of Protected Health Information (PHI) for the Treatment, Payment, or Healthcare Operations

I understand that:

- I have the right to review and obtain a copy of this facility's Notice to signing this consent.
- This facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested.
- I have the right to request restrictions as to how my PHI may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.
- It is this facility's procedure to share PHI with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary PHI for each transaction.

Signature of Patient or Legal Representative _____

Printed Name of Patient or Legal Representative _____

Date _____

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PERSONAL REPRESENTATIVE AUTHORIZATION FOR MEDICAL RELEASE FORM

1. I authorize this facility to speak to the following family members or my personal representative regarding:

   ☐ All medical information, including but not limited to records pertaining to examination, treatments, consultation, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and other non-medical information in my life.

   ☐ Only the following types of information;

   _____

   _____

   _____

2. The above medical information shall only be released to the following persons:

Family Member/Personal Representative	Relationship
_____	_____
_____	_____

3. I understand I may terminate this Medical Authorization form. I must notify this facility in writing regarding termination and effective date.

4. This Authorization shall remain valid (check one)

   ☐ Until revoked in writing.

   ☐ Until _____, 20_____

5. I know that I am entitled to receive a copy of this agreement.

Name (print): _____

Signature: _____ Date: _____

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 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.

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

By: _____ _____
Physician's or Authorized Representative's Signature Date

Mark Suski
Print or Stamp Name of Physician,
Medical Group, or Association 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.