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 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 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 or patient to collect or contest any medical fee shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any malpractice claim, 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 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: ____________________ ________
Physician's or Authorized Representative's Signature (Date)

____
Print or Stamp Name of Physician, Medical Group, or Association Name
Bethel Family Medical Group
720 N. Harbor Blvd. Ste B
Fullerton, CA 92832
T) 714 782-7700 F) 714-982-3979

By: ____________________ ________
Patient's or Patient Representative's Signature (Date)

By: ____________________
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.

(9-13)

BETHEL FAMILY MEDICAL GROUP

Patient Registration

Patient Information

Last Name 성:	First Name 이름:	Middle name:	Date of Birth 생년월일:

Street address 주소:	City 도시:	State 주:	Zip 집코드:

Home Phone 집 전화:	Cell phone 셀폰:	E-mail 이메일:

Gender 성별 M/F 남/여	Social Security # 소셜 번호:	Driver License 운전면허:

Responsible Party (Guarantor)

Guarantors Name 보호자 성함:

Guarantors Address 보호자 주소:

Guarantors Social Security Number 보호자 소셜 번호:

Guarantors Date of Birth 보호자 생년 월일:

Patient relationship to Guarantor 보호자와 환자와의 관계:

Emergency Contact (응급 연락처)

Name 이름:	Relationship to patient 환자와의 관계:	Phone 전화:

I/We do hereby consent to and authorize the performance of all treatments, surgeries and medical services deemed advisable by the physicians and staff of Bethel Family Medical Group to me or to the above-named minor of whom I am the parent or legal guardian. I hereby certify that, to the best of my knowledge, all statements contained hereon are true. I understand that I am directly responsible for all charges incurred for medical services for myself and my dependents regardless of insurance coverage. I furthermore agree to pay legal interest, collection expenses, and attorney's fees incurred to collect any amount I may owe. I also hereby authorize Bethel Family Medical Group to release information requested by insurance company and/or its representatives. I fully understand this agreement and consent will continue until cancelled by me in writing.

________________________________ ____________________
Signature of Patient/Responsible Party — Date

________________________________ ____________________
Name of Patient/Responsible Party (Please Print) — Relationship to Patient

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (성함):	Gender (성별): M (남), F (여)	Date of Birth (생년월일):

Allergy (알레지): Yes (예) No (아니요) If yes, to what (무엇에 알레지가 있습니까)?
What kind of reaction (어떤 반응이 있으셨습니까)?

Medical History (병내력, 입원/치료 내력)	Surgery (수술 내력):

Current Medications (현재 쓰시는 약/성분, 용량, 횟수):	Past Meds (예전에 쓰시던 약):

Family History (가족 병 내력):			
	Age(나이)	Alive(생존)	Significant Health Problems (병 내력)
Mother (모친):		Yes/no	
Father (부친):		Yes/no	
Siblings (형제/자매):		Yes/no	
Relatives (친척 병 내력/암, 풍, 심장마비, 당뇨, 혈압 등):			

Social History (사회 내력)	
Smoking (담배): Yes (예), No (아니요) How much (몇갑)?	Drinking alcohol (술): Yes (예), No (아니요) How often (얼마나 자주)?
Marital status (결혼내력): Married (결혼), Single (미혼), Divorced (이혼), Widowed (사별)	Exercise (운동): Yes (예), No (아니요) How often (얼마나 자주)?

Tests and Procedures (예전에 하셨던 검사 기록)	Date (년도)	Result (결과)
Colonoscopy/EGD (대장/위장 내시경)		
Chest x-ray (흉부 사진)		
Abdominal ultrasound (복부 초음파)		
Carotid ultrasound (대동맥 검사)		
Treadmill stress test (심장 검사)		
Echocardiogram (흉부 초음파)		
EKG (심전도 검사)		
Last eye check up (안과 검사)		
DEXA (골밀도 검사)		
Mammogram (여성 유방암 검사)		
Pap smear (여성 자궁암 검사)		
Hepatitis shots A and/or B (A 형/B 형 간염 주사):		
Tetnus shot (파상풍 주사):		
Pneumonia shot (폐렴 예방 주사):		
Zoster vaccination (대상포진 주사):		

Bethel Family Medical Group

720 North Harbor Ste B, Fullerton, CA 92832
Wonbae Choe, M.D. 714-782-7700

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

☐ I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at:

____

Signed: ______________________ Date: ____________________________

Print Name: ___________________ Telephone: _________________________

If not signed by the patient, please indicate relationship:

☐ Parent or guardian of minor patient

☐ Guardian or conservator of an incompetent patient

Name and Address of Patient: ____

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Por la presente reconozco que he recibido una copia del Aviso de esta práctica médica de prácticas de privacidad. Además, reconozco que una copia del aviso actual será fijada en la zona de recepción, y que una copia de la Notificación de Prácticas de Privacidad modificado estará disponible en cada cita.

☐ Me gustaría recibir una copia del Aviso de Prácticas de Privacidad modificada por e-mail a:

____

Firmado: ______________________ Fecha: ________________________

Imprimir Nombre: __________________ Teléfono: ______________________

Si no está firmada por el paciente, por favor indique la relación:

☐ El padre o tutor del paciente menor de edad

☐ Tutor o curador de un paciente incompetente

Nombre y dirección del paciente: ______________________________________

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