ARROYO OAKS MEDICAL ASSOCIATES, INC.

CONFIDENTIAL PATIENT REGISTRATION FORM

Name: _____ (Last) _____ (First) Sex: _____ Birth date: _____

Address: _____ City: _____ ST: _____ Zip: _____

Social Security #: _____ Driver's License #: _____

Primary Phone: ( ) Home ( ) Cell (____): _____ Secondary Phone: ( ) Home ( ) Cell (____): _____

Employer: _____ Occupation: _____ Work #: (____) _____ ext _____

Address: _____ City: _____ ST: _____ Zip: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Separated

Spouse's Name: _____ Birth date: _____ Referred by: _____

Emergency Contact Name: _____ Relationship: _____ Contact #: (____) _____

PERSON RESPONSIBLE FOR PAYMENT

Name: _____ /Driver's Lic. #: _____ Relationship: _____ DOB: _____

Address: _____ City: _____ ST: _____ Zip: _____ Home #: (____) _____

Employer: _____ Address: _____ Work #: (____) _____ ext _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Group/plan: _____ Policy ID #: _____

Policy Holder's Name: _____ DOB: _____ SS #: _____

Relationship to Patient: _____

Secondary Insurance Company: _____ Group/plan: _____ Policy ID #: _____

Policy Holder's Name: _____ DOB: _____ SS #: _____

Additional information: _____

I hereby authorize my physician and any physicians and/or assistants to whom he/she may designate to render treatment as deemed necessary by my physician.
I hereby authorize Arroyo Oaks Med. Assoc., Inc. to release any and all medical information necessary to process my insurance claims; and, payment of medical and/or surgical benefits directly to Arroyo Oaks Med. Assoc., Inc. This authorization shall be valid until revoked in writing. A photostat of this authorization shall be valid as an original.
I am aware the office policy is to present my insurance card at each visit and this will be the insurance processed for that date of service. Failure tp present my insurance card may jeopardize my benefits and will forfeit any contractual obligation. Arroyo Oaks Med. Assoc., Inc. may have with my insurance, including retroactive billing and negotiated discounts. I am responsible for knowing my plan benefits as well as any restrictions. I understand that I am responsible for any portion of the bill not covered by my insurance and I agree to pay in full at time of service.
I have read and understand all of the above and hereby state the information is correct to the best of my knowledge. My signature indicates that I approve and grant request of the authorizations.

_____ _____ _____

Signature: Patient or Legal Representative | Today's Date | If signed for minor, relationship of guardian

ARROYO OAKS MEDICAL ASSOCIATES, INC.
2230 LYNN ROAD, SUITE 200
THOUSAND OAKS, CA. 91360
(805) 495-1066
RONALD de la PENA, MD. PRIVACY OFFICER

Notice of Privacy Practices

This notice describes how your health information may be used and disclosed and how you can access this information. Please review it carefully.

At our facility we have always kept your health information secure and confidential. A new law requires us to continue maintaining your privacy, to give you this notice and to follow the terms of this notice.

The law permits us to use or disclose your health information to those involved in your treatment. For example, a review of your file by a specialist doctor whom we may involve in your care.

We may use or disclose your health information for payment of your services. For example, we may send a report of your progress to your insurance company.

We may use or disclose your health information for our normal healthcare operations. For example, one of our staff will enter your information into our computer.

We may share your medical information with our business associates, such as a billing service. We have a written contract with each business associate that requires them to protect your privacy.

We may use your information to contact you. For example, we may send a reminder card or other information. We may also want to call and remind you about your appointments. It you are not home, we may leave this information on your answering machine or with the person who answers the telephone.

In an emergency, we may disclose your health information to a family member or another person responsible for your care.

We may release some or all of your health information when required by law.

If this practice is sold, your information will become the property of the new owner.

Except as described above, this practice will not use or disclose your health information without your written prior authorization.

You may request in writing that we not use or disclose your health information as described above. We will let you know if we can fulfill your request.

You have the right to know of any uses or disclosures we make with your health information beyond and above normal uses.

As we will need to contact you from time to time, we will use whatever address or telephone number you prefer.

You have the right to transfer medical records to another practice. There may be fees associated with this transfer.

You have the right to request an amendment or change in your health information. Give us your request to make changes in writing. If you wish to include a statement in your file, please give it to us in writing. We may or may not make the changes you request, but will be happy to include your statement in your file. If we agree to an amendment of changes, we will not remove no alter earlier documents, but will add new information.

You have the right to receive a copy of this notice.

If we change any of the details of this notice, we will notify you of the changes in writing.

You may file a complaint with the Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, Washington, DC 20201. You will not be retaliated against for filing a complaint.

However, before filing a complaint, or for more information or assistance regarding your health information policy, please contact our Privacy Officer at (805) 495-1066

This notice goes into affect as of April 14, 2003.

Acknowledgement of Receipt of Notice of Privacy Practices

ARROYO OAKS MEDICAL ASSOCIATES, INC.
2230 LYNN ROAD, SUITE 200
THOUSAND OAKS, CA. 91360
(805) 495-1066
RONALD de la PENA, MD. PRIVACY OFFICER

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 I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:

Relationship:

- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: _____

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9-30-02

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: _____ _____
Physician's or Authorized Representative's Signature (Date)

By: _____
Print Patient's Name

ARROYO OAKS MEDICAL ASSOC., INC.
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.

Arroyo Oaks Medical Associates, Inc.
2230 Lynn Road Suite 200
Thousand Oaks, Ca. 91360

ONLINE ACCESS TO MEDICAL RECORDS

We are pleased to offer our patients **secure online access** to their medical records including viewing and downloading lab results via **Patient Fusion** patient portal.

ACCOUNT #_____ DATE:_____ DOCTOR:_____

PATIENT:_____ BIRTH DATE:_____ M)__ (F)__

E-MAIL ADDRESS:_____

If you are interested, please check the appropriate box below. A **Patient Fusion** invitation will be sent by email with a **five day** expiration. Please call the office and request a new invitation if unable to open the account within five days.

( ) Yes, I would like online access to my medical records.

( ) No, I would not like online access to my medical records.

_____
Signature

ARROYO OAKS MEDICAL ASSOCIATES, INC.

"No Show" and "Cancellation" Appointment Notification

At Arroyo Oaks Medical Associates clinic, our goal is to provide quality care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients. The following policy is with regard to patients who fail to keep their scheduled office visit appointment and testing appointment.

Please be courteous and call Arroyo Oaks Medical Associates clinic promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need to see one of our physicians. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely care.

- Patients who fail to show for their scheduled office visit appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $50.00.
- Patients who fail to show for their scheduled testing appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "No Show/Cancellation" fee of $50.00.
- These fees are not covered by insurance and is therefore the sole responsibility of the patient.

How to cancel your appointment
To cancel or reschedule appointments call Arroyo Oaks Medical Associates at 805-495-1066. If you have any problems getting through, you can leave a message with your name, appointment date, cancellation reason, and request for rescheduling.

This is a courtesy letter, any future missed appointments will incur a fee.

Thank you for your understanding and cooperation,

The Physicians and Staff at Arroyo Oaks Medical Associates, Inc.

X _____

I acknowledge that I have read and understand

Arroyo Oaks Medical Associates, Inc. 2230 Lynn Road, Suite 200 | Thousand Oaks, CA 91360 |
Tel. 805.495.1066 | Fax: Family Practice & OB/Gyn 805.497.0162 | Internal Medicine 805.497.1782

OB/GYN HISTORY for Name: _____ **Age:** _____ **Date:** _____

Primary Care Physician: _____

How did you find Dr. de la Peña? Recommended by (please circle):
Doctor, family, friend/colleague, self, advertising

MENSTRUAL HISTORY

Age at first period _____
Are your periods regular (once a month?) _____
When was your last period? _____
Do you have any abnormal bleeding? _____
Bleeding between periods? _____
Bleeding after menopause? _____

Children's Birthdays: #1_____ #2_____ #3_____

Other:

PREGNANCY

Have you ever been pregnant? _____
Number of pregnancies _____ Deliveries _____
Normal _____ Cesarean_____
Number of miscarriages/abortions?_____
Complications with pregnancy or delivery? _____
If yes, what? _____

Birth weights _____ Normal _____ Cesarean_____
_____ Normal _____ Cesarean_____
_____ Normal _____ Cesarean_____

GYN CANCER SCREENING

When was your last Pap smear? _____ Was it normal? _____
Have you had a hysterectomy? _____ When? _____ Why? _____
Do you have your ovaries?_____Both?_____One?_____Explain:_____

SOCIAL HISTORY

Sexual history:
(Optional:) Virgin ( ) Sexually active: Yes ( ) No ( ) Straight ( ) Gay/Lesbian ( )
(Optional:) Marital Status: Single ( ) Married ( ) Divorced ( ) Widowed ( )
Habits past & present: Tobacco? _____ # cigarettes/day: _____
Alcohol?___ # drinks/day_____ Drugs?___ What kind?_____
Coffee?___ Cups/day___ Tea?___ Cups/days___ Soda?___ #/day_____
Hours of sleep/night___ Awaken during the night?___ # awakenings/week___ Do you snore?____
Do you feel depressed?___ Since when_____
Any weight changes___ Explain:_____
Do you exercise at least 30min three/wk_____

BREAST

Please list any current breast complaints? _____
Have you had any breast disease, cancer, or tumors? _____ Which? _____
Have you had a mammogram? ____ When? ___ Was it normal? _____
Do any of the women in your family have breast cancer? _____ Who? _____

MENOPAUSE (If this does not apply, check here___)

Do you have "hot flashes?"___ night sweats?___ insomnia?___ Bleeding after menopause? _____
What age did you start menopause? _____ Have you taken hormones before? ____
Are you taking hormones now?___ Which one?_____ How often?_____

MEDICAL HISTORY

Do you have or have you had in the past:
Diabetes _____ Hypertension _____ Seizures_____ Stroke _____Thyroid disease_____
Asthma _____ Cancer _____ Sickle Cell Disease _____ Tuberculosis _____ Hemorrhoids _____
Heart Attack_____ Blood clots in legs or lungs_____ Hepatitis/Liver problems_____
Chickenpox_____ Measles_____ German measles_____ Mumps_____ Other_____

Name:_____ DOB:_____ MR#_____

Review of Systems:

	Yes	No
General:		
Do you have chronic rash or eczema?	___	___
Skin growths or birthmarks changing or enlarging?	___	___
HEENT:		
Ear problems?	___	___
Eye problems?	___	___
Nosebleeds or nose problems?	___	___
Sinus problems?	___	___
Unusual headaches?	___	___
Teeth needing repair?	___	___
Chronic sore throats?	___	___
Chronic throat hoarseness or voice changes?	___	___
Thyroid problems?	___	___
Chronic cough?	___	___
Cardio-Vascular-Respiratory:		
Asthma?	___	___
Night sweats?	___	___
Hot flashes?	___	___
Chest pain?	___	___
High blood pressure?	___	___
Short of breath easily?	___	___
Gastrointestinal:		
Appetite changes?	___	___
Indigestion?	___	___
Food intolerance?	___	___
Heartburn?	___	___
Diarrhea frequently?	___	___
Bowel habit changes?	___	___
Liver or gall bladder problems?	___	___
Yellow jaundice?	___	___
Blood in your stool?	___	___
Genito-urinary:		
Kidney disease?	___	___
Bladder problems?	___	___
Urinary tract or kidney stones?	___	___
Blood in your urine?	___	___
Central Nervous System:		
Sleeping problems?	___	___
Fainting?	___	___
Convulsion?	___	___
Paralysis or weakness?	___	___
Unusual back pain?	___	___
Arthritis?	___	___
Varicose veins?	___	___

Name_____ DOB:_____ MR#_____

FAMILY HISTORY

Does anyone in your family have any of the above illnesses? (See Medical History) _____

Who and which ones? _____

_____

_____

_____

SURGERY

Have you had surgery? _____

Tonsillectomy _____ Appendectomy _____ Gallbladder surgery _____ Other _____

CONTRACEPTION

Are you using: Pill _____ Depo/Injection _____ IUD _____ Norplant _____

Condoms _____ Tubes tied/Sterilization _____ Vasectomy _____ Other _____ None _____

INFECTION

Have you had any sexually transmitted disease? _____

Syphilis___ Gonorrhea___ Chlamydia___ Herpes___ Yeast___ Trichomoniasis___ Bacterial Vaginosis___

Do you have vaginal discharge? _____ Pain while urinating? _____ Do you douche? _____

Are you using any medicine now for any female problem?_____ Which? _____

Have you ever had Hepatitis, a blood transfusion, or HIV? _____ Which? _____

MEDICINES

Are you taking: Vitamins _____ Iron _____ Calcium _____ Hormones_____ Other_____

Why are you taking them? _____

Which medications are you allergic to?_____ Symptoms: rash nausea vomiting other

Other medical concerns? _____

Medical Screening

When was the last year you had:	Colonoscopy_____	Eye exam_____	Dental exam_____
Blood check for:	Cholesterol___	Anemia_____	Diabetes_____
Vaccinations:	Flu _____	Pneumonia_____	Hepatitis_____

Confidential phone:

Cell phone: area code ( ) number:_____

Home phone: area code ( ) number:_____

Pharmacy Name: _____City: _____

Area code ( ) number: _____

Other comments:_____

_____

_____

Reviewed by: _____

5/1/13