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 (____): _____

E-Mail Address: _____

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 to 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 PEÑA, M.D. 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 heath 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. If 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 or 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 our health information policy, please contact our Privacy Officer at (805) 495-1066.

This notice goes into effect 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: _____

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 the **Patient Fusion** patient portal and **Smart Vault** personal portal.

If you are interested, please check the appropriate box below. A **Patient Fusion** and **Smart Vault** invitation will be sent by email with a 5-day expiration. Please call the office and request a new invitation if unable to open the account within 5 days.

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

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

Patient Name:	L	A	S	T																			
	F	I	R	S	T																		
Date of Birth:	M	M	/	D	D	/	Y	Y	Y	Y													
Email Address:																							
					O	F	F	I	C	E		U	S	E		O	N	L	Y				
Account #:											Doctor #:												

_____ _____

Signature Date

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

Arroyo Oaks Medical Group
Health Questionnaire

Name _____ Age _____ Chart # _____
Today's Date _____ Primary Physician _____
Date/Year of Last Complete Physical Examination _____

Current Illnesses or Symptoms _____
_____
_____

Past Medical History	**Yes**	**No**	**Year Diagnosed**
Heart Attacks	☐	☐	_____
Heart Failure	☐	☐	_____
Diabetes	☐	☐	_____
High Blood Pressure	☐	☐	_____
Asthma	☐	☐	_____
Chronic Lung Disease	☐	☐	_____
Arthritis	☐	☐	_____
Stomach Ulcers/Acid Reflux	☐	☐	_____
Liver Problems	☐	☐	_____
Cancer (what type?)	☐	☐	_____
High Cholesterol	☐	☐	_____
Anxiety/Mood Disorders	☐	☐	_____
Blood Disorders	☐	☐	_____
Skin Problems	☐	☐	_____
Osteoporosis	☐	☐	_____
Thyroid Disorders	☐	☐	_____
Other	☐	☐	_____

_____
_____

Screening Procedures/Exams
When was your last:
Rectal Exam?_____
Flexible Sigmoidoscopy/Colonoscopy? _____
Eye Exam? _____
Prostate Exam (males)? _____
Breast Exam (females)? _____
Mammogram (females)? _____
Pap/Pelvic Exam (females)?_____

Medications

	Name	Dose	How Often
1.			☐ Only as needed
2.			☐ Only as needed
3.			☐ Only as needed
4.			☐ Only as needed
5.			☐ Only as needed
6.			☐ Only as needed
7.			☐ Only as needed
8.			☐ Only as needed
9.			☐ Only as needed
10.			☐ Only as needed

Social History	**Yes**	**No**	**Describe if applicable**
Do you drink beer, wine, or liquor?	☐	☐	
Do you smoke cigarettes, cigars or pipes?	☐	☐	
Do you use chewing tobacco?	☐	☐	
Are you exposed to second-hand smoke?	☐	☐	
Do you use drugs(marijuana, cocaine, etc)?	☐	☐	
Have you ever had a blood transfusion?	☐	☐	
Have you ever had a sexually transmitted disease?	☐	☐	
Do you currently work?	☐	☐	

Family History

Does your family have a history of:	Yes	No	**Which Family Member**
Heart Attacks	☐	☐	
Heart Failure	☐	☐	
Diabetes	☐	☐	
High Blood Pressure	☐	☐	
Asthma	☐	☐	
Chronic Lung Disease	☐	☐	
Arthritis	☐	☐	
Stomach Ulcers/Acid Reflux	☐	☐	
Liver Problems	☐	☐	
Cancer (what type?)	☐	☐	
High Cholesterol	☐	☐	
Anxiety/Mood Disorders	☐	☐	
Blood Disorders	☐	☐	
Skin Problems	☐	☐	
Osteoporosis	☐	☐	
Thyroid Disorders	☐	☐	
Other	☐	☐	

Past Surgical History	Yes	No	Year
Tonsils/Adenoids	☐	☐	_____
Cataracts/Glaucoma	☐	☐	_____
Sinuses	☐	☐	_____
Thyroid	☐	☐	_____
Carotid Arteries	☐	☐	_____
Heart	☐	☐	_____
Lungs	☐	☐	_____
Breast	☐	☐	_____
Gallbladder	☐	☐	_____
Appendix	☐	☐	_____
Intestinal	☐	☐	_____
Joints	☐	☐	_____
Prostate (male)	☐	☐	_____
Hysterectomy/Ovaries (female)	☐	☐	_____
C-Sections (female)	☐	☐	_____
Other	☐	☐	_____

_____

Obstetric History (females)

Number of Total Pregnancies _____

Number of Full Term Pregnancies _____

Number of Preterm Pregnancies _____

Number of Miscarriages _____

Number of Elective Abortions _____

Immunization History	Yes	No	Year of Last
Have you had a Diphtheria-Tetanus Booster?	☐	☐	_____
Do you get yearly flu shots?	☐	☐	_____
Have you ever had a pneumonia vaccine ("Pneumovax")	☐	☐	_____

Previous/Current Alternative Health Care Professionals

Chiropractor _____

Acupuncturist _____

Herbalist _____

Other _____

Allergies

Medication Allergies (describe what happens) _____

_____

Food Allergies (describe what happens) _____

_____

Review of Systems

Do you have any of the following symptoms on an everyday basis?

	Yes	No	Yes	No		Yes	No
Weight Loss	☐	☐	Chest Pain	☐	☐	Urinary Bleeding	☐	☐
Fever	☐	☐	Cough	☐	☐	Urinary Pain	☐	☐
Headache	☐	☐	Short of Breath	☐	☐	Numbness/Tingling	☐	☐
Dizziness	☐	☐	Wheezing	☐	☐	Weakness	☐	☐
Passing Out	☐	☐	Heartburn	☐	☐	Fatigue	☐	☐
Nausea/Vomiting	☐	☐	Black Colored Stool	☐	☐	Swelling	☐	☐
Earache	☐	☐	Bleeding From Stool	☐	☐	Other _____	☐	☐
Sore Throat	☐	☐	Abdominal Pain	☐	☐	_____		
Neck Pain	☐	☐	Diarrhea	☐	☐	_____		
Neck Growths	☐	☐	Back Pain	☐	☐	_____		