Dan La, M.D.

6673 Foothill Blvd.

Tujunga, CA 91042

Patient's Name:_____

Email Address:_____

1. Who is the referring doctor?_____
2. Reason for consult:_____
3. Height:_____
4. Medical history and surgeries:_____
5. Do you smoke:_____Yes_____No
6. Anyone in the family with arthritis or lupus:_____
7. Any DRUG allergy?_____
8. Name and telephone number of your pharmacy:

   _____

   _____

   Mail in pharmacy:_____
9. List of prescribed medications:
   You may give the medical assistant your medications.

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

Dan La, MD Inc.
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Patient Demographics

Welcome to our office. We are committed to providing the best most comprehensive care possible. We encourage you to ask questions. Please assist us by providing the following information. All information is confidential and is released only with your consent.

SOCIAL SECURITY NUMBER:

Today's Date

Please Print

Patient Last Name	Patient First Name	Birth Date:	Marital Status S M D W	SEX:
Home Address:		City:	State:	Zip:
Home Telephone:	Work Telephone:	Message Telephone:	Driver's License #	
Language Preference	Ethnicity: **Please Check** ☐ (1) American Indian, or Alaskan ☐ (2) Asian, Pacific Islander ☐ (3) Black, not Hispanic Origin ☐ (4) Caucasian ☐ (5) Hispanic ☐ (6) Other: _____			
Occupation:	Employer's Name:			
Employer Address:		City:	State:	Zip:
Spouse's Name:	Spouse's Employer Name & Address:			
Name of Primary Care Physician:		**Who referred you to this office:**		

EMERGENCY NOTIFICATION – Please list someone who **DOES NOT LIVE WITH YOU**

Name:	Relationship:		
Home Address:	City:	State:	Zip:
Home Telephone:	Work Telephone:		

FINANCIAL INFORMATION – Person responsible for all fees **OR** Is the MAIN POLICY HOLDER

Subscriber Last Name:	Subscriber First Name:	Relationship to Patient:	Birthday:
Address:	City:	State:	Zip:
Insurance Company Name:	Member Date of Birth:	Member Number	Member Social Security

Medicare Patients: Signature on File: I request payment of authorized Medicare benefits be made on my behalf to Dan La, MD Inc for any services furnished me by the listed provider/ supplier. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Patient's Signature:_____ **Date:**_____

Assignment of Insurance Benefits:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Dan La, MD Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Patient's Signature:_____ **Date:**_____

I have read, understood, and agreed to all the financial policy for payment of professional fees stated on back side of this form. I acknowledge that I am ultimately responsible for all professional fees rendered. **My signature also represents my consent for medical treatment.**

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.

_____
Patient's or Patient Representative's Signature **Date**

By: Dan La, M.D. Inc.
Physician's or Authorized Representative's Signature

_____
Print Patient's Name

Dan La, M.D. Inc. 6673 Foothill Blvd. Tujunga, CA 91042
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.

Office Financial Policy

Dan La, M.D. Inc.

Basic Policy: Payment for service and previous balances are due at the time of service in our office.

Missed Appointments: In fairness to other patients and the doctor, we require at least 24 hours' notice to cancel appointments. You will be charged for missed appointments or dismissed from the practice after recurrent missed appointments.

For Patients with Insurance: We bill most insurance carriers for you, if proper paperwork is provided to us. We will bill most secondary insurance companies for you. Co-payments and deductible are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you.

Medicare Patients: We will bill Medicare for you. All co-payments or deductibles are due and payable at the time service is provided.

Medicaid Patients: All Medicaid patients must provide a current valid identification card before being seen.

Procedure Fees: All co-pays, deductibles, and payments for non-covered surgical procedures are due prior to your surgery. Prior authorization may be required by your carrier.

Non-covered Services: Any care not paid for by your existing insurance coverage will require payment in full at the time of services are provided or upon notice of insurance claim denial.

Personal Injury Cases: This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.

Patient's Name:_____ **Date:**_____

Patient's Signature:_____

Effective 1/1/2016

Dan La, M.D. Inc.
6673 Foothill Blvd.
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
&
CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS

I hereby acknowledge that I understand and have been provided with a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that I have been informed that a copy of the current notice is posted in the reception area.
I understand this medical practice reserves the right to change their notice of Privacy Practices and that any change, identified by its "effective date", will be posted in the reception area.

I will be sure to request a copy of the most current (amended or revised) notice on my first visit following the effective date.
I consent to the use and disclosure of my protected health information to carry out treatment, payment, or health care operations.

Effective date of notice: 04/14/2008

_____ _____
Signature of patient or patient's representative Date

_____ _____
Printed name of patient or patient's representative Relationship to patient, representative, or authority to act for the patient

OFFICE USE ONLY

Reason acknowledgement was not obtained:

_____
_____
_____