STUDIO CITY MD
PATIENT REGISTRATION FORM

(Please Print)

Today's date:			PCP:		
PATIENT INFORMATION					
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Street address:		Social Security no.:			Home phone no.: ( )
P.O. box:	City:		State:		ZIP Code:
Occupation:	Employer:				Employer phone no.: ( )
Birth date: / /	Age:	Sex: ❑ M ❑ F			

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

Is this person a patient here? ❑ Yes ❑ No

DATE(S) OF INJURY:			
1.	2.	3.	4.
Occupation:	Employer:	Employer address: City/Zip	Employer phone no.: ( )
Attorney:	Contact:	Attorney address: City/Zip	Attorney phone no.: ( )

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information 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 [Name of Practice] or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Patient Services Form

Some services are available on premises from Studio City MD physician. However, you are free to obtain any and all medical care from your own primary care physician or any other health care provider of your choice. Notice of the availability of theses services on the premises is offered only as a convenience to our patients and not as an endorsement or recommendation. Please consult with your health insurance provider to determine any out of network or co-pay charges, which might apply.

Initials: _____ Date: ___/___/____

I _____ hereby declare that I have completely and truthfully disclosed all my information correctly. I attest I am not a member, employee, or agent of any media or law enforcement agency. I know it is illegal as a “patient” or for a “patient” to film, record, or take pictures during any medical evaluation; and is direct violation of HIPAA regulations, and patient / physician confidentiality. I declare under penalty of perjury, that the information on this form and during your medical exam is true and correct.

Initials: _____ Date: ___/___/____

Print Name: _____

Signature: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate Malpractice and Related Claims**: 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 both parties that this agreement bind all parties whose claims may arise out of or relate to treatment or services 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 Dr. Meyerovich, the physician's partners, associates, association, corporation or partnership, 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 of any court by the physician or a physician's agent to collect any fee from the patient shall not waive any right to compel arbitration of any malpractice or related claim.

Article 3: **Procedures and Applicable Law**: A demand for arbitration must be communicated, in writing, to all parties. Within thirty days of the demand, the parties shall confer in good faith so as to select a mutually agreeable arbitrator who must be a retired judge from either the JAMS or the AAA panel. If the parties are unable to agree on an arbitrator within 30 days, the parties may confer for an additional 30 (thirty) days so as to select a mutually agreeable neutral arbitrator.

If the parties are unable to select a mutually agreeable arbitrator, one or both parties shall send a written demand for a neutral arbitrator, or the parties may agree to the selection of a neutral arbitrator through the process of party arbitrators. The process shall work as follows: Each party shall select an arbitrator (party arbitrator) within 30 (thirty) days and a third arbitrator who must be a retired judge (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of the 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 neutral arbitrator, not including attorney's fees or witness fees, or other expenses incurred by a party for that party's own benefit. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees whether the arbitrator is selected directly by the parties or through party arbitrators. 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 statutory or common law.

Each 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 the provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including but not limited to, California Code of Civil Procedure 3333.1 and 3333.2. Any party may bring before the arbitrators a Motion for Summary Judgment and/or Motion for Summary Adjudication in accordance with the California Code of Civil Procedure. Discovery shall be conducted pursuant to California Code of Civil Procedure 1283.05, however depositions may be taken without prior approval of the 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 expressly provided for herein, the arbitrators shall be governed by the California Code of Civil Procedure provisions related to arbitration.

Article 5: **Revocation**: This agreement may be revoked by written notice delivered to physician within 30 (thirty) 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 date as of first medical services _____
Patient's/ Representative's Initials

Article 7: **Severability**: If any provision of this arbitration agreement is held invalid or unenforceable, that provision shall be severed from this agreement, and the remaining provisions shall not be affected by the invalidity of any severable 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 of this agreement.

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: _____ Date:____
Physician/Authorized Representative

By: Studio City, MD

By: _____ Date:____
Patient/Authorized Representative

By: _____
Print name of Patient

_____
Print name of Authorized Representative, if any

Studio City M.D.

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipts

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices***. Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice. If you have any questions about our ***Notice of Privacy Practices***, please contact us.

*I acknowledge receipt of the **Notice of Privacy Practices**.*

Print Name: _____

Signature: _____

Date: _____

REQUEST FOR RELEASE OF MEDICAL RECORDS

To:

_____

(Physician's Name)

_____

(Address)

_____

(City, State, Zip Code)

I hereby request that my medical records be released to:

Studio City M.D.

4208 Lankershim Blvd.
Studio City, California 91602
Tel: (323) 300-6788
Fax: (323) 300-6790
Email: info@studiocitymd.com

PATIENT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY: _____

PATIENT'S SIGNATURE: _____

DATE: _____

Studio City, M.D.

NARCOTIC MEDICATION AGREEMENT

You have agreed to receive narcotics for the treatment of your pain. It is important that you have an understanding of the risks and responsibilities that go along with this treatment. Please ***read each statement and sign*** this agreement/contract below. If you have any questions regarding this information or the office policy regarding the prescribing of narcotics, please request clarification.

I, _____, understand that:

Any medical treatment is initially a trial, and that continued prescription is based on evidence of benefit. I understand that the goal of using narcotics is to decrease my pain and increase my functional level. If my pain does not significantly decrease and/or my function increase, the medication will be stopped.

I am aware that the use of such medicine has certain risks associated with it, including, but not limited to: sleepiness or drowsiness, constipation, nausea, itching, vomiting, lightheadedness, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal and the possibility that the medicine will not provide complete relief.

The overuse of narcotic medication can result in serious health risks including respiratory depression or even death.

This medication will be strictly monitored and all of my medications should be filled at the same pharmacy. (Should the need arise to change pharmacies our office must be informed). The pharmacy that I have selected is:

Pharmacy: _____

Phone: _____

I **cannot** receive this medication by phone. I will not call the office to have a prescription called in.

I am responsible for making and keeping scheduled appointments. Early refill requests will not be honored.

I will take the narcotic medication **only as prescribed**. Any changes**must** first be discussed and agreed upon with the ***Studio City MD*** physician.

Medications **will not** be replaced if they are lost, get wet, are destroyed, left on an airplane, etc. If my medication has been stolen and I complete a police report regarding the theft, an exception **may** be made. It is expected that you will take the highest possible degree of care with your medication and prescription. They should not be left where others might see or otherwise have access to them.

I agree that only my ***Studio City MD*** physician will prescribe my narcotic medication. I will not obtain or use narcotics or other controlled substances from a source other than ***Studio City MD***. I will instruct my other physicians to confer with the ***Studio City MD*** physician for any changes or need for additional narcotic medications. If it is brought to the attention of the clinic that other providers are prescribing medications for me, the ***Studio City MD*** reserves the right to discontinue prescribing medications and/or discharge me from the clinic.

I will inform my ***Studio City MD*** physician of any changes in my medical condition, any changes in any prescription and/or over the counter medication that I take and of any adverse affects that I may experience from any of the medications that I take.

I agree to tell my ***Studio City MD*** physician my complete and honest personal drug / medication usage and history.

I will not use any illegal "street drugs" while receiving medications from ***Studio City MD***.

I will communicate fully and honestly with my physician about the character and intensity of my pain, the effect of the pain on my daily life, and how well the medicine is helping to relieve the pain

Routine blood work and random drug screens may be a part of my treatment plan. I agree to have them done on the day the physician requests it.

The prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

If the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to my records.

It is a felony to obtain narcotic medications under false pretenses. This could include getting medication from more that one doctor, misrepresenting myself to obtain medications, using them in a manner other then prescribed or diverting the medications in any other way (selling).

I know that narcotic medications will be stopped if any of the following occurs:

- I trade, sell, or misuse the medication
- The clinic finds that I have broken any part of this agreement
- I do not go for a blood or urine test when asked
- My blood or urine test shows the presence of medications that the staff are not aware of, the presence of illegal drugs, or does not show medications that I am receiving a prescription for
- I get narcotics from sources other than ***Studio City MD.***
- Any member of the professional staff of ***Studio City MD*** feels that it is in my best interests that narcotic treatment is stopped
- Any aggressive behavior toward physician or staff
- I consistently miss scheduled appointments

It is understood that failure to adhere to this agreement may result in cessation of therapy with controlled substance prescribing (no narcotic prescriptions will be written) by ***Studio City MD*** physicians.

I have read the Narcotic Medication Agreement and without question understand all of this agreement. By signing this agreement I affirm that I have read, understand and accept all of the terms of this agreement.

Patient signature: _____ Date: _____

Clinic Witness: _____ Date: _____