New Patient Registration Form

Orange County Eye Institute
See Well. Live Well.

*Last Name _____ *First Name _____ Middle Initial _____

*Date of Birth: _____ Age: ____ Social Security#: _____

*Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

*Address :_____

*City :_____

*State:_____ *Zip: _____

Email: _____

Occupation:_____
(if retired, please list former occupation)

Preferred: ☐ Cell ☐ Home ☐ Work

Cell #: _____
OK to text? ☐ Yes ☐ No

Home#: _____

Work #: _____

Ethnicity (optional): _____ Race (optional):_____

*Preferred Language: _____

Emergency Contact:_____

Emergency Ph #: _____

*Referred by: ☐ Internet ☐ Insurance Portal ☐ Dr./Friend/Family(name)_____

Primary Care Doctor: _____ Phone #: _____

Street / City: _____

Preferred Pharmacy: _____ Phone #: _____

Street / City: _____

Medical Insurance Information

Primary Insurance Name: _____ Provider Ph#: _____

Member ID: _____ Group#:_____

Secondary Insurance Name: _____ Provider Ph#: _____

Member ID: _____ Group#:_____

Responsible Party Name: _____ Relationship to Patient: _____

Address: _____ Social Security#: _____

Phone# : _____ Date of Birth: _____

History of Present Eye Illness

Please describe your symptoms and when began: _____

If you are having difficulty seeing: **Is vision worse for (circle):** DISTANCE ☐ READING ☐ RIGHT EYE ☐ LEFT EYE ☐
Is your poor vision (circle): CONSTANT ☐ INTERMITTENT ☐

Check any of the following if you have had or are known to have:

☐ Bell's Palsy	☐ Botox	☐ Cataract	☐ Color Visual Abnormality	☐ Crossed Eyes
☐ Drooped Lid	☐ Dry Eyes	☐ Eye Injury	☐ Macular/Retinal Disorder	☐ Floaters
☐ Glaucoma	☐ Iritis/Uveitis	☐ Keratoconus	☐ Lazy Eye (Amblyopia)	Which eye ?
☐ Night Blindness	☐ Ocular Migraine	☐ Pterygium		For how long?
☐ Vision Loss	☐ Visual Field Defect	☐ Other (list) _____		

Check any eye surgeries/procedures you have had:

☐ Refractive/Lasik/RK/PRK	Which eye? Left ☐ Right ☐	Surgeon:	Date(s):
☐ Cataract	Which eye? Left ☐ Right ☐	Surgeon:	Date(s):
☐ Eye lid	Which eye? Left ☐ Right ☐	Surgeon:	Date(s):
☐ Pterygium	Which eye? Left ☐ Right ☐	Surgeon:	Date(s):
☐ Other Laser procedures	Which eye? Left ☐ Right ☐	Surgeon:	Date(s):
☐ Injections	Which eye? Left ☐ Right ☐	Doctor Name:	Last Injection:

FAMILY HISTORY: Have any of your blood relatives had any of the following (check all that apply):

☐ Glaucoma	Which relative?	☐ Macular Degeneration	Which relative?
☐ Diabetes	Which relative?	☐ Retinal Detachment	Which relative?
☐ Migraines	Which relative?		

EYE MEDICATIONS you use and frequency (drops, ointment, pills): _____

Previous ophthalmologist: _____ **Practice Name:** _____
Phone#: _____ **City:** _____ **State:** _____

Retina Specialist: _____ **Practice Name:** _____
Phone#: _____ **City:** _____ **State:** _____

Do you wear glasses? ☐ No	☐ Yes, Last exam date: _____ **How old are your current glasses?** _____ **Do you have a copy of your glasses prescription?** ☐ Yes ☐ No **Is there a prism or slab off in your lenses?** ☐ Yes ☐ No ☐ Unsure **Type (circle):** READING○ DISTANCE○ BIFOCAL○ TRIFOCAL○ PROGRESSIVE○
Do you wear contact lenses? ☐ No	☐ Yes, Last exam date: _____ **Do you have a copy of your prescription?** ☐ Yes ☐ No **Type (circle):** HARD○ SOFT○ DAILY○ EXTENDED○ GAS PERMEABLE○

Optometrist: _____ **Practice Name:** _____
Phone#: _____ **City:** _____ **State:** _____

Medical History

Check any of the following if you have had or are known to have:

☐ Arrhythmia	☐ Diabetes	☐ Herpes	☐ Migraine Headaches	☐ Sinus
☐ Asthma	☐ Epilepsy	☐ High Blood Pressure	☐ Multiple Sclerosis	☐ Sjogren's Syndrome
☐ AIDS	☐ Emphysema	☐ High Cholesterol	☐ Myasthenia Gravis	☐ Skin Cancer
☐ Arthritis	☐ Gastric Bypass	☐ Histoplasmosis	☐ Pacemaker	☐ Sleep Apnea
☐ Cancer/tumor	☐ Genetic Disorder	☐ HIV Positive	☐ Parkinson's	☐ Stroke
☐ Carotid Surgery	☐ Gout	☐ Kidney Stones	☐ Psoriasis	☐ Thyroid Disorder
☐ Chemotherapy	☐ Hardening of arteries	☐ Leukemia	☐ Rosacea	☐ Tuberculosis
☐ COPD	☐ Heart Disease	☐ Lupus	☐ Seizures	☐ Vertigo/Dizziness
☐ Depression	☐ Hepatitis	☐ Lymphoma	☐ Sickle Cell	

☐ Other (list here) _____

What is your current: Height _____ Weight _____ Blood Pressure_____ A1C_____

Do you smoke? ☐ No ☐ Yes - How often? _____ ☐ Former Smoker – How long? _____

Do you drink alcohol? ☐ No ☐ Yes - How often? _____

List ANY known ALLERGIES: _____

List ANY DAILY MEDICATIONS, dose, frequency: (includes birth control pills, nonprescription drugs, recreational drugs, herbal remedies, vitamins)**:**

_____

_____

List ANY surgeries or hospitalizations you have had at any point in your life: _____

_____

_____

List any medical specialist you think we should know about (endocrinologist/cardiology/rheumatology/etc.):

Doctor's Name:_____

Practice name: _____ **Phone#:** _____

City: _____ **State:** ____

Vaccination Status of Patients 65 or older

Have you received a pneumonia vaccination? ☐ Yes ☐ No

Have you received a shingles vaccination? ☐ Yes ☐ No

Advanced Care of Patients 65 or older

Do you have a health care proxy if you are unable to make your own medical decisions? ☐ Yes ☐ No

Do you have an advanced medical directive or living will? ☐ Yes ☐ No

HIPAA NOTICE OF PRIVACY PRACTICES

George M. Salib, M.D. Inc. HIPAA Notice of Privacy Practices Effective 01/01/2023
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact George M. Salib, M.D. at (949) 770-1322. This notice describes the privacy practices at our office.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. You may revoke such permission at any time by writing to George M. Salib, M.D.

How this Medical Practice May Use or Disclose Health Information

This medical practice collects medical and related identifiable patient information (such as billing information, claims information, referral and health plan information) and stores it in a chart, in administrative or billing files, and on a computer. The medical record is the property of this medical practice, but the information in the medical record is accessible to the patient. This information is considered "protected health information" (PHI) under the HIPAA Privacy Rule. The law permits us to use or disclose health information for the following purposes without the patient's written authorization:

1. Treatment. We may use and disclose your health information for your treatment and to provide you with treatment-related health care services. For example, we may disclose your health information to other physicians or other health care providers who will provide services that we do not provide or we may share this information with a pharmacist who needs it to dispense a prescription, or a laboratory that performs a test. We may also disclose medical information to members of patients' families or others who can help them-when they are sick or injured, or following the patient's death.
2. Payment. We may use and disclose PHI to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get health plans to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs, and business planning and management. We may also share PHI with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of this PHI. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan, health care clearinghouse, or one of their business associates, California law prohibits all recipients of health care information from further disclosing it except as specifically required or permitted by law.
3. Health Care Operations. We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.
4. Appointment Reminder, Treatment Alternatives and Health-Related Benefits and Services. We may use and disclose medical information to contact and remind our patients about appointments. If the patient is not home, we may leave this information on the patient's answering machine or in a message left with the person answering the phone.
5. Sign-in Sheet. We may use and disclose medical information about our patients by having them sign in when they arrive at our office. We may also call out their names when we are ready to see them.
6. Notification and Communication with Family. We may disclose our patients' health information to notify or assist in notifying a family member, personal representative or another person responsible for their care about their location or general condition in the event of their death, unless a patient had instructed us otherwise. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with our patient's care or helps pay for care. If our patient is able and available to agree or object, we will give the patient the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over the patient's objection if we believe it is necessary to respond to the emergency circumstances. If our patient is unable or unavailable to agree or object, our health professionals will use their best judgment in communication with the patient's family and others.
7. Research. We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.
8. Required by Law. As required by law, we will use and disclose our patients' health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
To Avert a Serious Threat to Health or Safety - We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the treatment.
9. Public Health. We may, and are sometimes required by law, to disclose our patients' health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform our patients or their personal representative promptly unless in our best professional judgment, we believe the notification would place a patient at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
10. Health Oversight Activities. We may, and are sometimes required by law, to disclose our patients' health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.
11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose our patients' health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about our patients in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify them of the request and they have not objected, or if their objections have been resolved by a court or administrative order.
12. Law Enforcement. We may, and are sometimes required by law, to disclose out patients' health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
13. Coroners, Medical Examiners, and Funeral Directors. We may, and are often required by law, to disclose our patients' health information to a coroner, medical examiner, or funeral director in connection with their investigations of deaths, or other similar circumstance.
14. Organ or Tissue Donation. We may disclose our patients' health information to organizations involved in procuring, banking or transplanting organs and tissues.
15. Public Safety. We may, and are sometimes required by law, to disclose our patients' health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

HIPAA Notice of Privacy Practices (continued)

16. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if the patient has agreed to the disclosure on behalf of themselves or their dependent.
17. Specialized Government Functions. We may disclose our patients' health information for military or national security purposes or to correctional institutions or law enforcement officers that have the patient in their lawful custody.
18. Workers' Compensation. We may disclose our patients' health information as necessary to comply with workers' compensation laws.
For example, to the extent our patients' care is covered by workers' compensation, we will make periodic reports to their employer about their conditions. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
19. Change of Ownership. In the event that this medical practice is sold or merged with another organization, our patients' health information/record will become the property of the new owner, although our patients will maintain the right to request that copies of their health information be transferred to another physician or medical group.
20. Breach Notification. In the case of a breach of unsecured protected health information, we will notify our patients as required by law. If they have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances, our business associate may provide the notification. We may also provide notification by other methods as appropriate.

Our patient's Health Information Rights

1. Right to Inspect and Copy. Our patients have the right to inspect and copy your medical and billing records by written request to George M. Salib, M.D.
2. Right to Amend - Our patients have a right to request that we amend their health information if they believe it is incorrect or incomplete by written request to George M. Salib, M.D. Our patients must make a request to amend in writing, and include the reasons they believe the information is inaccurate or incomplete. We are not required to change our patients' health information, and will provide them with information about this medical practice's denial and how they can disagree with the denial.
3. Right to an Accounting of Disclosures. Our patients have the right to an accounting of certain disclosures by written request to George M. Salib, M.D.
4. Right to Request Restrictions. Our patients have the right to request restriction or limitation on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to George M. Salib, M.D. We are not required to agree with your request, but we will try to comply.
5. Right to Request Confidential Communication. Our patients have the right to request that they receive their health information in a specific way or at a specific location. For example, they may ask that we send information to a particular email account or to their work address. We will comply with all reasonable requests submitted in writing to George M. Salib, M.D. which specify how or where our patients wish to receive these communications. We will accommodate reasonable requests.
6. Right to Paper Copy of Notice of Privacy Practices. Our patients have a right to notice of our legal duties and privacy practices with respect to their health information, including a right to a paper copy of this Notice of Privacy Practices, even if they have previously requested its receipt by email. If we have a website, we must post our current Notice of Privacy Practices on our website.

Changes to this Notice

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received.

You have a right to request a paper copy of the current notice at any visit or by written request to George M. Salib, M.D.
George M. Salib, M.D., Inc, 24422 Avenida De La Carlota #110, Laguna Hills, CA 92653, USA Phone: (949) 770-1322.

Release of Medical Information

I authorize release of my medical information to the following persons:

Name:_____ Relationship:_____

Address: _____ Phone#: _____

Name:_____ Relationship:_____

Address: _____ Phone#: _____

Name:_____ Relationship:_____

Address: _____ Phone#:_____

I hereby acknowledge that I was offered a copy of this medical practice's Notice of Privacy Practices and that I will receive a copy of any amended Notice of Privacy Practice at each appointment at my request.

_____ _____

***Patient or Responsible Party Signature** ***Date**

Office Policies

Copy of Medical Records, Disability, DMV, or Any Other Medical Forms / Paperwork

If you require copies of medical records, please send a written request to authorize the release of such records. There is a $25 upfront charge for copies of medical records or any medical paperwork/form. Please allow 1-2 weeks from the date of your request. Patients may also obtain their medical records from their patient portal at no charge. Please allow 1-2 weeks after your appointment, for your medical records to become available through the patient portal.

I have read and understand the policy above. **I Agree _____ *(initials)**

Missed/Cancelled Appointments

We may charge a $50 late cancellation/missed appointment fee unless we are notified 48 hours in advance. We may charge a $100 late cancellation/missed appointment fee for a scheduled in-office procedure. The cancellation fee is entirely patient responsibility and will not be covered by your insurance company.

I have read and understand the policy above. **I Agree _____ *(initials)**

Late to Appointments

If you are more than 15 minutes late for your appointment, out of respect for our other patients, we may ask you to reschedule.

I have read and understand the policy above. **I Agree _____ *(initials)**

Patient Notifications

Refraction Policy

The refraction is a service which measures your best corrected vision. A refraction is used to write a prescription for eyeglasses.

After your first appointment, to obtain your best vision, a refraction may be recommended for you. Please be aware that a refraction is NOT a covered benefit by Medicare or most medical insurance plans. Medical insurance plans consider refraction a "vision" service. It may be covered under VSP insurance, but the Orange County Eye Institute is not a contracted VSP provider.

You may choose to schedule a refraction with our office or you may choose to schedule with your own optometrist/optical shop. If you choose to receive a refraction in our office, the fee for the refraction will be collected at the time of service. Any copayment, co-insurance, or deductible may apply.

I have read and understand the refraction policy above. **I Agree _____ *(initials)**

Precautions following Dilation

It may be necessary to dilate your eyes during your eye examination or treatment. Dilation results in light sensitivity and an inability to see clearly for a few hours. We provide free disposable sunglasses. Patients should wear sunglasses outdoors and be cautious when walking and going up or down stairs. We recommend that you not drive or operate dangerous machinery after dilation until your eyes are back to normal. We also recommend that someone accompany you to your appointment to drive you home, or that you wait until your eyes return to normal so that you can drive safely.

I have read and understand the dilation precaution above. **I Agree _____ *(initials)**

Consent to Audio and Video Recording

For quality assurance purposes, the Orange County Eye Institute has audio and video surveillance in its office spaces, whereby it records all conversations in its office common areas. We do not record in the restrooms or patient exam rooms. While I am on the Orange County Eye Institute's premises, I understand and consent to the video and audio recording of my conversations. I also acknowledge that I have no expectation of privacy in my communications while I am on its premises.

I understand there is audio and video recording. **I Agree _____ *(initials)**

NOTICE AND ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING

George M. Salib, M.D. and Dr. Satvinder Gujral, M.D. are licensed and regulated by the Medical Board of California. To checkup on a license or file a complaint go to www.mbc.ca.gov, email: licensecheck@mbc.ca.gov or call (800) 633-2322.

_____ _____

***Patient or Responsible Party Signature** ***Date**

Insurance and Billing

Insurance Coverage Terms

Your insurance plan is an agreement between you and your insurance company. It's your responsibility and not that of the Orange County Eye Institute to know your insurance plan terms and conditions. As a courtesy, we try to verify your eligibility/benefits. However, insurance coverage is known only after all the claims are processed by your insurance company. Be aware that some medical insurance policies do not cover routine exams or refractions.

I have read and understand the insurance coverage terms above. **I Agree _____ *(initials)**

Prior Authorization

If your insurance company requires prior authorization from your Primary Care Provider, it is your responsibility to obtain the relevant authorization prior to your first visit. Without a valid authorization, the full cost of your visit will be your responsibility.

I have read and understand the prior authorization policy above. **I Agree _____ *(initials)**

HMO, PPO and MEDI-CARE ADVANTAGE Insurances: In-Network/Out-of-Network Status

Any or all of the providers/doctors at this office, and this office itself, may or may not be in network with the patient's insurance, and this may vary according to which location the patient is seen. The Orange County Eye Institute will not be responsible for informing the patient whether our providers/doctors and/or the office itself ("we") are IN-NETWORK or OUT-OF-NETWORK with the patient's insurance. It is solely the patient's responsibility to verify if we are IN-NETWORK or OUT-OF-NETWORK with their insurance plan prior to their first visit and prior to all subsequent visits. The patient is fully responsible for all payments due to the Orange County Eye Institute regardless of whether we are IN-NETWORK or OUT-OF-NETWORK. Additionally, IF we are OUT-OF-NETWORK, the patient will be fully responsible for ALL charges (including additional OUT-OF-NETWORK costs) due to the Orange County Eye Institute that were not paid by the insurance whether or not they were informed of our in or out of network status prior to any appointments or procedures/surgeries.

I have read and understand the policy above. **I Agree _____ *(initials)**

Insurance Claims Processing

If contracted with your insurance, the Orange County Eye Institute will file an insurance claim on your behalf. If we are not contracted with your insurance, it is the patient's responsibility to file all insurance claims.

I have read and understand the insurance claims policy above. **I Agree _____ *(initials)**

Insurance Claim Disputes

The negotiation of payments due to our office and the settling of any claim disputes is entirely the responsibility of the patient.

I have read and understand the insurance claims/disputes policy above. **I Agree _____ *(initials)**

Copays and Outstanding Balances

All account balances and copays are due at the time of service. We require all account balances to be paid in full prior to your next office visit. Should you require, we will work with you on a convenient payment plan.

I have read and understand the copay and outstanding balance policy above. **I Agree _____ *(initials)**

If your Account is Sent to Collections

Unpaid debt to George M. Salib M.D., Inc./Orange County Eye Institute or OCEI is handled by a third-party collection company. You are responsible for settling any attorney fees, interest, or penalties applicable by law.

I have read and understand the collections policy above. **I Agree _____ *(initials)**

Insurance and Billing (continued)

Patient Responsibility to Provide Accurate Insurance Information

Insurance companies provide a limited time to submit claims. I acknowledge and agree to be responsible for the full cost of my visit and testing if my insurance information is not provided, inaccurate, ineligible or inactive at the time of my visit.

I have read and understand the policy above. **I Agree _____ *(initials)**

Medicare Accept Assignment Policy

Orange County Eye Institute will accept the fee approved by Medicare for any "covered services". The patient will be responsible for any amount approved but not paid by Medicare, for example, the annual deductible and the 20% co-insurance. The patient is also responsible for the full amount of any services not-covered by Medicare. Most diagnostic eye examinations and tests are covered by Medicare. However, refractions and the fitting and supply of glasses or contact lenses are non-covered services.

I agree to assume financial responsibility for co-insurance and deductibles as specified by Medicare. I also agree to assume financial responsibility for charges of any non-covered services that I choose to have performed.

I have read and understand the medicare assignment policy above. **I Agree _____ *(initials)**

Insurance and Billing Policy Acknowledgement and Consent

I have read and consent to the above insurance and billing policies.

I understand that all charges for professional services not covered by my insurance are my responsibility.

I authorize payments of medical benefits to George M. Salib, M.D. Inc.

_____ _____

***Patient or Responsible Party 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 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. ☐ I Agree _____ *(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 Signature Date

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

George M. Salib M.D. Inc

Print or Stamp Name of Physician, Medical Group, or Association Name

***Print Patient's Name**

(If representative, print name and relationship to patient)