PATIENT INFORMATION

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL:_____

ADDRESS: _____ CITY: _____STATE: _____ ZIP:_____

MAILING ADDRESS (IF DIFFERENT INCLUDE CITY STATE AND ZIP CODE)

_____

SS#: _____ DATE OF BIRTH: _____ MALE ___ FEMALE ___ M S W D

OCCUPATION: _____ EMPLOYER: _____

HOME NUMBER: _____ CELL NUMBER:_____ WORK NUMBER:_____

EMAIL: _____ @ _____

RACE: _____ ETHNICITY: _____ LANGUAGE:_____

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RESPONSIBLE PARTY INFORMATION (FOR MINORS OR PATIENTS INSURED UNDER FAMILY MEMBER INSURANCE)

RESPONSIBLE PARTY/PARENT NAME: _____ RELATIONSHIP TO PATIENT: _____

SS#: _____ DATE OF BIRTH: _____ OCCUPATION: _____

SECOND PARENT NAME: _____ RELATIONSHIP TO PATIENT: _____

SS#: _____ DATE OF BIRTH:_____ PHONE NUMBER: _____

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SPOUSE (IF DIFFERENT FROM RESPONSIBLE PARTY): _____ DATE OFBIRTH:_____

SS#: _____ PHONE NUMBER _____

****

EMERGENCY CONTACT (IF WE CAN NOT REACH YOU IMMEDIATELY)

NAME: _____ PHONE: _____

PREFERRED PHARMACY NAME AND CROSS STREET:

_____

PRIMARY CARE PROVIDER:___ _____

YOUR SIGNATURE IS NECESSARY TO PROCESS ANY INSURANCE CLAIMS AND TO ENSURE PAYMENT OF SERVICES RENDERED: I authorize the release of all medical information necessary to process this claim and that is pertinent to my medical care. I assign all medical and or surgical benefits, including major medical benefits to which I am entitled to Desert Cities Allergy/Otolaryngology. A photocopy of this is to be considered as valid as the original.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES. I HAVE READ THIS INFORMATION AND UNDERSTANT IT.

PATIENT OR GUARDIAN SIGNATURE:_____ DATE:___ _____

DESERT CITIES ALLERGY/OTOLARYNGOLOGY INC.

OFFICE POLICY

Dear Patients

Note: read through ALL policies, it contains important information

In response to the complex healthcare industry, we have taken steps to optimize our operations in order to spend more time on patient care and less time on administration. This will require your help. Please carefully read the items below as they will be strictly enforced. Our goal is to provide high quality, compassionate and timely healthcare.

1. There will be a $25.00 charge for all appointments not kept or rescheduled at least 24 hours prior to your visit. ($50 for Saturday apt.) There will be a $50.00 charge for all allergy test appointments not kept or rescheduled 48 hours prior to your visit. If you are scheduled for surgery there will be a $100.00 charge for all surgery appointments not kept or rescheduled at least 1 week in advance.
2. Know your insurance plan. Many visits may not be covered. It is incumbent upon you to know what your benefits are. Our office cannot keep up with the changed in your health plans. If your insurance changes you are responsible for notifying our office of this change.
3. Copayments, Deductibles, and Coinsurance payments are due at the time of service. We do not bill for copayments. We accept cash and credit card payments no checks under $100.00.
4. There is an additional charge to fill out all forms and for any administrative requests to include copying medical records.
5. There is a charge for all returned checks
6. All pharmacy refill requests should be done by calling your pharmacy and asking them to fax our office a refill request. This should be done before you are out of your medication.
7. You must update us with new address and telephone information immediately. You also need to inform us of any name changes and new paperwork will need to be completed.
8. In an effort to help our allergy patients, we ask everyone not to wear perfume/cologne etc. when coming into our office, we appreciate your cooperation.
9. Reminder calls are not always done, even when we do not call, patients are responsible for remembering their appointments.
10. Due to limited space in the office, we ask that you only bring one person with you to your apt, besides the patient.

I have read and agree to follow the above mentioned guidelines.

Patient Name (please print)	Patient/Guardian's signature	Date

Desert Cities Allergy/Otolaryngology, Inc.

Eligibility Form

Patient Name _____ Date of Birth _____

Insurance Information

Your Insurance is a method for you to receive reimbursement for fees you have paid to the physician for services rendered. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based on your contract with them, not with our office. It is your responsibility to pay deductible, co insurance, and any other balances not paid by your insurance as per your contract. We will assist you in receiving reimbursement as much as possible, but you are responsible for your bill.

I am enrolled with _____ my coverage began _____

(Name of Insurance) (Date of Eligibility)

_____ _____

Subscriber's Name Printed Subscriber or Responsible Party

_____ _____

Subscriber ID # Group #

I understand that if my eligibility has not been established within the next 60 days, I or the person financially responsible for me will assume full responsibility for all charges incurred by myself. I agree that the above information is true and accurate. If I have submitted false information, I or the person financially responsible for me will pay in full all such charges, within 30 days.

_____ _____

Signature (Patient or Parent) Date

DESERT CITIES ALLERGY, EAR, NOSE & THROAT, INC.

Majid Torabi, M.D., F.A.C.S.
Board Certified Otolaryngology, Head & Neck Surgery
Also specializing in Allergy, Sinus & Immunology

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 shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, 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.
Filing by Physician 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. However, following the assertion of any claim against Physician, 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 by US mail postage prepaid to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees, and expenses, along with a pro rata share of the neutral arbitrator's fee and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision (s) of this Agreement is declared void and/or unenforceable, such provision (s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California Law.

I understand that I have the right to receive a copy of this 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 Duly Authorized Representative Signature (Date)

By: _____
Patient's Signature (Date)

By: _____
Print or stamp Name of Physician, Medical Group or Association Name

_____
Print Patient's Name

By: _____
Signature of Translator (if applicable) (Date)

By: _____
Patient's Representative's Signature (if applicable) (Date)

_____
Print Name of Translator

_____
Print name and Relationship to Patient