PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical practice, that 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 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 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 jurisdiction 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 limitations, 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. However, following the assertion of any claim against the 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 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 thereafter. 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 incurred by a party for such party's own benefit.

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 addition 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 333.1 and 333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

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 of 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 arbitration 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 and if not revoked will govern all medical services received by the patient.

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 or Patient's Representatives 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: _____ Date _____

Physician's or Duly Authorized Representative's Signature

_____

Print or Stamp Name of Physician or representative

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

By:_____ Date _____

Patient's Signature

_____

Print Patient's Name

By:_____ Patient's Representative Signature Date _____

_____Print Name and Relationship to Patient

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from this hospital.

We will use your health information for payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. Tin's information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At Aspire Pain Medical Center, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective 01/01/2013, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Aspire Pain Medical Center, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves us a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Aspire Pain Medical Center, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,

- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Aspire Pain Medical Center is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem If you have questions and would like additional information, you may contact the practice's Privacy Officer. If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W. Room 509F, HHH Building
Washington, D.C. 20201

OFFICE POLICY

PAYMENT IS DUE WHEN SERVICE IS RENDERED. We will bill most insurance companies for you as a courtesy, provided we have all the necessary information. It is your responsibility to verify with your insurance carrier as to whether you are covered for the medical services provided to you, e.g. physician consults, epidurals, facet blocks, IDET. Any deductibles, co-payments, or balances not paid by the insurance company are your financial responsibility. This applies to all insurances including Medicare.

CO-PAYMENTS AND DEDUCTIBLES ARE DUE WHEN SERVICES ARE RENDERED. Insured patients are responsible for all charges not paid by the insurance company within 45 days after the date of service. Payment arrangements can be made on an individual basis AT OUR DISCRETION. We reserve the right to withdraw the extension of credit.

CANCELLATION POLICY. Patients who fail to cancel an appointment within 24 hours of the appointment time will be subject to a $100.00 fee billed directly to the patient.

RETURNED CHECKS POLICY. PLEASE BE ADVISED THERE IS A SERVICE FEE OF $25 ON ALL RETURNED CHECKS.

PATIENT AGREEMENT AND ASSIGNMENT OF INSURANCE BENEFITS. I agree to pay reasonable attorney's fees and costs should legal proceedings be necessary to collect any portion of the bill or to enforce this agreement. I also agree to permit any Physician to consult with any other Physician should he/she believe it necessary and I agree to pay for said consult. If any surgical procedures are to be performed, I authorize my Physician to engage the services of another Physician and I agree to pay for said services. I hereby authorize my Physician to release any information acquired in the course of my examination and treatment. I further authorize payment of insurance benefits to be paid directly to my Physician.

AGREEMENT TO DISCLOSE INFORMATION. I hereby state that my ailment, injury (ies), etc., are not due to any type of personal injury, motor vehicle accident, etc., for which I am seeking damages. I agree that if at any time after receiving treatment as a direct result of any type of motor vehicle accident or personal injury, I will disclose this information to Aspire Pain Medical Center and sign the appropriate lien (s) in favor of Aspire Pain Medical Center. I understand that the disclosure of insurance and other information is necessary in order that the services I receive are paid in full. The non-disclosure of the information to Pasadena Rehabilitation Institute pertaining to my legal case for said injury might make me personally responsible for all charges incurred at Pasadena Rehabilitation Institute.

Initial _____

CONSENT TO TREATMENT. I understand that the treatment to be received by me at Aspire Pain Medical Center will be administered only upon full and complete disclosure of benefits, potential risks, and complications of said treatments, and that my informed consent to the treatment to be received by me will not be obtained prior to my receiving said treatment. Each of the physicians working at Aspire Pain Medical Center uses his or her independent medical judgment when providing you with medical care. The physician seeing you is responsible for the medical care you receive at Aspire Pain Medical Center.

I declare under penalty of perjury under the laws of the State of California that I have read the foregoing, that I understand it, and that by executing this document on this ____day of _____, 201__, in the City of Newport Beach, I accept and agree to its contents.

Patient's Signature _____ Date of Birth _____

Print Name _____ Date _____

Parent/Guardian _____ Date _____

Name:_____ **Date:** _____

Medication Information

Please indicate if you are taking any of the below medications and what the dosage/frequency is:

Generic Name	**Brand name**	**Dosage**
□Buprenorphine	Buprenex	
□Butorphanol	Stadol	
□Codeine		
□Fentanyl	Abstral, Actiq, Fentora, Onsolis	
□Hydrocodone	Vicodin, Norco	
□Hydromorphone	Dilaudid, Dilaudid-5, Dilaudid HP, Hydrostat IR, Exalgo	
□Levorphanol	Levo-Dromoran	
□Meperidine	Demerol	
□Methadone	Dolophine, Methadose	
□Morphine	Astramorph PF, AVINZA, Duramorph, Kadian, MS Contin, MSIR, Oramorph SR, Rescudose, Roxanol	
□Nalbuphine	Nubain	
□Oxycodone	OxyContin, Roxicodone	
□Oxymorphone	Numorphan	
□Pentazocine	Talwin	
□Propoxyphene	Cotanal-65, Darvon	
□Tapentadol	Nucynta	
□Tramadol	Rybix, Ryzolt, Ultram	

Additionally, if you are taking any Benzodiazepines (for example, Valium, Xanax, Ativam, Klonopin, etc.) please indicate below which medications as well as the dosage and frequency:

Name	Dosage	Frequency

Please indicate the same for any oral muscle relaxants (for example Soma, Flexeril, etc.) you are taking:

Name	Dosage	Frequency

Oswestry Disability Questionnaire **Name:**_____ **Date:**_____

This questionnaire has been designed to give us information as to how your pain is affecting your ability to manage in everyday life. Please answer by checking **one box in each section** for the statement which best applies to you. We realize you may consider that two or more statements in any one section apply but please just shade out the spot that indicates the statement **which most clearly describes your problem.**

Section 1: Pain Intensity

□ I have no pain at the moment
□ The pain is very mild at the moment
□ The pain is moderate at the moment
□ The pain is fairly severe at the moment
□ The pain is very severe at the moment
□ The pain is the worst imaginable at the moment

Section 2: Personal Care (eg. washing, dressing)

□ I can look after myself normally without causing extra pain
□ I can look after myself normally but it causes extra pain
□ It is painful to look after myself and I am slow and careful
□ I need some help but can manage most of my personal care
□ I need help every day in most aspects of self-care
□ I do not get dressed, wash with difficulty and stay in bed

Section 3: Lifting

□ I can lift heavy weights without extra pain
□ I can lift heavy weights but it gives me extra pain
□ Pain prevents me lifting heavy weights off the floor but I can manage if they are conveniently placed eg. on a table
□ Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned
□ I can only lift very light weights
□ I cannot lift or carry anything

Section 4: Walking*

□ Pain does not prevent me walking any distance
□ Pain prevents me from walking more than1 mile □ Pain prevents me from walking more than 1/2 mile □ Pain prevents me from walking > 100 yards
□ I can only walk using a stick or crutches I am in bed most of the time

Section 5: Sitting

□ I can sit in any chair as long as I like
□ I can only sit in my favorite chair as long as I like
□ Pain prevents me sitting more than one hour
□ Pain prevents me from sitting more than 30 min
□ Pain prevents me from sitting more than 10 min
□ Pain prevents me from sitting at all

Section 6: Standing

□ I can stand as long as I want without extra pain
□ I can stand as long as I want but it gives me extra pain
□ Pain prevents me from standing for more than 1 hr
□ Pain prevents me from standing for more than 30 min
□ Pain prevents me from standing for more than 10 min
□ Pain prevents me from standing at all

Section 7: Sleeping

□ My sleep is never disturbed by pain
□ My sleep is occasionally disturbed by pain
□ Because of pain I have less than 6 hours sleep
□ Because of pain I have less than 4 hours sleep
□ Because of pain I have less than 2 hours sleep
□ Pain prevents me from sleeping at all

Section 8: Sex Life (if applicable)

□ My sex life is normal and causes no extra pain
□ My sex life is normal but causes some extra pain
□ My sex life is nearly normal but is very painful
□ My sex life is severely restricted by pain
□ My sex life is nearly absent because of pain
□ Pain prevents any sex life at all

Section 9: Social Life

□ My social life is normal and gives me no extra pain
□ My social life is normal but increases the degree of pain
□ Pain has no significant effect on my social life apart from limiting my more energetic interests e.g. sport
□ Pain has restricted my social life and I do not go out as often
□ Pain has restricted my social life to my home
□ I have no social life because of pain

Section 10: Traveling

□ I can travel anywhere without pain
□ I can travel anywhere but it gives me extra pain
□ Pain is bad but I manage journeys over two hours
□ Pain restricts me to journeys of less than one hour
□ Pain restricts me to short necessary journeys under 30 minutes
□ Pain prevents me from traveling except to receive treatment