WELCOME TO OCEAN MEDICAL

Account #

version 032113

PATIENT INFORMATION (Please Answer All Questions Legibly)

NAME (Last, First, Middle Initial)	Birthdate	Age	Social Security #

Sex: Male _____ Female _____ Marital Status: Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Home Street Address (P.O. Boxes are NOTacceptable)			
City	State	Zip Code	Home Phone #

Driver's License #	Cell #	Email	If Visiting From Out of Town, Local Phone # and Address

PATIENT'S EMPLOYMENT INFORMATION - IF STUDENT, NAME OF SCHOOL

Name of Employer or School		Occupation	
Employer Address			
City	State	Zip Code	Work Phone #

FINANCIALLY RESPONSIBLE PARTY - IF SAME AS PATIENT CHECK HERE ☐ IF DIFFERENT THAN PATIENT COMPLETE THIS SECTION

NAME (Last, First, Middle Initial)	Birthdate	Age	Social Security #
Home Street Address (P.O. Boxes are NOTacceptable)			
City	State	Zip Code	Home Phone #

Driver's License #	Cell #	Email	If Visiting From Out of Town, Local Phone # and Address

Employer	Employer Street Address		
City	State	Zip Code	Work Phone #

Method of Payment Cash _____ Check _____ Credit Card _____ Travelers Check _____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Company	Insured's Name (Last, First, Middle Initial)		Insured's Social Security #
Group #	Subscriber #	Insured's Birthdate	Do you have a Prescription Plan?
Annual Deductible Amount	Has PATIENT'S deductible been met for this year?	Co-Payment amount	Insurance Benefit (e.g. 80/20)

SECONDARY INSURANCE INFORMATION - OCEAN MEDICAL DOES NOT ACCEPT HMO PLANS AS SECONDARY INSURANCE

Name of Secondary Insurance Company	Insured's Name (Last, First, Middle Initial)		Insured's Social Security #
Group #	Subscriber #	Insured's Birthdate	Do you have a Prescription Plan?
Annual Deductible Amount	Has PATIENT'S deductible been met for this year?	Co-Payment amount	Insurance Benefit (e.g. 80/20)

REFERRAL INFORMATION

_____ Doctor: _____ _____ Internet _____ Employer

Phone #: _____ _____ Yellow Pages _____ Sign on Building

_____ Friend/Family _____ Other: _____

Emergency Contact Name (Last, First, Middle Initital	Phone #	Relationship

FINANCIAL AGREEMENT - READ BEFORE SIGNING

I Understand That Fees Are Payable When Service Is Rendered Unless Prior Arrangements Have Been Made. I Understand That I Am Financially Responsible For All Charges Whether Or Not Covered By Insurance. Payment For Services Rendered To Me And/Or My Dependents Will Not Be Delayed Or Withheld Because Of Pending Insurance Claims. I Understand That I Am Financially Responsible For Any Collection Agency Costs Or Legal Costs Resulting From Any Delays. I Authorize Payment of Medical Benefits To Ocean Medical Provider of Services.

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MY CLAIM.

Signature _____ Date _____ Relationship to Patient _____

Received By:	Entered By:	Date Entered:

PHYSICIAN-PATIENT ARBITRATION & COPYRIGHT WAIVER 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 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 mothers' 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 U.S. 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 Sec. 1280-1295 and the Federal Arbitration Act (9 U.S.C. Sec. 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees 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.

Article 7: Copyright waiver: I understand that any written information or reviews of Ocean Medical Family & Urgent Care, Inc. ("Ocean Medical") including all staff and providers are waived as the intellectual property rights of the person who wrote the review are upon signature, the copyright intellectual property of Ocean Medical. I agree in the event that if I am unsatisfied with my visit I will not post online comments to that effect but will address them in letter to the Office Manager to better help with your grievance. Websites acting as platforms for outside commentary are not liable for defamation suits however you are responsible for any defamation or slander of Ocean Medical and its staff. It is understood that web sites are subject to copyright laws and must abide by those laws for this waiver agreement. This waiver is written for which I agree to assign copyright to all Ocean Medical reviews to Ocean Medical Family & Urgent Care, Inc. In addition, Ocean Medical has ownership of any anonymous review and will in turn require that such an online review Ocean Medical deems necessary that by designated staff may remove the review(s). This copyright waiver negates any Terms of Service agreement you have entered into with any internet site company.

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) AND THAT ANY WRITTEN COMMENTS ARE THE PROPERY AND COPYRIGHT OF OCEAN MEDICAL.

By: _____
Physician's or Duly Authorized Representative Signature (Date)

By: OCEAN MEDICAL FAMILY & URGENT CARE

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

_____
Print Name of Translator

By: _____
Patient's Signature (Date)

_____
Print Patient's Name

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

_____
Print Name and Relationship to Patient

A signed copy of this document is to be given to the patient. The Original is to be filed in Patient's medical records.

Ocean Medical
FAMILY & URGENT CARE
1106 S. Pacific Coast Highway
Redondo Beach, CA 90277-4902
Phone: 310-316-1661 Fax: 310-316-1846

NOTE: THE APPROPRIATE AUTHORIZATIONS MUST BE SIGNED TO EXPEDITE THE FILING OF YOUR INSURANCE CLAIM.

[ ] AUTHORIZATION AND AGREEMENT: By my signature below, I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due me under my insurance plan. I agree to pay the balance of charges not paid under my plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment and payment (including to my insurance company). Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. IF I AM UNINSURED, I understand I am fully responsible for all charges.

Patient Signature: _____ Date: _____

[ ] **AUTHORIZATION AND CONSENT FOR MEDICAL AND SURGICAL TREATMENT:** By my signature below, I hereby authorize Ocean Medical to furnish the necessary medical or surgical treatment, or procedures, including diagnostic x-ray and laboratory procedures, anesthesia, drugs and supplies as may be ordered by the attending physician(s), his assistants or designees. I am aware that the practice of medicine and surgery is not an exact science, that I have been explained the risks associated with the treatment/procedures to be performed, and I acknowledge that no guarantees have been made to me as to the result of treatment or diagnostic procedures conducted at Ocean Medical.

Patient Signature: _____ Date: _____

[ ] MEDICARE B SIGNATURE AUTHORIZATION: By my signature below, I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services or it's intermediaries or carriers, or to the billing agent of Ocean Medical any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any deductible and coinsurance.

Patient Signature: _____ Date: _____

Version 3/20/13

PATIENT CONTACT INFORMATION/RESTRICTION

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home. I wish to be contacted in the following manner (check all that applies):

___ Cell Phone ( ) _____
- ___ O.K. to leave messages with detailed information
- ___ Leave message with call back number only

___ Home Telephone ( ) _____
- ___ O.K. to leave messages with detailed information
- ___ Leave message with call back number only

___ Work Telephone ( ) _____
- ___ O.K. to leave message with detailed information
- ___ Leave message with call back number only

___ Written Communication
- ___ O.K. to fax ( ) _____

___ Other _____

APPOINTMENT CONFIRMATION WILL BE MADE TO HOME NUMBER

I hereby consent to the release of Protected Health Information to the following individuals. I understand this authorization will be in effect until it is revoked. I acknowledge receipt of the Notice of Privacy Practices.

Name	Relationship
_____	_____
_____	_____

_____ Patient Signature

_____ Date

_____ Print Name

_____ Date of Birth