PHOENIX
Medical Associates

Dr. Maryam Amini
1399 Ygnacio Valley Road #14
Walnut Creek, CA 94598
(925) 934-4123

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 Arbitrate: 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 jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, 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 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 e 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 issue 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 dispute within this arbitration agreement, including, but not limited to, Code of Civil Procedure §667.7, Civil Code §3333.1 and §3333.2.

Article 4: General Provision: 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 limitation, 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 patients.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

_____
Patient'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.

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 TRAIL. SEE ARTICLE 1 OF THIS CONTRACT.

Phoenix Advanced Medical Associates
1399 Ygnacio Valley Rd., Suite 14, Walnut Creek, CA 94598
Phone: 925-934-4123 Fax: 925-934-4125

_____
Maryam Amini, M.D.

_____
Patient (Date)

_____
Physician

_____
Print Name

_____
Patient's Agent or Representative (Date)

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Acknowledgement of Privacy Policy

I have been advised of Phoenix Advanced Medical Associates Office Privacy Policy. A copy of the Policy is available upon request to review or retain.

Insurance Authorization

I authorize release of any medical or other information necessary to all my insurance companies. I understand I am responsible for my billing including deductible and co-pays. I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies. I authorize payment directly to the provider.

Lab Testing

It may be necessary for the office to do additional tests which will be sent to an outside lab. The fees for these tests are separate from the fees for your office visit, and are payable directly to the lab by you. If we have your current insurance information on file, we will forward that information to the lab. If your claim is denied, the lab will send you a bill for their services. We are not affiliated with the lab billing.

Copy Records Fee

Due to increased paperwork in the office, we are no longer able to copy records on a courtesy basis. Payment is required prior to picking up copied records , or when copied records are picked up.

A signed Records Release Form is required and the copy fee is 25 cents per page.
Postage will be additional if records are mailed, payable prior to mailing records.

I have read and understand the above information.

Patient Signature: _____ **Date:**_____

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PATIENTS INFORMATION

Who referred you to this office? _____

Other MD's:

❑ Mr ❑ Miss ❑ Mrs. ❑ Ms. _____
Last Name: First Name: MI:

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name? (Former name): _____

Marital status (Circle One) Single / Mar / Div / Sep / Wid

Birth Date: Age: Sex: ❑ M ❑ F Social Security Number: _____

Address: _____ City: _____ State: _____ Zip Code:_____

Home Phone:_____Cell Phone: _____

E-mail: _____

Current Occupation:_____ Employer: _____ Work Phone Number: _____

INSURANCE INFORMATION

Primary Insurance: _____

Secondary Insurance: _____

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address): _____

Relationship to patient: _____ Phone #: _____ Work Phone #: _____

The above information is true to the best of my knowledge. I hereby authorize all insurance benefits to be paid to Phoenix Advanced Medical Associates. I understand that I am responsible for charges as designated by my insurance companies (e.g., deductibles, co-payments). I am also responsible for all charges not covered by insurance, and for any finance fees incurred on unpaid balances. I authorize Phoenix Advanced Medical Associates to release any information to my insurance companies when requested by them.

Patient/Guardian Signature: _____ Date: _____

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We are currently updating our system and we need some more information for your chart. Please fill out as much as possible. Thank you.

Name:_____

DOB:_____

In the future, may we send you text messages just to remind you of your appointments?

_____

Cell Phone Number:_____

Cell Phone Carrier:_____

Pharmacy Information

Name of Pharmacy:_____

Address:_____

City:_____ Zip:_____

Phone Number:_____

Fax Number:_____

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Pt Name: Date:

FINANCIAL AGREEMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy or your financial responsibility.

Patients must fill out Patient Information Forms PRIOR to seeing the doctor. We will request to photocopy your insurance card(s) for your file.

Appointments ~ 24 hour notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a **cancellation fee of $50** may then be added to your account.

Referrals ~ If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have your referral, YOU WILL BE REQUESTED TO SIGN A FINANCIAL WAIVER. It is then your responsibility to provide us with the referral within 48 hours or you will be personally responsible for that day's services.

Co-Payments ~ By law we MUST collect your carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. Should you not pay at the time of service and we subsequently send you a statement, an administrative fee of $20 may be added to your account.

Deductibles ~ By law we MUST collect any amount designated by your insurance that is labeled as a deductible. If it is your first time being seen in the office we will collect a security deposit of $150. If insurance pays for the visit in full, you will receive a refund.

Out of Network Plans ~ You will be responsible for any balance your plan indicates as due on their explanation of benefits form. We will adjust the charges to coincide with your plan's UCR (Usual, Customary and Reasonable) charges. All patients will be responsible for their co-insurance and deductible. If we do not 'participate' with your plan, we will send a courtesy bill to that carrier on your behalf. However, should they not pay your claim within 45 days, you will be responsible for the full amount due. Should you receive payment from your insurance carrier, please forward it to the physician's office. Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to **Phoenix Advanced Medical Associates** for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I also authorize any holder of medical information about me to be released to my insurance company (or their agent) information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administrating claims of benefits.

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Self-Pay Patients ~ Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

Medicare ~ We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one. Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to **Phoenix Advanced Medical Associates** for any services furnished to me. I authorize any holder of medical information about me to release to the CMS (and its agents) any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits.

Divorced/Separated Parents of Minor Patients ~ The parent who consents to the treatment of a minor child is responsible for payment of services rendered, **Phoenix Advanced Medical Associates,** will not be involved with separation or divorce issues.

Check Payments ~ If you decide to make a payment by check and its received back due to NSF (Non-Sufficient Funds), a additional charge of **$100** will be added to your account.

You are responsible for the timely payment of your account. Should it be necessary for us to use an outside agency to collect payment from you, you will be additionally responsible for whatever charges we incur as a result of this.

We accept CASH, CHECK, & CREDIT

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us any special concerns.

Patient's Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

Responsible Party Print Name: _____ Relationship: _____