ProHealth
Occupational Medical Group

Patient Registration Form

Date/*Fecha*: _____/_____/_____ **Reason for visit/***Razon por visita*:_____

Patient Information/*Informacion de paciente*

Name/*Nombre*:_____ **Social Security/***Seguridad Social*:_____

Street Address/*Domicilio*:_____ **Birth Date/***Fecha De Nacimiento*: _____

City/*Cuidad*:_____ **State/***Estado*:_____ **Zip/***Codigo Postal*:_____ **Age/***Edad*: _____ **Sex/***Sexo*: ☐**M** ☐**F**

Home Phone #/*Numero de Casa*:_____ **Cell Phone #/***Numero de Celular*:_____

Cell Carrier/*Compania de Cellular*:_____ **DL#/***Numero de Licencia*:_____

Occupation/*Ocupacion*: _____ **Email**: _____

Marital Status/*Estado Civil*: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed**

Emergency Contact Name/*Contacto de Emergencia*: _____ **Relation/***Relacion*:_____

Emergency Contact Phone #/*Numero de Contacto*:_____

Patient Employer Information

Employer Name/*Nombre de Empleador*: _____ **Department/***Departamento*:_____

Employer Phone #/*# de Empleador*:_____

Business Street Address/*Direccion de Empleador*:_____

City/*Cuidad*:_____ **State/***Estado*:_____ **Zip/***Codigo Postal*:_____

Supervisor Name/*Nombre del Supervisor*:_____ **Supervisor Email**:_____

Supervisor Phone #/*Telefono de su supervisor*:_____ **Employee #**:_____

Insurance

Is your private insurance or employers workers compensation insurance responsible for your visit?
Quien es responsable para su cita hoy? Su insurancia privada? O la insurancia del empleador?

☐**Private Insurance** / ☐**Employer Workers Comp Insurance** / **Name of insurance**:_____

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Patient Medical History

Patient Name/Nombre:_____ **Date/**Fecha**:**_____

Patient Signature/Firma**:**_____ **Account #:**_____

Yes	No	List allergies you have:
		Allergies (specify)

Yes	No	List medications you take:
		Medications (specify)
		1.
		2.

Yes	No	Do you have any of the following?
		Cancer (specify type):
		Asthma
		Heart Disease(CAD)
		Stroke (CVA)
		Depression/Anxiety
		Diabetes
		Hypertension
		Other:

Yes	No	Have you had Surgeries or Operations?
		Specify:

Yes	No	Does your family have any of the following?		
		Cancer or Leukemia	☐ Father	☐ Mother
		Diabetes:	☐ Father	☐ Mother
		Heart Disease:	☐ Father	☐ Mother
		High Blood Pressure	☐ Father	☐ Mother
		Strokes:	☐ Father	☐ Mother

Yes	No	Do you use alcohol, drugs, or smoke?
		Tobacco Use: How much? _____ Week
		Alcohol Use: How much? _____ Week
		Drug Use: Describe drug & use: _____

Yes	No	Are you employed?
		How long employed? _____
		Position? _____

Yes	No	Menstrual History
		Are you pregnant?
		Last menstrual date?
		Last pap smear date?

Left or right handed? ☐Left ☐Right

Last tetanus shot date? _____

Please check your symptoms

Constitutional	Yes	No	**Cardiovascular**	Yes	No	**Neurological**	Yes	No	**Genitourinary**	Yes	No
Change in appetite			Chest Pain/ Pressure			Headache			Discharge		
Chills			Fainting			Weakness			Frequent Urination		
Fatigue			Irregular Heart Beat			Numbness			Nighttime Urination		
Fever			**Gastrointestinal**			Poor Balance			Painful Urination		
Sweats			Abdominal Pain			Tingling			**Skin**		
Weight loss			Constipation			**Musculoskeletal**			Easy Bruising		
Eyes & Vision			Diarrhea			Joint Pain			Rash/itching		
Blurred/Double			Nausea			Muscle Pain			Skin Sores		
Glasses/Contacts			Vomiting			Swelling			**Endocrine**		
Eye Discharge			**Ears, Nose,Throat**			**Hematologic**			Excessive Hunger		
Eye Pain			Dizziness			Frequent Infections			Excessive Thirst		
Respiratory			Ear Pain			Swollen Glands			Heat/Cold intolerance		
Congestion			Nasal Congestion			**Immune System**					
Cough			Sore Throat			Allergies			**Psychiatric**		
Shortness of Breath									Anxiety/nerves		
Wheezing									Depression		

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Historia Medica De Lastimadura

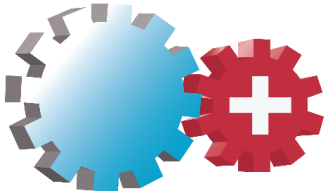
Patient Name/Nombre:_____ **Date/**Fecha**:**_____

Patient Signature/Firma**:**_____ **Account #:**_____

Si	No	De que alergias padece
		Allergias (especifique)
Si	No	List medications you take:
		Medicamentos (especifique)
		1.
		2.
Si	No	Padece de lo siguente?
		Cancer (Que tipo):
		Asma
		Enfermedad del Corazon
		Ataque Fulminante
		Deprecion/Ancieda
		Diabetes
		Diverticulitis
		Hiperlipidemia
		Hipertencion
		Hipertiroidismo
		Ulcera Peptica
		Algun Otro:
Si	No	A tenido operaciones o sirugias?
		Especifique:

Si	No	Does your family have any of the following?		
		Enfermedades de la sangre	☐ Padre	☐ Madre
		Cancer or Leucemia	☐ Padre	☐ Madre
		Diabetes:	☐ Padre	☐ Madre
		Enfermedades del Corazon:	☐ Padre	☐ Madre
		Alta Precion:	☐ Padre	☐ Madre
		Ataque Fulminante:	☐ Padre	☐ Madre
		Enfermedad Mental:	☐ Padre	☐ Madre
Si	No	Consume Alcohol, Usa Drogas, o Fuma?		
		Uso de Tobaco: Cuanto? _____ por semana		
		Consume alcohol: Cuanto? _____por semana		
		Usa Drogas: Describe el uso y tipo _____		
Si	No	Tiene Empleo?		
		Cuanto tiempo tiene trabajando? _____		
		Capacidad? _____		
Si	No	Ciclo Menstrual		
		Esta embarazada?		
		Fecha de ultimo ciclo menstrual?		
		Fecha de la ultima prueba de Papanicolaou?		
Mano Dominante?		☐Zurdo	☐Derecho	
Fecha de la ultima prueba de tetanus? _____				

Please check your symptoms											
Constitucional	Si	No	**Cardiovascular**	Si	No	**Neurologico**	Si	No	**Genitourinary**	Si	No
Cambio en apetito			Dolor/Precion de pecho			Dolor de Cabeza			Desecho		
Escalofrio			Desmayos			Mareos			Orinafrecuentemente		
Fatiga			Latidos irregulars			Adormecimiento			Orina por la noche		
Fiebre			**Gastrointestinal**			Problemas Equilibrio			Dolor cuando orina		
Sudores			Dolor Abdominal			Hormigueo			**Piel**		
Perdida de peso			Estrenimiento			Debilidad			Moretea facilmente		
Ojos y Vision			Diarrea			**Musculoesqueletico**			Zarpullido/Comezon		
Borrosa o doble			Nausea			Dolor en las coyunturas			Rojez		
Lentes/Contactos			Vomito			Dolor de musculo			Llaga en la piel		
Secrecion Ocular			**Oidos, Nariz, Garganta**			Hinchazon			**Sistema Endocrino**		
Dolor en el ojo			Mareos			**Sistema Inmunologico**			Hiper/ hipotiroidismo		
Respiratorio			Dolor de oido			Fiebre del heno					
Congestion			Congestion nasal			Alergias			Intolerancia		
Tos			Secrecion Nasal			**Hematologica**			**Psiquiatrico**		
Falta de aliento			Estornudos			Infecciones frecuentes			Ansiedad/ Nervios		
Resollar			Dolor de Garganta			Hinchazon de glandulas			Depresion		



ProHealth
Occupational Medical Group

Consent For Medical Services And Financial Agreement

1. I attest that all information provided is correct to the best of my knowledge. I authorize the release of any medical information necessary to proceed with my treatments and also to process my medical claims.
2. FINANCIAL DISCLOSURE: Dr. Soheil Younai has financial interest in this facility. If you or the provider have any objections, please notify us so that we can refer you to other facilities.
3. INDEPENDENT MEDICAL PROVIDER: Your care at this facility will be managed by your doctor, surgeon, and other medical providers, some of which are not employed by this center but have privileges to care for you at this facility. Although this medical facility provides support for these independent healthcare providers, it neither dictates your care, nor is responsible for their actions. I acknowledge and hold harmless this facility for any and all of my independent medical provider's actions.
4.MEDICAL CONSENT: The undersigned consent authorizes any medical treatment, examination, Laboratory procedure, x-ray examination, or physical therapy that may be considered advisable or necessary for the patient in the judgement of the attending physicians.
5. FINANCIAL AGREMENT: The undersigned agrees, whether signing as a patient or agent, that in consideration of the services to be rendered to the patient, the undersigned shall have the obligation to pay the account of the patient with **ProHealth Valley Occupational Medical Group** in accordance with the Regular rates and terms of the **ProHealth Valley Occupational Medical Group** as in effect. Such account shall be due and payable at the time of discharge unless other arrangements are approved in writing prior to such arrangements. If the patient's account is not paid when due it shall bear interest from the due date at the maximum for the account of the patient on any deferred basis, and payment is not made when due **ProHealth Valley Occupational Medical Group** shall have the immediate right to charge such sum to the credit cards of the undersigned listed hereon, the undersigned's signature(s) herein constituting complete authorization to **ProHealth Valley Occupational Medical Group** to charge such of credit cards. If the patient's account is referred to a collection agency and/or an attorney for collection, the undersigned shall pay all attorneys' fees for costs of collection.
6. MEDICARE: Patient's Certification, Authorization to Release Information, and Payment Request: The undersigned certifies that the information given in applying for payment under Title XVIII of the Social Security Act is correct. The undersigned authorizes any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or carriers any information needed for this or any related Medicare claim. The undersigned requests that payment of authorized benefits be made on the patient's behalf.
7. RELEASE OF INFORMATION: **ProHealth Valley Occupational Medical Group** may disclose all or any part of the patient's record to any person or corporation which is or may be liable under a contract to **ProHealth Valley Occupational Medical Group** or to the patient or to a family member or employer of the patient for all or part of the **ProHealth Valley Occupational Medical Group** charges, including, but not limited to, hospital or medical service companies, workmen's compensation carriers, welfare funds, or the patient's employer. All such information would be available after a written request and the approval of the attending physician.
8. RELEASE OF MEDICAL RECORDS: The undersigned authorizes the release of information in the patient's medical records to his/her private physician and to any physician, hospital, or agency to which **ProHealth Valley Occupational Medical Group** refers the patient. The undersigned also authorizes any physician, hospital, or agency to which the patient is referred to the release of information to **ProHealth Valley Occupational Medical Group** regarding treatment by said physician, hospital, or agency.
9.DISCLOSURE: The x-ray and physical therapy departments are owned and operated by **ProHealth Valley Occupational Medical Group. ProHealth Valley Occupational Medical Group** bills for services provided by the Orthopedist and other Specialists performing services in this clinic inclusive of the EMH nerve conduction studies.
10. INSURANCE ASSIGNMENT: The undersigned hereby authorizes payment directly to **ProHealth Valley Occupational Medical Group** of any benefits payable to the patient including disability insurance and payment under Title XVIII of the Social Security Act, which is applicable to the patient's account. The undersigned understands that he/she is financially responsible to **ProHealth Valley Occupational Medical Group** for the charges not covered by the patient's insurance plan.
11. RELEASE FOR FUTURE CONTACT: The undersigned hereby authorizes **ProHealth Valley Occupational Medical Group's** staff to contact the patient for information relating to the patient's medical condition.

The undersigned certifies that he/she has read the foregoing and is the patient, or duly authorized by the patient as patient's general agent to execute the above and hereby accepts its terms.

_____ _____
Patient Signature **Date**

_____ _____
Witness **Date**

Husband, Wife, Guardian or Nearest Relative, Or Person Assuming Responsibility for the account

ProHealth
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Consentimiento para servicios médicos y acuerdo financiero

1. Doy fe de que toda la información proporcionada es correcta a mi leal saber y entender. Autorizo la divulgación de cualquier información médica necesaria para continuar con mis tratamientos y también para procesar mis reclamos médicos.
2. DIVULGACION FINANCIERA: El Dr. Soheil Younai tiene interés financiero en esta instalación. Si usted o el proveedor tienen alguna objeción, notifíquenoslo para que podamos derivarlo a otras instalaciones.
3. PROVEEDOR MEDICAL INDEPENDIENTE: Su atención en este centro será administrada por su médico, cirujano y otros proveedores médicos, algunos de los cuales no son empleados por este centro pero tienen privilegios para cuidar de usted en este centro. Aunque este centro médico proporciona apoyo a estos proveedores de atención médica independientes, no dicta su atención, ni es responsable de sus acciones. Reconozco y eximo de responsabilidad a este centro por todas y cada una de las acciones de mi proveedor médico independiente.
4.CONSENTIMIENTO MEDICAL: El consentimiento suscrito autoriza cualquier tratamiento médico, examen, procedimiento de laboratorio, examen por rayos X o fisioterapia que pueda considerarse aconsejable o necesario para el paciente en el juicio de los médicos asistentes.
5. AGREMENT FINANCIERO: El abajo firmante acuerda, ya sea firmar como paciente o agente, que, en consideración de los servicios que se prestarán al paciente, el abajo firmante tendrá la obligación de pagar la cuenta del paciente con **ProHealth Glendale Occupational Medical Group** de acuerdo con las tarifas regulares y los términos de la **ProHealth Glendale Occupational Medical Group** en vigor. Dicha cuenta deberá pagarse en el momento de la aprobación de la gestión, a menos que se aprueben otros acuerdos por escrito antes de dichos acuerdos. Si la cuenta del paciente no se paga cuando se vence, tendrá intereses a partir de la fecha de vencimiento en el máximo para la cuenta del paciente sobre cualquier base diferida, y el pago no se hace cuando se **ProHealth Glendale Occupational Medical Group** tendrá el derecho inmediato de cargar dicha suma a las tarjetas de crédito de los abajo firmantes enumerados en el presente documento, firma(s) del(los) abajo(s) que constituyen autorización completa para **ProHealth Glendale Occupational Medical Group** para cobrar tales tarjetas de crédito. Si la cuenta del paciente es referida a una agencia de cobro y/o a un abogado para el cobro, el abajo firmante pagará todos los honorarios de los abogados por los costos de cobro.
6. MEDICARE: Certificación del Paciente, Autorización para Divulgar Información y Solicitud de Pago: El abajo firmante certifica que la información dada al solicitar el pago bajo el Título XVIII de la Ley de Seguridad Social es correcta. El abajo firmante autoriza a cualquier titular de información médica u otra información sobre el paciente a divulgar a la Administración del Seguro Social o a sus intermediarios o transportistas cualquier información necesaria para esta o cualquier reclamación relacionada de Medicare. El abajo firmante solicita que el pago de los beneficios autorizados se realice en nombre del paciente.
7. RENUNCIA A LA INFORMACION: **ProHealth Glendale Occupational Medical Group** puede revelar todo o parte del registro del paciente a cualquier persona o corporación que sea o pueda ser responsable bajo un contrato a **ProHealth Glendale Occupational Medical Group** o al paciente o a un familiar o empleador del paciente por la totalidad o parte de los cargos de **ProHealth Glendale Occupational Medical Group,** incluyendo, pero no limitado a, compañías de hospital o servicio médico, compañías de compensación de trabajadores, fondos de bienestar o el empleador del paciente. Toda esta información estaría disponible después de una solicitud por escrito y la aprobación del médico asistente.
8. RENUNCIA DE LOS RECORDADOS MEDICALES: El abajo firmante autoriza la divulgación de información en los registros médicos del paciente a su médico privado y a cualquier médico, hospital o agencia a la que **ProHealth Glendale Occupational Medical Group** remita al paciente. El abajo firmante también autoriza a cualquier médico, hospital u agencia a la que se remite al paciente a la divulgación de información a **ProHealth Glendale Occupational Medical Group** con respecto al tratamiento por parte de dicho médico, hospital u agencia.
9.DISCLOSURE: Los departamentos de rayos X y terapia física son propiedad y son operados por **ProHealth Glendale Occupational Medical Group. ProHealth Glendale Occupational Medical Group** factura por los servicios proporcionados por el Ortopedista y otros Especialistas que realizan servicios en esta clínica, incluyendo los estudios de conducción nerviosa de EMH.
10. ASIGNAMIENTO DE SEGURO: El abajo firmante autoriza el pago directamente a **ProHealth Glendale Occupational Medical Group** de cualquier beneficio pagadero al paciente, incluyendo el seguro de discapacidad y el pago bajo el Título XVIII de la Ley de Seguridad Social, que es aplicable a la cuenta del paciente. El abajo firmante entiende que él / ella es financieramente responsable de **ProHealth Glendale Occupational Medical Group** por los cargos no cubiertos por el plan de seguro del paciente.
11. RENUNCIA PARA EL CONTACTO FUTURO: El abajo firmante autoriza al personal **de ProHealth Glendale Occupational Medical Group** a ponerse en contacto con el paciente para obtener información relacionada con la condición médica del paciente.

El abajo firmante certifica que ha leído lo anterior y es el paciente, o debidamente autorizado por el paciente como agente general del paciente para ejecutar lo anterior y por la presente acepta sus términos.

_____ _____
Firma del paciente **Fecha**

_____ _____
Witness **Date**

Esposo, Esposa, Guardián o Pariente más Cercano, o
Persona asumiendo la Responsabilidad de la cuenta

ProHealth
Occupational Medical Group

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 lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings.

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 of 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 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 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 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 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 application 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 judgement or summer 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 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 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 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's or Patient Representative 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 Authorized Representative's Signature

By: _____ **Date:**_____

Patient's or Authorized Representative's Signature

By:_____

Print Patient's Name

_____

Print or Stamp of Physician Medical Group Association

_____

(If Representative, Print name and Relationship to patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records. (2-08)