

Referred by: \_\_\_\_\_

PATIENT NAME: Last \_\_\_\_\_ First: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Sex: [ ] M [ ] F

Address: \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip Code \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_ Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Other

Date of Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_ at \_\_\_\_:\_\_\_\_ AM / PM Date Last Worked \_\_\_\_\_ Claim #: \_\_\_\_\_

Occupation: \_\_\_\_\_ Previous Treatment: [ ] Yes [ ] No Dominant Hand [ ] Right [ ] Left Auto Accident: [ ] Yes [ ] No

Current Employer's Name: \_\_\_\_\_ Employer's Address: \_\_\_\_\_

Medical Insurance Information (other than Worker's Compensation)

Insurance #1 Primary Ins: \_\_\_\_\_ Phone: \_\_\_\_\_ Group: \_\_\_\_\_ ID#: \_\_\_\_\_ Subscriber: \_\_\_\_\_ Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

If you have Medicare, do you have a Secondary Insurance? [ ] Yes [ ] No

Insurance #2 Secondary Ins: \_\_\_\_\_ Phone: \_\_\_\_\_ Group: \_\_\_\_\_ ID#: \_\_\_\_\_ Subscriber: \_\_\_\_\_ Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Worker's Compensation Information: Insurance Carrier: \_\_\_\_\_ Claim #: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Extension: \_\_\_\_\_ Fax#: \_\_\_\_\_ Is this an accepted claim? [ ] Yes [ ] No

Date of Injury: \_\_\_\_\_ Employer at the time of injury: \_\_\_\_\_ Phone #: \_\_\_\_\_

Your Work Comp Attorney Information Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Primary Treating Physician: Doctor's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Your Personal Injury [PI] Attorney Information Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Address: \_\_\_\_\_

Consent for Treatment: I \_\_\_\_\_, knowing that I am suffering from a condition[s] requiring medical and or hospital care do herewith voluntarily consent to such care including diagnostic and therapeutic procedures to be provide by medical personnel: physicians, physician's assistants, dentist, chiropractor, physical therapist, medical assistants.

Proposed Medical Procedure: \_\_\_\_\_

Risk of Treatment: [ ] Infection [ ] Permanent Disability [ ] Los Time from Work [ ] Scar

I acknowledge that no guarantees have been made to me as to the results of treatment or examination in this clinic. This consent has been fully explained to me and I certify that I understand its contents. Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Notice of Primary Treating Physician Designation: Claim Number: \_\_\_\_\_ Date of Injury: \_\_\_\_\_ I \_\_\_\_\_ hereby exercise my right to change my treating physician pursuant to Labor Code 4600-4601. I hereby appoint Behzad Emad, M.D., Q.M.E. located at 5757 Wilshire Blvd., Suite 500 Los Angeles, California 90036, as my treating physician. Signed \_\_\_\_\_ Date: \_\_\_\_\_

Release of Medical Information: I, \_\_\_\_\_, hereby request and authorize \_\_\_\_\_ to release all or part of my medical records, including x-rays to: Behzad Emad, M.D. 5757 Wilshire Blvd. Suite 500 Los Angeles, California 90036 Signed \_\_\_\_\_ Date: \_\_\_\_\_

Authorization to Pay Physician: I hereby authorize my insurance company[s] to pay by check made out to and mailed directly to Behzad Emad, M.D. the medical and surgical expense benefits allowable, and otherwise payable to me under my current insurance policy, as payment toward the total charges for Professional Services Rendered. This payment will not exceed my indebtedness to above mentioned assignee and I have agreed to pay, in a current manner, any balance of said Professional Service charges over and above this insurance payment. Signed \_\_\_\_\_ Date: \_\_\_\_\_

Treatment and Arbitration Agreement: With regard to medical care and "services provided or to be provided, IT IS AGREED that: THE ATTENDING PHYSICIAN will, to the best of his skill and knowledge, provide to the patient such medical care and services as are possible and practical in the light of circumstance. The PATIENT will cooperate fully with the ATTENDING PHYSICIAN by obtaining such medications as arE prescribed, by following the instruction of the ATTENDING PHYSICIAN, by adhering to such treatment regimen or course of action as may be set forth, and by paying all fees and charges in full as billed or as provided by prior special arrangements. IT IS AGREED, that: because of differences in human constitution and response, it is in no way possible to warrant the outcome of such medical care and service.

In the event or any controversy between the PATIENT or a dependent [whether or not a minor] or the heirs-at-law or personal representative of a PATIENT, as the case may be, and the ATTENDING PHYSICIAN [including his agents and employees], involving a claim in tort or contractual, the same shall be submitted to arbitration. Within fifteen [15] days after the PATIENT or ATTENDING PHYSICIAN shall give notice TO the other or demanding arbitration or such controversy. The parties to the controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable amount of time after such notices have been given, the two arbitrators, so selected, shall select a neutral arbitrator and give notice or the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of neutral arbitrator. All notices or other papers required to be served shall be served by United States mail. Except as provided herein, the arbitration shall be conducted in accordance with and governed by the provision of Title 9 of the California Code of Civil Procedure. The PATIENT may withdraw from the arbitration portion of this agreement within 30 days from the date of this agreement by notification of his intent to do so to the attending physician by registered mail. By our signatures, we consent to this agreement and acknowledges receipt of a true copy thereof.

Date: \_\_\_\_\_ Patient Signature: \_\_\_\_\_ Parent or Guardian Signature: \_\_\_\_\_

Please print Patient name: \_\_\_\_\_ Dated: \_\_\_\_\_ Attending Physician: \_\_\_\_\_