PATRICIA SCHECHTER, D.O.
Naomi Waak P.A.-C

General/Family Practice
5905 Capistrano #C, Atascadero, CA 93422 Telephone (805) 461-7144

Name: _____ Birth date: _____
SSN: _____ Age: _____ Gender: _____
Race: _____ Height: _____ Weight:_____

Primary Phone: _____
Secondary Phone: _____ Work Phone: _____

Street/Mailing Address: _____
City, State, Zip: _____

Email: _____
Please leave email if its ok for us to contact you with results

Occupation: _____
Company Name: _____
Company Address: _____

Primary Pharmacy/Location: _____

Primary Insurance:
_____
Insured Name: _____
Insured SSN: _____
DOB: _____

Secondary Insurance:
_____
Insured Name: _____
Insured SSN: _____
DOB: _____

Partner/Spouse Name : _____
Phone #: _____

Contact in Case of Emergency : _____ Phone #: _____

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION

I hereby authorize directly to Dr. Patricia Schechter, D.O. Family Practice Group for surgical and/or medical services rendered. I shall be personally liable for any unpaid balance to the doctor. I authorize all medical and pharmacy records be released to Dr. Patricia Schechter, D.O. Family Practice Group . I hereby authorize Dr. Patricia Schechter, D.O. Family Practice Group to release any medical records to my insurance carrier or its representatives.

Signed:_____ Date:_____

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Patient or Parent/Guardian (if Minor)

MEDICAL HISTORY

Surgeries (Circle and state DATE when procedure occurred)

Appendectomy
Breast implant/enhancement
Breast surgery
Carpal Tunnel Surgery
Colonoscopy
C-section
Cyst removal
Eye surgery
Gall Bladder surgery
Gastric Bypass
Hemorrhoid Surgery
Hernia Repair
Hysterectomy
Knee surgery
Tonsillectomy
Tubal Ligation
Wisdom teeth removal
Other
_____
_____

Social History

Alcohol use
Drinks per **day**/per **week**?
_____
Disability
Explain if applicable
_____
Exercising Regularly
How many times per week?___
What type of exercise?
_____
Marital Status
Divorced/Separated?__
Married?___
Single?___
Living Situation
Alone? ___
with children?___
with parents?___
with roommate(s)?___
with spouse/Partner?___
Prescription drug abuse?___
Sexual Satisfaction?___
Tobacco use?___
Packs per **day**/**week**?
_____
Other
_____
_____

Personal Medical History

Please circle and explain

Alcoholism
Arthritis
Asthma
ADHD
Bleeding tendency
Cancer
Depression
Diabetes
Eczema
Insomnia
Hypertension (High Blood Pressure)
Headaches/Migraines
Heart Problems
High Cholesterol
MI (Heart Attack) *less than age 50*
Seizures
Stroke
Substance Abuse
Tuberculosis

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Gynecological Medical History (Female Only)

How old when periods started?_____
How long periods last? _____
LMP: _____
How many children? _____
How many Pregnancies? _____
How many miscarriages/abortions? _____
Menopause started (date)? _____

Childhood Diseases

Measles
Mumps
Chickenpox
Diabetes

Have you ever been hospitalized or under medical care for a long time? ____

If yes, for what reason?

_____

Family History (Circle and state which family member-and specify maternal or paternal)

Alcoholism
Alzheimer's disease
Arthritis
Asthma
ADHD
Bleeding tendency
Cancer
Depression
Diabetes
Eczema
Headaches/Migraines
Heart Problems
High Cholesterol
Hypertension
MI (Heart Attack) *less than age 50*
Seizures
Stroke
Substance Abuse
Suicide
Tuberculosis
Unknown cause of death

Explanation of above, or any extra information you would like the doctor to know:

_____

_____

_____

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Medication Information

Name:_____ **DOB:**_____

Please list all medications with strength & dosage and supplements you are currently taking and name of doctor who prescribed them.

Medication/Doctor

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Supplements

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Medication Allergies	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Patient Signature _____ **Date** _____

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Dear Patient,

Please be informed that you are responsible for any charges exceeding your insurance coverage. Remember that it is your responsibility to check if your insurance company covers the service before services are rendered.

Thank you,

Dr. Patricia Schechter

Please sign below indicating agreement to the responsibility of charges exceeding your insurance coverage.

_____ _____

Patient Signature Date

_____

Patient Name (Printed)

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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 contact 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 rights 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 service 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, 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.

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 30 days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within 30 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, not including counsel fees or witness fees, or other expenses uncured 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 the capacity of arbitrator under this contact. This immunity shall supplement, not supplant, any other applicable statutory or common law.**

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 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 with this arbitration agreement including, but not limited to, Code of Civil Procedure Section 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 judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of the Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

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 notice thereof is received, the claim, if asserted in civil action, would be barred by the applicable California statue 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 rating to arbitration.**

Article 5: Revocation**: This agreement may be revoked by written notice delivered to the physician with in 30 days of the 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 rendered before the date it is signed (including, but not limited to emergency treatment) patient should initial below:**

Effective as of the date first medical services: _____*Patient's or Patient's Representative's Initials*

If any provision of this 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 the arbitration agreement. By my signature below, acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTCIE DECEIDE BY NEUTRAL ARBITRTATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRAIL. SEE ARTICLE 1 OF THIS CONTRACT.

By:_____ By: _____

Physician's or Authorized Representative's Signature/Date

Patient or Representative's Signature/ Date

_____ _____

Print or Stamp Name of Physician, Medical Group

Print Patient's Name

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ADDITIONAL OFFICE FEES

Please be aware of the fees for items preformed for you by the staff.
These items are costs your insurance may not cover.

- Refills without appointments $15
- Prior Authorizations for medications and procedures $35
- Copies $0.25/page
- No Show/Failure to cancel appointment within 24 hours $75
- Patient Assistance Program forms $45

Additional Fees for Forms are posted in the waiting room

Please sign this form to indicate your knowledge of the fees.

Patient Name: _____

Signature: _____

Date: _____

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A copy of the *NOTICE OF PRIVACY RIGHTS* is posted in the waiting room, hard copy available upon request and is available online.

NOTICE:
By signing this form, you are stating you have reviewed the *NOTICE OF PRIVACY RIGHTS:*

Patient or Representative Signature/ Date

Print Patient Name
(if Representative, Print Name & Relationship to Patient)

Please provide the names and contact information of whom we can discuss your medical information.

Release of Information:

I authorize Dr. Schechter's office to release medical information to the following people:

Name and Relationship to patient	**Address**	**Phone**
Name and Relationship to patient	**Address**	**Phone**
Name and Relationship to patient	**Address**	**Phone**

☐ **All Immediate Family**

☐ **Do not release to anyone but me**

Patient or Representative Signature/ Date

Print Patient Name
(if Representative, Print Name & Relationship to Patient)