NewportCare®
Medical Group
3300 West Coast Highway
Newport Beach, CA 92663

Patient Information for Medical Records

Today's Date _____

Patient Name _____

Birth Date _____ Age _____ Sex _____ Social Security No. _____

Address _____ City _____

State _____ Zip Code _____ Telephone No. _____

Occupation _____ Driver's License No. _____

Employer-Name _____ Employer Telephone No. _____

Employer Address _____

☐ Married ☐ Single ☐ Divorced ☐ Widow

EMAIL ADDRESS: _____

Spouse/or Responsible Parent _____

Birth Date _____ Age _____ Sex _____ Social Security No. _____

Address _____ Telephone No. _____

Occupation _____ Driver's License No. _____

Employer-Name _____ Employer Telephone No. _____

Employer Address _____

Emergency Contact(Other than husband or wife) person not living with you

Name _____ Relationship _____

Address _____ Telephone No. _____

- Please Complete if patient is under 21 years of age or a student

Father's Name _____ Mother's Name _____

Father's Occupation _____ Mother's Occupation _____

Father's Employer _____ Mother's Employer _____

Address _____ Address _____

Medical Insurance Information

Primary Insurance Subscriber _____ Secondary Insurance Subscriber _____

Insurance Co. _____ Insurance Co. _____

Identification No. _____ Identification No. _____

Group No. _____ Group No. _____

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3300 WEST COAST HIGHWAY
NEWPORT BEACH, CA 92663

Patient Name: _____

Referred to this office by _____

What is being examined today? _____ Which Side _____

How long have you had this illness/problem/symptoms _____

How did illness/problem/symptoms/accident occur _____

_____

_____

Have you seen a physician for this problem? ☐ Yes ☐ No

Doctor _____ Address _____

Treatment(special tests, injections, medications, etc) _____

_____

Have you had a previous problem in this area? ☐ Yes ☐ No

If so, please describe _____

_____

Have you lost time from work because of this current injury/problem? ☐ Yes ☐ No

If so, data last worked _____

Type of work you do _____

_____

If this is an injury, when and how did it happen? _____

☐ Home ☐ Work ☐ Automobile ☐ Other _____

Data_____ Hour_____ Last Worked _____

Auto Insurance _____ Auto Insurance Policy No. _____

If an industrial injury, name and address of employer at time of injury _____

_____

Attorney information _____

_____

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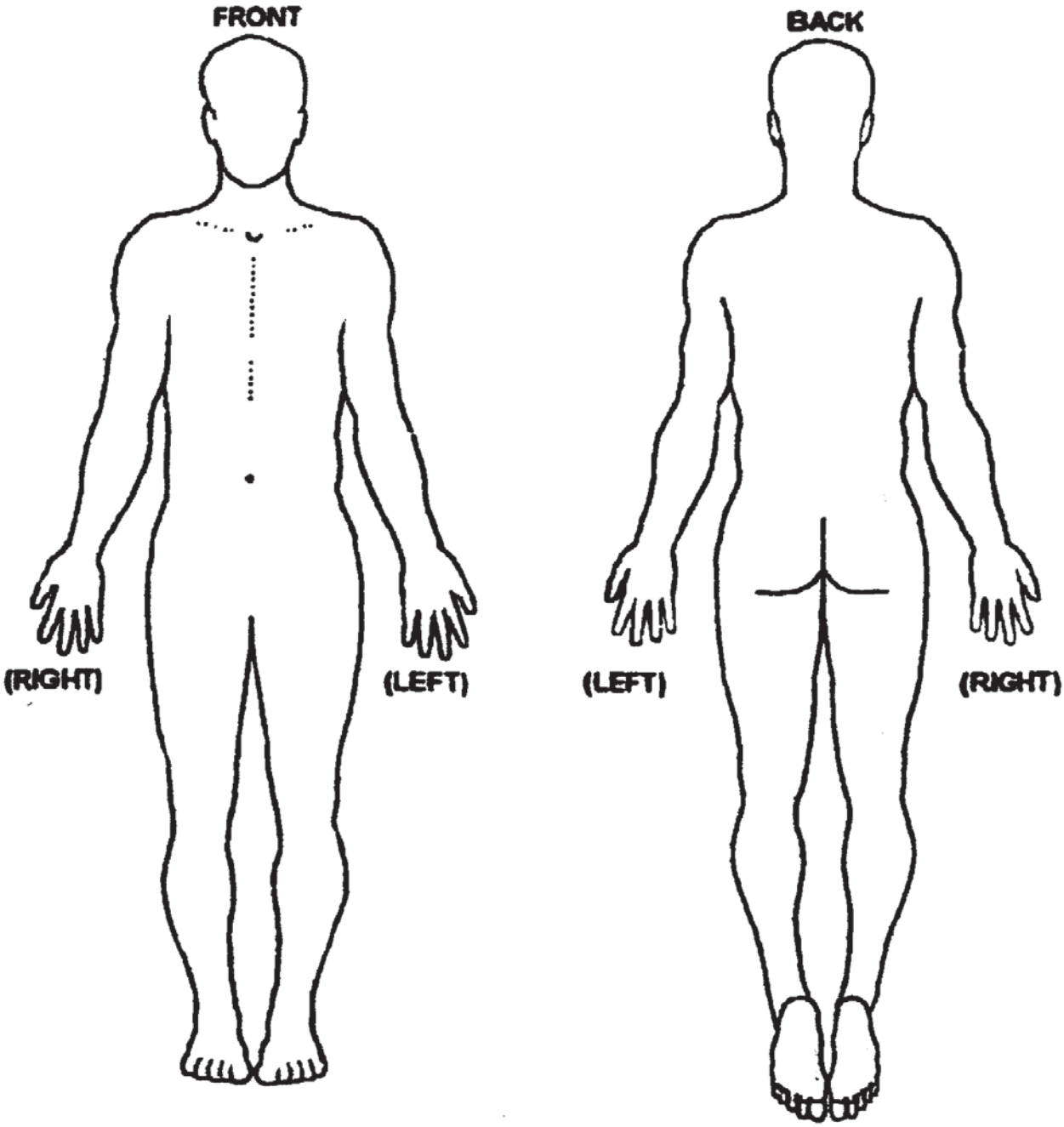
Pain Drawing

Please indicate where you are having symptoms by using the proper symbols and arrows to show where the pain goes or shoots. Be sure to show all areas involved and to indicate where the pain is the worst.

Aching / Pain (XXXX)
Numbness / Tingling (OOOO)
Pins / Needles (: : : :)
Burning (////)
Spasm / Cramp (△△△△)



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Pain Assessment

Where is your pain?

☐	Location	
☐	Head	
☐	Neck	
☐	Shoulder	L / R
☐	Arm	L / R
☐	Hand	L / R
☐	Mid Back	
☐	Low Back	
☐	Buttocks	L / R
☐	Hip	L / R
☐	Leg	L / R
☐	Foot	L / R

How long has it been there?

Duration (wks / yrs)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

When having pain is it generally…

- ☐ Mild discomfort
- ☐ Dull, achy pain
- ☐ Hard, aching pain, frequently worse
- ☐ Severe pain, sharp/shooting at times
- ☐ Burning pain
- ☐ Very severe, sharp, stabbing
- ☐ Extremely disabling

How often are you having pain?

- ☐ Rarely, if ever
- ☐ Occasional (If so, how often? _____)
- ☐ Recurrent (few days every month)
- ☐ Frequent (more than half the time)
- ☐ Very frequent (nearly every day)
- ☐ Constantly

How much of your pain is in your neck/back and how much is in your arm/leg? (must total 100%)
_____% neck/back + _____% arm/leg = 100%

Rate your pain at it's worst and at it's best:
(0 = No pain, 10 = Worst imaginable pain)

0 1 2 3 4 5 6 7 8 9 10 at is worst

0 1 2 3 4 5 6 7 8 9 10 at is best

What treatment have you received?

- ☐ None
- ☐ Physical Therapy
- ☐ Chiropractic
- ☐ Traction
- ☐ Acupuncture
- ☐ Anti-inflammatory med
- ☐ Muscle relaxants
- ☐ Narcotic medications
- ☐ Epidural injections
- ☐ Other: _____

Have you experienced any of the following:

- ☐ Numbness / Tingling in arms; (L), (R)
- ☐ Numbness / Tingling in hands; (L), (R)
- ☐ Numbness / Tingling in legs; (L), (R)
- ☐ Numbness / Tingling in feet; (L), (R)
- ☐ Weakness in legs; (L), (R)
- ☐ Weakness in arms; (L), (R)
- ☐ Clumsiness of hands; (L), (R), (both)
- ☐ Balance problems
- ☐ Bladder problems: _____
- ☐ Bowel problems:_____
- ☐ Pain that wakes you from sleep (night pain)

What makes your pain better?

- ☐ Lying down
- ☐ Sitting
- ☐ Lying down
- ☐ Standing
- ☐ Walking
- ☐ Lifting
- ☐ Sleeping
- ☐ Ice
- ☐ Looking up/down
- ☐ Looking L / R
- ☐ Looking up/down
- ☐ Bending Forward
- ☐ Bending Backwards
- ☐ Sneeze / Cough
- ☐ Twisting
- ☐ Heat
- ☐ Other (please describe):_____

What makes your pain worse?

- ☐ Sitting
- ☐ Standing
- ☐ Walking
- ☐ Lifting
- ☐ Ice
- ☐ Looking L / R
- ☐ Bending Forward
- ☐ Bending Backwards
- ☐ Sneeze / Cough
- ☐ Heat
- ☐ Other (please describe):_____

What time of day is your pain usually worst?

- ☐ Morning
- ☐ Mid-day
- ☐ Evening
- ☐ Same all day
- ☐ At night

Describe the course of your condition as:

- ☐ Rapidly worse
- ☐ Slowly worse
- ☐ Unchanged
- ☐ Rapidly better
- ☐ Slowly better

What studies have been done?

- ☐ None
- ☐ MRI
- ☐ Myelogram
- ☐ DEXA Scan
- ☐ X-rays
- ☐ CT scan
- ☐ Bone Scan
- ☐ EMG

Have you had previous orthopedic surgery? ☐ No ☐ Yes Did it help you? ☐ No ☐ Yes
If yes, what type of surgery, who was the surgeon and when was it done?

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Past Medical History

Please rate your general health
☐ Excellent ☐ Fair
☐ Good ☐ Poor

What medical problems do you have?
☐ None
☐ Cancer (what type?) _____
☐ Heart Disease
☐ Lung Disease (i.e. pneumonia, asthma, COPD)
☐ Liver Disease (i.e. jaundice, hepatitis)
☐ Diabetes
☐ High Blood pressure (hypertension)
☐ Rheumatic Fever
☐ High Cholesterol
☐ Anemia or Bleeding Problems
☐ Thyroid Disease
☐ Kidney Disease
☐ Urinary Tract Infections
☐ Other Serious Health Problems: _____
_____

Past Surgical History:
Have you had any previous surgery?
☐ None
☐ Tonsillectomy
☐ Appendectomy
☐ Cholecystectomy (Gallbladder)
☐ Heart (bypass) ☐ Thyroid surgery ☐ Hip Replacement ☐ Knee Replacement
☐ Knee Arthroscopy ☐ Pacemaker ☐ Cancer Surgery (describe:)_____
☐ Other (list:)_____

Allergies: ☐ None
Please list all drug allergies and reactions:
_____
_____

Family History:
Do any of the following medical problems run in your family? If so, please list family member:
☐ None
☐ Heart disease
☐ Diabetes
☐ Hypertension
☐ High Cholesterol
☐ Thyroid disease
☐ Renal (Kidney) Disease
☐ Pulmonary (Lung) Disease
☐ Liver Disease
☐ Cancer
☐ Scoliosis
☐ Osteoporosis
☐ Other Serious Health Problems; list:
_____

What is your height? _____
How much do you weigh? _____

Females only: Are you pregnant?_____

Medications: None
Please list all medications that you take and dosage:
_____
_____

Who do you live with? _____Do you smoke? ☐ No ☐ Yes; _____packs per day _____years
☐ Used to, but quit

Do you drink alcohol (beer, wine, liquor)? ☐ No Yes; how much/often? _____

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Review of Systems

Please check and describe any signs or symptoms which you are currently experiencing from any of the following organ systems; if none, please write "NONE".
Please list any other problems you may be experiencing that you do not see listed.

Constitutional Symptoms:
☐ Fever ☐ Chills ☐ Night Sweats ☐ Weight Loss ☐ Fatigue ☐ Appetite Loss

Eyes:
☐ Corrective Lenses ☐ Cataracts ☐ Blurry Vision ☐ Double Vision

Ears, Nose, Mouth, Throat:
☐ Hearing Loss ☐ Sinus Congestion ☐ Hoarse Voice ☐ Painful/Difficulty Swallowing

Cardiovascular (Heart, circulation):
☐ Chest Pain ☐ Cool Extremities (poor circulation) ☐ Cold Sensitivity

Respiratory (Lungs):
☐ Shortness of Breath ☐ Painful Breathing ☐ Wheezing ☐ Cancer

Genitourinary (i.e. urinary tract infection, prostate):
☐ Urinary Frequency ☐ Urinary Incontinence ☐ Painful Urination
☐ Sexual Dysfunction ☐ Enlarged Prostate ☐ Cancer

Gastrointestinal:
☐ Reflux ☐ Ulcers ☐ Cancer
☐ Diarrhea ☐ Constipation ☐ Bloody Stool
☐ Nausea ☐ Vomiting

Musculoskeletal:
☐ Joint Pain, where?_____
☐ Joint Swelling
☐ Joint Stiffness ☐ Fibromyalgia

Skin/Breast:
☐ Cancer, where?_____ What type?_____
☐ Lumps or Masses, where? _____
☐ Rashes

Psychiatric:
☐ Depression ☐ Manic
☐ Eating Disorder

Neurological:
☐ Stroke ☐ Trouble Speaking ☐ Peripheral Nerve Disorder, list?_____
☐ Balance Problems ☐ Seizures ☐ Tremor ☐ Reflex Sympathetic Dystrophy

Endocrine:
☐ Diabetes ☐ Hypoglycemia ☐ Thyroid
☐ Parathyroid ☐ Adrenal ☐ Osteoporosis

Hematologic/Lymphatic:
☐ Anemia ☐ Clotting Disorder
☐ Platelet Disorder ☐ Sickle Cell
☐ Lymphedema
☐ Swollen Lymph Nodes, where?_____
☐ Tender Lymph Nodes, where?_____

Immunologic:
☐ Rheumatoid ☐ Lupus

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CHECKOUT ORDERS
DOCTOR'S USE ONLY

Patient Name: **DOB:** / / **Date:** / /

Exam:

☐ Normal Cervical ☐ Normal Thoracic ☐ Normal Lumbar ☐ Abnormal Gait
☐ + Straight Leg Raise

☐ Normal Shoulder ☐ Normal Hip ☐ Normal Knee
☐ + Impingement Signs ☐ Crepitus, Joint Line Pain

☐ Other:_____

Xray:
☐ WNL
☐ Abnormal:
☐ Degenerative changes without spondy

MRI:
☐ WNL
☐ Abnormal:

Notes:

☐ PT _____
☐ Chiro _____
☐ Injections _____

Plan:
☐ Online Review

IM in office injection:
☐ B12 ☐ Toradol _____mg ☐ Demerol_____mg ☐ Trigger Point _____

Medications Given:
☐ Mobic 15mg ☐ Norco 5/325mg ☐ Steroid Taper ☐ Neurontin 300g
☐ Percocet 5/325mg ☐ Flexeril 5mg ☐ Other:_____ ☐ Naproxen 500g

Devices Ordered:
☐ NMES ☐ TENs ☐ H-wave ☐ Lumbar Brace ☐ Cervical Collar
☐ KneeHab

MRI:
☐ Right ☐ Left ☐ w/ & w/o contrast
☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Other:_____
☐ Shoulder ☐ Hip ☐ Knee ☐ Ankle ☐ Foot

Physical Therapy:
☐ Cervical Spine ☐ Thoracic Spine ☐ Lumbar Spine ☐ Other:_____
☐ Shoulder ☐ Hip ☐ Knee ☐ Ankle ☐ Foot Frequency _____ /wk for _____wks

Injection/ Procedure
☐ Epidural_____ ☐ SNB_____ ☐ Facet_____
☐ RFA_____ ☐ Surgery_____ ☐ Dictated ☐ Transcribed

Signature: _____

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Physician Order Rx/Request for Authorization: Prescription Form/ Certificate of Medical Necessity

Patient Name _____ Physician Name _____

Surgery Center _____ Primary ICD-9 Code(s) _____ DOI: _____ ☐ Right ☐ Left

Product Description	Product Description	Product Description
Place Sticker Here	Place Sticker Here	Place Sticker Here

Narrative Report:
My signature below acknowledges that, in my judgment, the prescribed item is medically indicated & necessary and consistent with current accepted standards of medical practice and treatment of this patients physical condition. My signature also serves to confirm the veracity of all information included in this document.

Products: ☐ Compression Stocking ☐ Walker Boot ☐ Post-Op Shoe ☐ Knee Immobilizer ☐ Post-Op Knee ☐ LSO ☐ Abdominal Binder ☐ Sling ☐ Shoulder Immobilizer ☐ Cervical Collar ☐ Wrist Brace ☐ Crutches ☐ Thumb Spica ☐ Front Wheel Walker ☐ Other _____

Pneumatic Intermittent Compression (PIC) Device with bilateral calf wraps

☐ **TAKE HOME PORTABLE DEVICE**

Place Label With Serial # Here

DEVICE: Pneumatic Intermittent Compression Device - Duration 1-30 Days
APPLIANCE(S): Segmental Gradient Pressure Pneumatic Appliance(s) X2 - Duration 1-30 Days
MEDICAL COMPLICATIONS: ☐ CVI ☐ Diabets ☐ DVT ☐ Lymphedema ☐ Other: _____

Narrative Report: In my evaluation of this patient. I have noted there is a higher risk of developing Deep Venous Thrombosis (DVT), due to the type of surgery performed combined with other risk factors. I am Prescribing DVT Prophylaxis involving the use of a pneumatic compression device and the necessary appliances. This patient will have decreased ability and duration of ambulation following surgery, which will significantly increase the risk factors associated with DVT, Pulmonary Embolism (PE), DVT and PE can be major complications associated with these surgeries, resulting in significant morbidity and mortality rates, as stated by the American College of Chest Physicians.

Significant published data is available on the incidents of DVT/PE, the effectiveness of various prophylactic techniques and the risks of hemorrhage when heparin is used, all of which provide positive and compelling evidence in support for the use of intermittent compression devices in DVT prevention. The plantar and lower leg wraps have added the advantage of reproducing the physiological mechanism of venous return. Impaired venous blood flow in post abdominal/orthopedic surgeries, trauma, and other conditions that impede or significantly decrease ambulation of patients most certainly will decrease circulation which can result in edema, pain, delayed healing and increased risk of DVT and PE. The clinical trials show clear evidence that these complications and risk factors can be significantly minimized with the use of the PIC devices.

For these reasons, PIC device and compression wraps are prescribed for this patient to maximize the most positive outcome of surgery and minimize the potential for serious complications. I have successfully used this device in my practice and my patients tolerate the treatment protocol with a very high degree of compliance. I feel this protocol is the most beneficial and cost effective treatment of my patients in greatly reducing the development of DVT, which when ignored can result in significant increase in morbidity and mortality and increased utilization of health care resources and dollars.

Rental to Purchase Option

NewportCare Medical Group makes every effort to provide you with equipment that is yours to keep. However, from time to time your doctor may prescribe a rental piece of equipment such as T.E.N.S. If you need a T.E.N.S. prescribed by your doctor, you may know your insurance may help pay for it. T.E.N.S. are normally rented on a monthly basis. If you wish to purchase the T.E.N.S. because you may need it for extended use, we will apply any daily rental rates to the purchase price. In making your decision to rent or purchase this equipment, you should know that you will be responsible for 20% of the service charge. If you choose the purchase option, you will be responsible for the purchase amount less than the rental.

Option
☐ Rental
☐ Purchase

Patient Acknowledgment & Authorization to Assignment of Benefits(PA/AOB)

I acknowledge receiving instruction, have demonstrated or verbalized my understanding in the proper use and care of the equipment or supplies received today described on this document & will follow them. I understand company business hours and a NewportCare Medical Group representative will be contacting me regarding my financial responsibilities related to this agreement. I acknowledge receipt & understand the Company Patient Information Privacy Notice and that all information on this document is correct. I understand and agree that I am responsible for payment or products and services provided by NewportCare Medical Group. I agree to make payment, in full, upon receipt of payment from insurance company to policy holder if not endorsed and forwarded to NewportCare Medical Group. I authorize release of any medical information necessary to process this claim and certify the above information is correct. I authorize any and all payments of medical benefits to NewportCare Medical Group for the products and services rendered.

Patient Signature _____ Date _____

Product Delivery Acknowledgment (Required for Medicare Claims)

Patient Signature _____ Date _____

Patient Sticker Here

License# _____ NPI# _____ Physician Signature _____

3300 West Coast Highway. Newport Beach, CA 92663
Office: (949)491-9991 Fax: (949)258-5858

NewportCare® Medical Group

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Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1966 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for the following:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.

Only upon request you organization will provide a copy of Notice of Privacy Practices containing a more detailed description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at this address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are required to agree to my requests, and by agreeing to such requests: you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on the consent.

Patient Name(Print)

Signature

Relationship to Patient

Date

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Release of Records

I _____ , hereby give NewportCare Medical Group authorization to discuss my medical condition and test results with:

Please list all the names and phone numbers as appropriate.

Spouse _____

Mother _____

Father _____

Sister(s) _____

Brothers(s) _____

Son(s) _____

Daughter(s) _____

Caregiver _____

Answering machine at phone number _____

Other _____

No one but patient _____

Patient Name(Print)

Signature

Relationship to Patient

Date

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Acknowledgment of Receipt of Notice of Privacy Practices

The practice reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices

Patient Name(Print) _____

Signature _____

Relationship to Patient _____

Date _____

Documentation of Attempt to Obtain Acknowledgment of Receipt of Privacy Practices

Attempt to Obtain Acknowledgment

An attempt was made to obtain an acknowledgment of Notice of Privacy Practices on

The Acknowledgment was not obtained because:

*The patient was undergoing emergency treatment

*The patient declined to sign the Acknowledgment

*Other _____

Patient Name(Print) _____

Signature _____

Relationship to Patient _____

Date _____

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Financial Interest Consent

I, _____ (patient), acknowledge and accept that my physician(s) may have financial interest in hospitals, surgery centers, imaging centers, physical therapy and/or surgical devices that he/she chooses to utilize. I hereby recognize my rights to choose another physician or request the services of another facility or device be used.

Patient Name(Print)

Signature

Relationship to Patient

Date

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NewportCare Medical Group
Office Financial Policy

Thank you for choosing NewportCare Medical Group. We are committed to the success of your treatment. We hope you understand that payment of your bills is considered part of your treatment. The following is a statement of our financial policy, which we require you read, agree to and sign, prior to any treatment. This financial policy applies to all services rendered by the doctors and physical therapists.

It is our policy that the patient, rather than the insurance company, is responsible for complete payment of our charges. All patients with insurance coverage are required to pay for non-covered services, any deductible amount not previously met and any copay amount due, at the time of services rendered. For patients with dual insurance coverage we will bill both the primary and secondary insurance if you have provided us with the necessary information.

Patients insured with plans which we are NOT contracted with will be required to pay for the first visit in full. For any follow-up visits you will need to pay 30% at the time services are rendered. There will be a 30% down payment prior to any surgery needed.

If you are insured with a plan which we ARE contracted with (including Medicare), you will need to pay for any non-covered services, any outstanding deductible and your copy amount, at the time of each visit. If for any reason the insurance company failed to pay, the patient will be responsible for the entire balance.

Patients with no insurance coverage are expected to pay for the services at the time services are rendered.

Failure to make payment arrangements, or pay outstanding balances within 60 days of notification of amount due, may result in termination of care from NewportCare Medical Group

Our accepted methods of payments are cash, check, Visa, MasterCard or Discover Card. If requested, a short payment schedule may be arranged for those patients who have special financial conditions.

Again, thank you for trusting us with your care. If you have any questions regarding financial responsibility of payment options, please contract our insurance department.

"I have read, understand and agree to the provisions of this policy"

Patient Name(Print)

Patient Signature / Guarantor

Date

Phone: 949 / 491 - 9991 FAX: 949 / 258 - 5858
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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 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 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 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 the 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 applicable 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 judgment or summary 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 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 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 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'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.

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: _____ _____
Patient's or Patient Representative's Signature Date

By: _____ _____
Physician's or Authorized Representative's Signature Date

By: _____
Print Patient's Name

NewportCare Medical Group
Print or Stamp Name of Physician, Medical Group, or Association Name

_____
(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.

SUBMIT RESET