PATIENT INFORMATION RECORD

Patient

Last Name________________________________First Name______________________________

Address____________________________________City__________________________________

State______________Zip Code________________ Cell # _______________________________

Email ____

Male/Female_________ Date of Birth_____________ Age_____________________________

Marital Status______________________________Occupation__________________________

Employer Name____

Employer Phone #____________________________

Spouse/Guardian

Name_______________________________________Occupation___________________________

Spouse/Guardian's Phone #______________________________

How did you hear about us____

Last Physician's Name____

I understand that none of the medical services provided by this office are covered by Medicare and some may not be considered "reasonable and necessary" by some insurance plans. I understand that I am personally responsible for payment for ALL services.

Patient's Signature___________________________________Date_________________

INFORMED CONSENT

Name of Patient ______________________________________

To all patients:

As a result of current excessive rates for malpractice insurance, I have decided to continue my practice without coverage for certain procedures. This means that I reaffirm my pledge to care for you in the best way I can.

It also requires that YOU affirm that your primary interest is better health for you and your family, and not monetary gain through legal action.

If you feel that I may be practicing in a 'negligent manner' or with 'reprehensible ignorance' (the definition of malpractice), then you should not come to me for medical care. A feeling of mutual trust is essential for the best results in improving your health.

You should be aware that none of the medical services provided by me and my associates are covered by Medicare and some may not be considered "reasonable and necessary' by other health insurance plans. You, therefore, will be personally responsible for payment for all such 'non-covered services'.

I have read this notice and am in agreement with it. I further declare that I am not an agent of any state or federal government or acting on their behalf, but am seeking medical services solely for my own benefit.

Signature____Date_________________________

MEDICARE OPT-OUT CONTRACT

(Pursuant to #405.415 of the Medicare Regulations)

By signing this contract, I understand that I will not submit (or request that my physician submit) a claim to Medicare or its agents for services, even if such services would be otherwise covered by Medicare.

I agree that I (or my legal representative) accept full responsibility for payment of services rendered to me by Ismael Mena, D.O. and I understand that no Medicare reimbursement will be provided for such services.

I (or my legal representative) understand that Medicare limits do not apply to what Dr. Mena may charge for items or services.

I (or my legal representative) agree not to submit a claim to Medicare or ask Dr. Mena to submit a claim to Medicare.

I (or my legal representative) understand that Medicare payment will not be made for any items or services furnished by Dr. Mena that would otherwise have been covered by Medicare if there were a private contract and proper Medicare claim had been made.

I (or my legal representative) understand that I am entering in to this contract with the knowledge that I have the right to obtain Medicare-covered services from physicians or practitioners who have not opted-out of Medicare, and that I am not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians who have not opted-out.

I (or my legal representative) understand that Medigap plans do not, and that other supplemental plans may not elect to make payments for items and services not paid for by Medicare. Therefore, I understand that Dr. Mena's services will likely not be covered by these plans.

I (or my legal representative) understand that Ismael Mena, D.O. is thus excluded from Medicare under #1128, 1156, 1892 or any other section of the Social Security Act.

Patient Name ____

Patient Signature____Date_____________________

PATIENT HEALTH HISTORY FORM

Date: _______/_________/________

NAME: ____ **Birthdate:** _____/______/_____

Last First M. I.

Age:____________ **Sex:** ❑ **F** ❑ **M**

Main reason for the visit:

Describe briefly your present symptoms:

List current health problems for which you are being treated:

Major Hospitalizations (include when, & for what reason):

Do you experience any of these general symptoms EVERY DAY?

- ❑ Debilitating fatigue
- ❑ Depression
- ❑ Disinterest in sex
- ❑ Disinterest in eating
- ❑ Shortness of breath
- ❑ Panic attacks
- ❑ Discharge
- ❑ Headaches
- ❑ Dizziness
- ❑ Insomnia
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Itching/rash
- ❑ Constipation
- ❑ Fecal incontinence
- ❑ Urinary Incontinence
- ❑ Low grade fever
- ❑ Chronic pain/inflammation
- ❑ Bleeding

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug

Laboratory procedures (e.g., stool analysis, blood and urine chemistries, hair analysis):

Outcome:

Circle the level of stress you are experiencing on scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems:

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right your weight today:

Have you had an unintentional weight loss or gain of 10 pounds or more in the last 3 months:

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman)?

What are your current health goals:

HEALTH HABITS

❑ Tobacco:	❑ Alcohol:	❑ Caffeine:	❑ Water:
Cigarettes: #/day________	Liquor:_______ Wine:__________	Coffee:_______	Glasses: #/day____
Vaping: #/day________	Beer:_________	Tea:_______	
		Other sources:___________	

PAST MEDICAL HISTORY

Do you now or have you ever had:

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _________________
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems

❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones

❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS

Other medical conditions (please list):

FAMILY HEALTH HISTORY

(Parents and Siblings)

❑ Arthritis
❑ Asthma
❑ Alcoholism
❑ Alzheimer's disease
❑ Cancer (type)_________________
❑ Depression
❑ Diabetes
❑ Other

❑ Drug addiction
❑ Eating disorder
❑ Genetic disorder
❑ Glaucoma
❑ Heart disease
❑ Infertility
❑ Learning disabilities

❑ Mental Illness
❑ Migraine headaches
❑ Neurological disorders
❑ Obesity
❑ Osteoporosis
❑ Stroke
❑ Suicide

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SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
Pregnancies:
Miscarriages:
Abortions:
Have you reached menopause? Y / N At what age?
Do you have regular periods? Y / N

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 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 Arbitrated:** It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, 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.

Filing by Physician 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 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 by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effect:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this 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: ______________________________
Physician's or Duly Authorized Representative Signature (Date)

By ______________________________
Print or Stamp Name of Physician, Medical Group or Association Name

By: ______________________________
Signature of Translator (if applicable) (Date)

____
Print Name of Translator

By: ______________________________
Patient's Signature (Date)

____
Print Patient's Name

By: ______________________________
Patient's Representative's Signature (if applicable) (Date)

____
Print Name and Relationship to Patient