Michael A. Zadeh, M.D.

www.zadehsurgical.com

PATIENT INFORMATION: **DATE:**

LAST NAME: _____ FIRST NAME: _____ MI: ___

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ DOB: _____ AGE: _____

SEX: ☐ M ☐ F MARITAL STATUS: _____ EMAIL ADDRESS: _____

PHONE #: HOME: _____ CELL: _____ OTHER:_____
NUMBER TO BE CONTACTED FOR SURGERY: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY:

NAME: _____ RELATION: _____

ADDRESS: _____ PHONE #: _____

IF NOT AVAILABLE, WHOM MAY WE LEAVE INFO WITH
NAME: _____ PHONE #: _____

EMPLOYER INFORMATION:

EMPLOYER: _____ OCCUPATION: _____

WORK TEL: _____ EXT: _____

HEALTH PLAN INFORMATION:

PRIMARY INS: _____ ID# _____ GRP# _____

NAME OF POLICY HOLDER: _____ RELATION: _____

POLICY HOLDER SS#: _____ DOB: _____ SEX: ☐ M ☐ F

SECONDARY INS: _____ ID# _____ GRP# _____
NAME OF POLICY HOLDER: _____ RELATION: _____
POLICY HOLDER SS#: _____ DOB: _____ SEX: ☐ M ☐ F

REFERRING PHYSICIAN: _____ PHONE #: _____

HOW DID YOU HEAR ABOUT US?

☐ Referring Physician ☐ Family/Friend ☐ Website ☐ Internet Search ☐ Other (Specify): _____

WOULD YOU LIKE TO BE ADDED TO OUR E-MAIL LIST TO RECEIVE IMPORTANT UPDATES AND INFORMATION?

☐ Yes ☐ No

AUTHORIZATION TO RELEASE INFORMATION

I HEREBY AUTHORIZE MICHAEL A ZADEH MD AND ZADEH SURGICAL INC TO: (1) RELEASE ANY INFORMATION NECESSARY TO INSURANCE CARRIERS REGARDING MY ILLNESS AND TREATMENTS; (2) PROCESS INSURANCE CLAIMS GENERATED IN THE COURSE OF EXAMINATION OR TREATMENT; AND (3) ALLOW A PHOTOCOPY OF MY SIGNATURE TO BE USED TO PROCESS INSURANCE CLAIMS FOR THE PERIOD OF LIFETIME. THIS ORDER WILL REMAIN IN EFFECT UNTIL REVOKED BY ME IN WRITING.

PATIENT NAME _____ SIGN _____

PARENT NAME (IF PATIENT IS A MINOR) _____

DATE _____

AUTHORIZATION TO PAY/ASSIGNMENT OF BENEFITS

I HEREBY IRREVOCABLY ASSIGN ALL MEDICAL AND SURGICAL BENEFITS, TO INCLUDE MAJOR MEDICAL BENEFITS TO WHICH I AM ENTITLED TO MICHAEL A ZADEH MD AND ZADEH SURGICAL INC. I HEREBY AUTHORIZE AND DIRECT MY INSURANCE CARRIER(S), INCLUDING MEDICARE, PRIVATE INSURANCE AND ANY OTHER HEALTH/MEDICAL PLAN, TO ISSUE PAYMENT CHECK(S) AND/OR GOVERNMENT BENEFITS DIRECTLY TO MICHAEL A ZADEH MD AND ZADEH SURGICAL INC FOR MEDICAL SERVICES RENDERED TO MYSELF AND/OR MY DEPENDENTS REGARDLESS OF MY INSURANCE BENEFITS, IF ANY. SUCH AMOUNT NOT TO EXCEED THE COVERAGE FOR THE SERVICES RENDERED. IT IS UNDERSTOOD BY THE UNDERSIGNED THAT HE/SHE IS FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCLUDING BUT NOT LIMITED TO (DEDUCTIBLES/COPAYS) NOT COVERED BY THIS AGREEMENT:

PATIENT NAME: _____ DATE _____

SIGNATURE OF INSURED _____

I AGREE THAT I WILL NOT FILE A LAWSUIT AGAINST MICHAEL A ZADEH MD FOR FRIVOLOUS (LACKING IN ANY ARGUABLE BASIS OR MERIT IN EITHER LAW OR FACT) REASONS.

PATIENT NAME _____ SIGNATURE _____

MEDICARE AUTHORIZATION

I REQUEST THAT PAYMENT UNDER THE MEDICARE INSURANCE PROGRAM BE MADE TO MICHAEL A ZADEH MD ON ANY CLAIM FOR SERVICES FURNISHED TO ME BY HIM DURING THE PERIOD _____ TO _____

PATIENT SIGNATURE _____ DATE _____

MEDICARE # _____

FINANCIAL RESPONSIBILITY

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT AND ARE DUE AT THE TIME OF SERVICE, UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR BUSINESS OFFICE. NECESSARY FORMS WILL BE COMPLETED TO FILE FOR INSURANCE CARRIER PAYMENTS.

I HAVE REQUESTED MEDICAL SERVICES FROM DR. MICHAEL ZADEH AND ZADEH SURGICAL, INC. ON BEHALF OF MYSELF AND/OR MY DEPENDENTS, AND UNDERSTAND THAT BY MAKING THIS REQUEST, I BECOME FULLY FINANCIALLY RESPONSIBLE FOR ANY AND ALL CHARGES INCURRED IN THE COURSE OF THE TREATMENT AUTHORIZED.

I FURTHER UNDERSTAND THAT FEES ARE DUE AND PAYABLE ON THE DATE THAT SERVICES ARE RENDERED AND AGREE TO PAY ALL SUCH CHARGES INCURRED IN FULL IMMEDIATELY UPON PRESENTATION OF THE APPROPRIATE STATEMENT. A PHOTOCOPY OF THIS ASSIGNMENT IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.

_____ _____

PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

COMPREHENSIVE PATIENT HISTORY

DATE: _____

PATIENT NAME: _____ DOB: _____

What is the reason for today's visit? _____
Referring M.D./Person who referred you: _____

List previous hospitalizations/Surgeries/Serious Injuries **When?**

_____ _____
_____ _____
_____ _____
_____ _____

List any medications you are taking: **Are you allergic to any meds?**
Prescription/Herbal/Vitamins

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Patient Social History
Alcohol Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Tobacco Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily
Drug Use: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Have you ever had any of the following?

Cancer	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No
Bleeding tendency	☐ Yes	☐ No

Family Medical History
Mother: _____
Father: _____
Siblings: _____
Spouse: _____
Children: _____

Have you experienced any of the following?

Good general health lately	☐ Yes	☐ No	Recent weight change	☐ Yes	☐ No
Fatigue	☐ Yes	☐ No	Headaches	☐ Yes	☐ No
Thyroid Disease	☐ Yes	☐ No	Chest Pains	☐ Yes	☐ No
Change in bowel habits	☐ Yes	☐ No	Nausea/Vomiting	☐ Yes	☐ No
Frequent Diarrhea	☐ Yes	☐ No	Blood in Stool	☐ Yes	☐ No
Stomach Pains	☐ Yes	☐ No	Asthma/Wheezing	☐ Yes	☐ No
Excessive Thirst	☐ Yes	☐ No	Enlarged Glands	☐ Yes	☐ No
Prostate Disease	☐ Yes	☐ No	Gallbladder Problems	☐ Yes	☐ No

Other _____

MICHAEL A. ZADEH M.D.
WWW.ZADEHSURGICAL.COM
16542 VENTURA BLVD. STE #304
ENCINO CA 91436

NOTICE OF PRIVACY PRACTICES

To file a complaint with DHHS, please contact:
Department of Health and Human Services, Office of Civil Rights, Hubert H Humphrey Building,
200 Independence Ave SW, Room 509F HHH Building, Washington DC 20201

Acknowledgement of Receipt of notice of privacy practices for protected health information (available from receptionist) a copy given at your own request.

Privacy Official: Row Zadeh (818) 789-1111

Patients Name: _____ Date: _____

I hereby acknowledge that I received a copy (available at your request) of the Notice of Privacy Practices for Michael A Zadeh MD. I further acknowledge that if the notice is amended I shall be notified of such changes and will be provided a copy at my request, on or after the effective date of the notice at future appointments.

Patients Signature: _____ Date: _____

Signature of Patient Representative: _____ Date: _____
(Person legally authorized to sign for an unemancipated minor or an adult who is unable to sign this form).

Relationship of Patient Representative: _____
(Parent, Guardian, Conservator, Durable Power of Attorney for Health Care, Etc.)

FOR OFFICE USE ONLY
An attempt was made to obtain the patients or personal representative's signature acknowledging receipt of the notice of Privacy Practices but the acknowledgement was not obtained because:

_____
_____

Employee Signature: _____ Date: _____

OUR COMITTMENT TO QUALITY MEDICAL CARE

Michael A. Zadeh, M.D. is committed to providing you with high quality medical care. We participate in continuing medical education to keep our knowledge and skills current and strive to ensure that our patients receive high quality medical care from this practice.

We also understand that as a patient, you may at times have concerns or complaints about our services. We encourage you to communicate your concerns to us or our staff. **Please tell us if you have a complaint or a complement – we value your feedback.**

Please tell us if you have questions about your care, suggestions to improve the delivery of health care in this office, or complaints about any aspect of your treatment. We appreciate being part of your health care team and ***greatly*** value your feedback. If you would prefer that your comment be anonymous, please complete a patient satisfaction survey located on our website or available from the receptionist.

If the above suggestions are not satisfactory, or for any reason, you may contact the Medical Board of California. For your information, we provide the following:

NOTICE

Medical doctors are licensed and regulated

by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

I have read and understand the options available to me in regards to my medical care. I understand that medical doctors are licensed and regulated by the Medical Board of California.

Patient/Patient Representative Signature _____ Date_____

Patient/Patient Representative Name _____
(Please Print)

Submit

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

MICHAEL A. ZADEH, MD, FACS: ZADEH SURGICAL, INC., Z MEDICAL SPA D.B.A. Z CENTER FOR COSMETIC HEALTH

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical and/or aesthetic malpractice, that is as to whether any medical and/or aesthetic 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 or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: a) Parties To The Agreement. The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law. The term "Doctor" as used in the Agreement includes the undersigned Doctor and his or her professional corporation or partnership, all independent contractors who practice medical and/or aesthetic techniques at the undersigned Doctors place of business, and any employees agents, successors-in-interest, heirs and assigns of the foregoing individuals or entities. The Doctor signing this Agreement signs it on behalf of all the foregoing individuals and entities, intends to bind each of them to arbitration to the full extent permitted by law.

b) Treatment Covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Doctor and Patient will be subject to compulsory, binding arbitration.

c) Other Doctors, Nurses, Medical Assistants, Aestheticians (if Applicable). Patients understands that he or she may at times receive treatment from one or more Doctors, Nurses, Medical Assistants, or Aestheticians who are independent contractors practicing at the same facility as the undersigned Doctor. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such Doctors, Nurses, Medical Assistants, Aestheticians practicing at the same facility as the undersigned Doctor will be subject to compulsory, binding arbitration.

Article 3: 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 related 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 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 court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 4: Procedures and Applicable Law: A demand for arbitration must communicate 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 Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations 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 5: 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 6: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 7: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services (including, but not limited to, prior consultations or treatment), the signing party must initial here.

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.

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

_____
Print Patient's Name (If Representative, Print Name and Relationship to Patient)

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

_____
Print Name of Physician, Medical Group or Association Name