Michael A. Zadeh, MD, FACS
Zadeh Surgical, Inc.
Z Center for Cosmetic Health

NEW PATIENT INTAKE FORM

PATIENT INFORMATION **DATE:**

LAST NAME: _____ FIRST NAME: _____ MI: ____

MAILING ADDRESS: _____

CITY: _____ STATE: ____ ZIP: _____ DOB: _____ AGE: ___

SEX: M___ F___ SOCIAL SECURITY #: _____ MARITAL STATUS: _____

PHONE NUMBER: _____ EMAIL: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

NAME: _____ RELATION: _____

ADDRESS: _____ PHONE #: _____

EMPLOYER INFORMATION

EMPLOYER: _____ OCCUPATION: _____

WORK TEL: _____ EXT: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ ID#: _____
GROUP #: _____ NAME OF POLICY HOLDER: _____
RELATION: _____ DOB: _____ SEX: M ___ F ___

SECONDARY INSURANCE: _____ ID#: _____
GROUP #: _____ NAME OF POLICY HOLDER: _____
RELATION: _____ DOB: _____ SEX: M ___ F ___

Michael A. Zadeh, MD, FACS
Zadeh Surgical, Inc.
Z Center for Cosmetic Health

GENERAL CONSENT FOR EVALUATION AND TREATMENT

MEDICAL HISTORY CONFIRMATION

I confirm that the medical-history information I provided is complete and accurate to the best of my knowledge. I will notify the practice of material changes before treatment or surgery.

Patient/Representative Initials: _____ Date: _____

I request evaluation and treatment by Michael A. Zadeh, MD, FACS, and authorized clinical personnel of Zadeh Surgical, Inc. and/or Z Center for Cosmetic Health. I understand that healthcare results cannot be guaranteed.

Scope of this consent

- This consent covers routine history, examination, clinical photography when medically necessary for the record, diagnostic testing, care coordination, and noninvasive treatment discussed with me.
- This consent does not replace a separate informed-consent discussion and written consent for surgery, anesthesia/sedation, implants, blood products, or any other procedure requiring specific consent.
- I may ask questions, decline a proposed intervention, or withdraw consent before an intervention begins, subject to emergency circumstances and applicable law.

Students, observers, and chaperones

The practice will identify clinical personnel involved in my care. I may request a chaperone for an examination. Students or nonessential observers may participate only with my permission.

Telehealth, electronic communication, and outside facilities

By signing below, you consent to the use of telehealth when necessary. If care is provided at a hospital, ambulatory surgery center, or other facility, that facility and other professionals may have separate consent, privacy, and billing documents.

Patient/Representative Signature: _____ Date: _____

Printed name/relationship: _____

Witness/Staff: _____

Michael A. Zadeh, MD, FACS
Zadeh Surgical, Inc.
Z Center for Cosmetic Health

FINANCIAL POLICY AND ASSIGNMENT OF BENEFITS

Patient responsibility

I am responsible for charges for services provided by Michael Zadeh, MD, FACS; Zadeh Surgical, Inc.; Z Center for Cosmetic Health. This includes copayments, coinsurance, deductibles, non-covered services, and charges denied because information I provided was inaccurate or incomplete. Insurance verification or prior authorization is not a guarantee of payment.

Insurance claims and assignment of benefits

I authorize Michael Zadeh, MD, FACS; Zadeh Surgical, Inc.; Z Center for Cosmetic Health to submit claims and supporting information permitted by law to my health plan. To the extent permitted by my plan and applicable law, I assign benefits payable for covered services directly to the selected practice entity. I remain responsible for patient balances after claim adjudication.

Estimates and cosmetic/self-pay services

Quotes and estimates are not guarantees of final cost. Additional medically necessary services, pathology, laboratory testing, anesthesia, facility, imaging, pharmacy, implant, or other professional charges may be billed separately. For uninsured or self-pay care, I will receive a Good Faith Estimate when required by federal law.

Refunds, credits, and collections

Credits and refunds will be processed after account review and claim adjudication when applicable. I agree to contact the billing office promptly about disputed charges. Nothing in this policy waives rights or remedies provided by law.

Separate entities and facilities

I understand that Michael Zadeh, MD, FACS; Zadeh Surgical, Inc.; Z Center for Cosmetic Health are entities that are separate from hospitals, surgery centers, laboratories, pathologists, anesthesiologists, radiologists, and other professionals unless expressly stated otherwise. Those entities may bill separately.

Patient/Representative Signature: _____ Date: _____

Printed name/relationship: _____

Michael A. Zadeh, MD, FACS
Zadeh Surgical, Inc.
Z Center for Cosmetic Health

CANCELLATION AND RESCHEDULING POLICY

We reserve appointment and surgery times specifically for each patient. Please notify our office as soon as possible if you need to cancel or reschedule.

Office Appointments: Appointments cancelled or rescheduled less than 24 hours before the scheduled appointment time, or missed without notice, may be subject to a $50 fee.

Surgical Procedures: A surgery cancelled or rescheduled less than 24 hours before the scheduled procedure time, or missed without notice, will be subject to a $300 rescheduling fee. This fee must be paid before another surgery date is reserved.

The practice may waive these fees when the cancellation results from a medical emergency, sudden illness, death in the immediate family, or another significant circumstance beyond the patient's reasonable control. Documentation may be requested when appropriate. No fee will be charged when the practice cancels the appointment or surgery, or when the physician determines that cancellation is medically necessary.

Cancellation fees are the patient's responsibility and will not be billed to insurance.

I acknowledge that I have read, understand, and agree to this policy.

Patient/Representative Signature: _____ Date: _____

Printed name/relationship: _____

ZADEH SURGICAL, INC.
Z CENTER FOR COSMETIC HEALTH
MICHAEL ZADEH, MD, FACS

CREDIT CARD AUTHORIZATION AGREEMENT FOR MEDICAL SERVICES

CREDIT CARD INFORMATION

Cardholder Name (as it appears on card): _____

Relationship to Patient (if not self): _____

Card Type: ▫ Visa ▫ MasterCard ▫ American Express ▫ Discover

Card Number: _____

Expiration Date (MM/YY): _____ CVV: _____

Billing Address (if different from above): _____

AUTHORIZATION AND FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges incurred for medical services provided by this practice, including but not limited to copayments, coinsurance, deductibles, and any non-covered services as determined by my insurance carrier.

I authorize ZADEH SURGICAL, INC.; Z CENTER FOR COSMETIC HEALTH; & MICHAEL ZADEH, MD to charge the credit card listed above for:

- Outstanding balances after insurance processing
- Copayments at the time of service not otherwise collected
- Deductibles and coinsurance amounts determined after claim adjudication
- Missed appointment or late cancellation fees, in accordance with practice policy

This authorization applies to all current and future services unless revoked in writing.

INSURANCE PROCESSING ACKNOWLEDGMENT

I understand that insurance verification is not a guarantee of payment. Final responsibility for payment is determined by my insurance carrier. Any balance not paid by my insurance will be charged to the card listed above in accordance with this agreement.

CHARGE NOTIFICATION AND RECEIPTS

I understand that charges may be processed after my insurance claim has been adjudicated. An itemized statement may be provided via mail, email, or patient portal. I may request a receipt for any charge upon request.

REVOCATION OF AUTHORIZATION

I understand that I may revoke this authorization at any time by submitting a written request to the practice. Revocation will not apply to charges incurred prior to receipt of the written notice.

HIPAA AND PAYMENT PROCESSING

I understand that my payment information will be stored and processed securely in compliance with applicable federal and state privacy and security regulations. My protected health information will not be disclosed except as permitted for treatment, payment, or healthcare operations.

DISPUTES

I agree to notify the practice of any billing discrepancies within 30 days of the charge. I understand that failure to do so may result in the charge being considered valid.

CARDHOLDER AUTHORIZATION

By signing below, I certify that I am an authorized user of the credit card provided and that I agree to the terms outlined in this authorization.

Cardholder Signature: _____ Date: _____

Printed Name: _____

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 _____

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

Michael A. Zadeh, MD, FACS
Zadeh Surgical, Inc.
Z Center for Cosmetic Health

CALIFORNIA REQUIRED PATIENT NOTICES

NOTICE TO PATIENTS - MEDICAL BOARD OF CALIFORNIA

Medical doctors are licensed and regulated by the Medical Board of California.

To check up on a license or to file a complaint go to www.mbc.ca.gov, email: licensecheck@mbc.ca.gov, or call (800) 633-2322.

I acknowledge receipt and understanding of the Medical Board of California notice above.

Patient/Representative Signature: _____ Date: _____

Printed name/relationship: _____

OPEN PAYMENTS DATABASE NOTICE

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov.

I acknowledge receipt of this notice at my initial office visit. The practice will provide me a copy if this notice is maintained on paper.

Patient/Representative Signature: _____ Date: _____

Printed name/relationship: _____

Michael A. Zadeh, MD, FACS
Zadeh Surgical, Inc.
Z Center for Cosmetic Health

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Effective date	07/01/2009
Privacy contact	Row Zadeh
Address	14658 Ventura Blvd., Sherman Oaks, CA. 91403
Phone / Email	(818) 789-1111/info@zadehsurgical.com

Your rights

- Get an electronic or paper copy of your medical record and other health information we maintain about you.
- Ask us to correct information you believe is incorrect or incomplete.
- Request confidential communications, such as contact at a particular phone number, email address, or mailing address.
- Ask us to limit certain uses or disclosures. We are not always required to agree, except in circumstances required by law.
- Receive an accounting of certain disclosures made during the applicable lookback period.
- Receive a paper copy of this notice even if you agreed to receive it electronically.
- Choose a legally authorized personal representative to act for you.
- File a complaint without retaliation if you believe your privacy rights were violated.

Your choices

In certain situations, you may tell us whether to share information with family, friends, caregivers, or others involved in your care or payment; participate in disaster-relief communications; or use information for marketing, sale, or fundraising. We will obtain written authorization when required by law. Most uses of psychotherapy notes, sale of health information, and marketing uses require written authorization.

How we typically use or share information

- Treatment: We may use your information and share it with professionals involved in your care.
- Payment: We may use and disclose information to bill you, submit claims, obtain payment, and coordinate benefits.
- Health care operations: We may use and share information to operate the practice, improve quality, train staff, manage risk, and contact you about care.

Other permitted or required uses and disclosures

- Public health and safety activities, including disease reporting, product recalls, adverse-event reporting, and preventing a serious threat to health or safety.
- Health research when authorized or permitted under applicable safeguards.
- Compliance with federal or state law and oversight by government agencies.
- Organ and tissue donation, coroners, medical examiners, and funeral directors.
- Workers' compensation, lawful law-enforcement requests, health oversight, and special government functions.
- Court or administrative orders, subpoenas, and legal proceedings, subject to applicable federal and California protections.

Specially protected information

Federal or California law may provide additional protection for particular records, including certain mental-health, substance-use-disorder, HIV, genetic, reproductive-health, and minor-consented care records. We will obtain authorization or meet other legal requirements when those laws apply.

To the extent we maintain substance-use-disorder patient records subject to 42 CFR Part 2, we will not use or disclose those records in civil, criminal, administrative, or legislative investigations or proceedings against you without your written consent or a qualifying court order and subpoena.

Michael A. Zadeh, MD, FACS
Zadeh Surgical, Inc.
Z Center for Cosmetic Health

NOTICE OF PRIVACY PRACTICES - CONTINUED

Your right to restrict health-plan disclosures

If you pay in full out of pocket for a particular item or service, you may ask us not to disclose information about that item or service to your health plan for payment or health care operations. We will honor the request unless disclosure is required by law.

Our responsibilities

- We are required by law to maintain the privacy and security of protected health information.
- We will notify you promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in the notice currently in effect.
- We will not use or share information other than as described in this notice unless you authorize it in writing, and you may revoke that authorization prospectively.

Complaints

You may complain to the practice privacy contact listed on the first page of this notice. You may also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, by visiting www.hhs.gov/hipaa/filing-a-complaint, calling 1-877-696-6775, or writing to 200 Independence Avenue, S.W., Washington, D.C. 20201. We will not retaliate against you for filing a complaint.

Changes to this notice

We may change the terms of this notice, and the changes may apply to information we already have. The current notice will be available on request, posted at the practice, and posted on the practice website that describes patient services.

PATIENT ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received the Notice of Privacy Practices for the selected practice entity. Signing this acknowledgment does not authorize uses or disclosures beyond those permitted by law and does not waive any privacy right.

Patient/Representative Signature: _____ Date: _____

Printed name/relationship: _____

Office use only - acknowledgment not obtained

Reason ☐ Patient declined ☐ Emergency ☐ Unable to sign ☐ Other: _____

Staff name / signature _____

Date: _____