

**PATIENT INFORMATION**

Last Name	First Name	MI	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address	City	State	Zip
Date of Birth     /     /	SSN	Preferred Language	
Home Phone	Cell Phone		
Employer	Work Phone	Ext.	
Emergency Contact	Relationship	Phone	

Would you like to sign up for our patient portal to receive access to your medical records and communicate securely with Centrelake? **(E-mail required)**   ☐ Yes ☐ No   **E-mail:**

**RESPONSIBLE PARTY INFORMATION**

Last Name	First Name	Relationship
City	State	Zip
Home Phone	Cell Phone	Date of Birth   /   /

**INSURANCE INFORMATION**

Primary Insurance Name	Address		
City	State	Zip	Phone
Policy Holder	Date of Birth     /     /	SSN	
Full Address (if different than patient)			
Policy #	Group #	Relationship to Patient	
Secondary Insurance Name	Address		
City	State	Zip	Phone
Policy Holder	Date of Birth     /     /	SSN	
Full Address (if different than patient)			
Policy #	Group #	Relationship to Patient	
On the Job Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury     /     /	Initial	
Motor Vehicle Accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Injury     /     /	Initial	
Adjuster/Attorney	Phone		

## HEALTH SCREENING

In compliance with the HITECH Act and the Centers for Medicare & Medicaid Services (CMS), we are required to gather your clinical health data. Please complete the information below.

• Please describe your smoking status:

- ☐ Current, every day   
 ☐ Current, some days   
 ☐ Former smoker   
 ☐ Never smoked  
☐ Smoker, current status unknown   
☐ Unknown if ever smoked

• If 50 or older, have you received an Influenza vaccine for this past flu season? ☐ Yes ☐ No ☐ N/A

• For women 40-69, when was your last mammogram in the last two years?    /    /

• If between 50-75, what was the date of your last colonoscopy?    /    /

• If between 50-75, what was the date of your last sigmoidoscopy?    /    /

• If between 50-75, have you been diagnosed with colon cancer? ☐ Yes ☐ No ☐ N/A

• If 64 or older, have ever been vaccinated for pneumonia? ☐ Yes ☐ No ☐ N/A

• Have you been diagnosed with active tuberculosis (TB) in the last 6 months? ☐ Yes ☐ No

• Are you on any active medications? ☐ Yes (please list below) ☐ No

Name	Dose	Date Started	/	/
Name	Dose	Date Started	/	/
Name	Dose	Date Started	/	/

• Do you have any known allergies? ☐ Yes (please list below) ☐ No

Allergen	Reaction	
Severity	<input type="checkbox"/> Mild <input type="checkbox"/> Mild to Moderate <input type="checkbox"/> Moderate <input type="checkbox"/> Moderate to Severe <input type="checkbox"/> Severe <input type="checkbox"/> Fatal	
Allergen	Reaction	Severity
Allergen	Reaction	Severity

**Mild:** hives, itching, nasal congestion, rash and watery eyes

**Moderate:** cramps, chest tightness, diarrhea, difficulty breathing, difficulty swallowing, dizziness, light headedness, flushing/redness of face, nausea, vomiting, palpitations, swelling of face/eyes/tongue, wheezing, weakness, and unconsciousness

**Severe:** anaphylactic shock

Why are you here to see us today?

• Approximately when did this issue begin?    /    /

I attest that the information on this form is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the procedure I am about to undergo.

Sign

Printed Name

Date    /    /

## PATIENT AGREEMENT FORM

## DIAGNOSTIC TESTING MEDICAL CONSENT

I consent to the administration and performance of all diagnostics procedures which in the judgment of his/her physician/healthcare practitioner is considered necessary and advisable. I also agree that if I decide to leave without receiving treatment and/or without the consent of my physician, then Centrelake Medical Group, Inc. ("Centrelake") will not be liable for any consequence of that decision.

## CONSENT TO RELEASE OF IMAGING RECORDS

Original imaging records are the property of Centrelake. Upon my request, Centrelake will release imaging records to serve my best interest. Once imaging records are released to patient, referring provider, or authorized recipient, I understand that I will not hold Centrelake liable for all known or unknown claim(s) that may arise should the imaging records become missing or lost. Imaging records may be duplicated at prevailing cost not to exceed \$30 per CD.

## INDEPENDENT CONTRACTOR NOTICE

The radiologists, physicians and other specialized medical service providers performing services at Centrelake's facilities are independent contractors and are not employees or agents of Centrelake. Independent contractors and practitioners are responsible for their own actions. Centrelake is not liable for the acts or omissions of any such independent contractors or practitioners.

## RELEASE OF INFORMATION &amp; HIPAA CONSENT

In order to obtain reimbursement, I understand that portions of my medical record may be disclosed to any person or corporation (or any agent affiliated of such) for all or any portion of charges by Centrelake, including, but not limited to insurance companies, health care service plans, worker's compensation carriers and employers. I hereby acknowledge that a copy of the current notice will be available in the reception area and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment by request.

## ASSIGNMENT OF BENEFITS

For services rendered herein, I hereby authorize that any payment that is made payable to me from my insurance company or responsible financial entity will be forwarded to Centrelake and its affiliated physicians. Payment shall not exceed Centrelake's regular charges for treatment. I understand that I am financially responsible to Centrelake and its affiliates for charges not covered by my insurance carrier.

## FINANCIAL AGREEMENT

In consideration of the services provided, I understand and agree that I am held financially responsible (undersigned may be patient, agent or financial responsible party) for all charges, whether or not charges are covered by my insurance. **In accordance with the medical insurance policy current rates and terms, all payments and/or balance owed must be forwarded and made payable to Centrelake. ALL CO-PAYMENTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE.** In some cases, a copayment or patient responsibility may be applied by my insurance company once the claim is processed (i.e., after date of service). I acknowledge and agree that I am financially responsible for all applicable co-payments and patient responsibility payments relating to the services provided. If it is necessary to utilize an attorney to enforce this agreement, or collect any judgment based upon this agreement, then I will be financially responsible and liable for all court costs and attorney fees accrued.

## AUTHORIZATION TO TRANSFER FUNDS

I understand should a credit balance appear on my account with Centrelake, then I authorize the use of credit balance to be applied to any unpaid balance due to Centrelake. Once all claims have been processed, I may receive a refund from Centrelake for any excess of funds that were paid at the time of service prior to submission of claim.

## CONSENT FOR ACQUISITION OF MEDICAL RECORDS

In order to provide the most accurate reading of my current studies and to assure that I am receiving the highest quality of care, I consent to Centrelake obtaining any of my previous images, radiology reports, pathology reports, or results of surgical intervention from outside facilities for comparison to my current studies and/or track abnormal results.

## CERTIFICATION

**I certify that I have read, agreed and accepted all the above terms and conditions and I may receive a copy of this agreement upon request.**

**PREGNANT:** Are you pregnant and/or have reason to suspect that you may be pregnant? ☐ YES ☐ NO

**If YES, please immediately notify the front office staff member AND technologist prior to your diagnostic procedure.**

## Patient, or Patient's Agent or Representative

*\*If patient is a minor, the parent, a legal guardian, or a person authorized by them in writing must sign.*

*\*If patient is incompetent, a legal guardian or conservator must sign.*

Print Name

Date / /

Patient Signature  
(or Patient's Agent or Representative)

## ARBITRATION AGREEMENT AND INFORMED CONSENT

**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 state and federal law, and not by a lawsuit or resort to court process except as state and federal 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 also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, and procedural disputes will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat patient while employed by, working or associated with or serving as back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the healthcare provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

**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 thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. 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, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in this arbitration of any person or entity that 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 the provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover noneconomic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that arbitration rules within the State of California shall govern any arbitration conducted pursuant to this Arbitration Agreement.

**Article 4: General Provision:** 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 legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should **initial here** \_\_\_\_\_ effective as the date of first professional services. If any provision of the 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.**

Print Name

Date       /       /

Patient Signature  
(or Patient's Representative)