Beach Cities Medical Weight Loss

PATIENT HEALTH HISTORY

Name: _____

Address: _____

City/State: _____Zip: _____

Phone: (home) _____ Cell:_____

Date of Birth: _____ Occupation:_____

Driver's License #_____ Expiration:_____

Emergency Contact Name:_____

Relationship:_____ Phone #_____

Primary Care Physician:_____

Your Email:_____

Can we leave a message via text, phone & email: (circle one) YES NO

Have you ever taken prescription medication for weight loss? YES NO

How much weight would you like to lose?_____

How many times per week do you exercise?_____

What kind of vitamins do you take?_____

Are you sensitive to medications?_____

Do you have a history of any of the following? Mark YES or NO

Heart Problems/chest pains	YES	NO
High or low blood pressure	YES	NO
Asthma	YES	NO
Diabetes	YES	NO
High cholesterol	YES	NO
Epilepsy/Seizures	YES	NO
Anxiety/Depression	YES	NO
Dizziness/Vertigo	YES	NO
Sleeping problems	YES	NO
Arthritis	YES	NO
Headaches	YES	NO
Drug or food allergies	YES	NO
Are you pregnant or breast feeding	YES	NO
Major illness/hospitalization	YES	NO
Do you have glaucoma	YES	NO
Thyroid condition	YES	NO
Do you smoke	YES	NO
Do you drink alcohol	YES	NO
Substance abuse within 6 months	YES	NO

How did you hear about us?

_____ Friend Referral: Friend's name_____

_____ Clipper Magazine _____ Facebook _____ YELP

_____ Internet Search _____ Driving By _____ Other:

Patient Consent:

The above information is a true representation of my current health status. I have read and understand the above and do hereby agree to treatment administered to me, including medications for weight control I, the undersigned, have been informed by Beach Cities Medical Weight Control of the possible side effects and consequences involved in treatment by medications, supplements and injections for the purpose of weight loss. nevertheless, I consent to such treatment and agree to hold Beach Cities Medical Weight Control, Inc., free and harmless for any claims, demands or suits for damages from any injury or complications, save negligence, that may result from such treatment.
If you suspect that you are pregnant, discontinue any medication dispensed by Beach Cities Medical Weight Control, Inc. Pregnant or nursing mothers should not be taking these medications.

Signed_____ Date:_____

IF THE PATIENT IS UNDER THE AGE OF 18, A PARENT OR LEGAL GUARDIAN MUST SIGN ON THEIR BEHALF.

BEACH CITIES MEDICAL WEIGHT CONTROL, INC.
SHORELINE MEDICAL WEIGHT LOSS, INC.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I hereby acknowledge that I received a copy of James A Hartleroad, M.D's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notice at each appointment.

If you would like to receive a copy of any amended Notice of Privacy Practices by email, please provide us your email:_____

X SIGNED:_____

X DATED:_____

Print Name:_____
Telephone:_____

Date of Birth:_____

If not signed by the patient, please indicate relationship:

_____ Parent or guardian of minor child

_____ Guardian or conservator of incompetent patient

Beach Cities Medical Weight Control, Inc. 714-472-6574
7772 Warner Ave. Suite 103, Huntington Beach, CA 92647

Shoreline Medical Weight Loss, Inc. dba Beach Cities Medical Weight Loss 2
562-375-4372
6420 E. Spring St., Long Beach, CA 90815

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 bind all parties whose claims may arise out of or relate to treatment or services 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 the assertion of any claim, against the 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 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. 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.

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 the 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 provision 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.

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 arbitration 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 and if not revoked will govern all medical services to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: **Retroactive Effect:** If the 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 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 Signature Date Print Patient's Name

BY: _____
James A. Hartleroad, M.D. Date