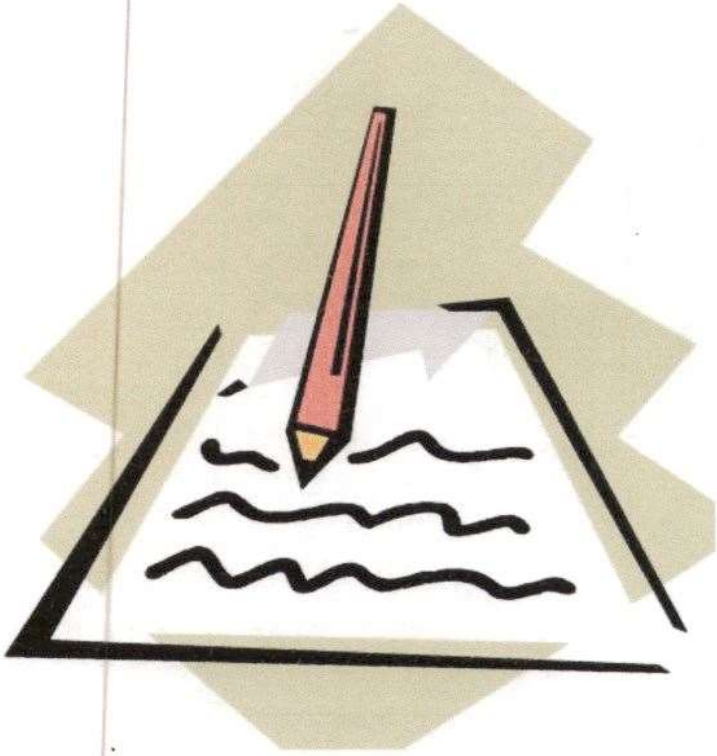
DR SHIMA HADIDCHI MD

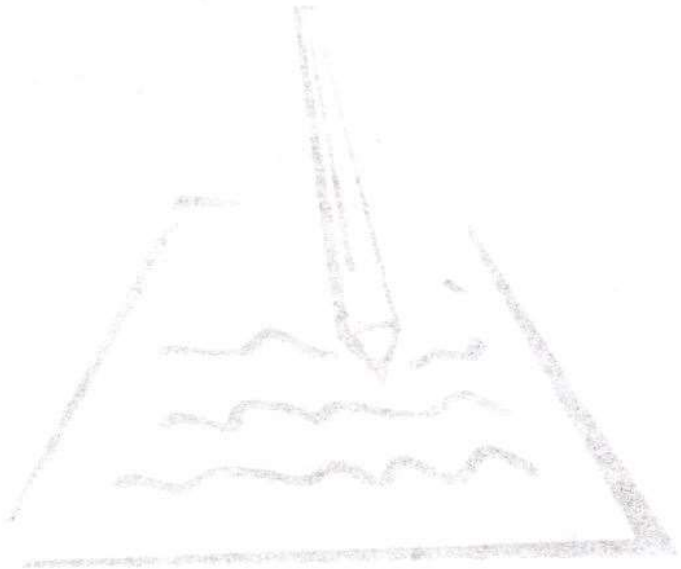
FAMILY PRACTICE

New Patient Packet



SHIMA HADIDCHI MD,
A PROFESSIONAL GROUP
INTERNAL MEDICINE, FAMILY PRACTICE
12740 HESPERIA RD, SUITE A
VICTORVILLE, CA 92395
PHONE: (760) 998-1999
FAX: (760) 881-3555

****Please Providing Accurate Information Which May Reduce Efficiency, Delays, Costs, and Other Risks During Visits and/or Treatment(s)**



Patient Information Sheet:

Patients Name:_____ Social Studies No._____

Date of Birth:_____ Sex: M / F (Circle One) Married /Single /Divorced /Widow

Address:_____

(Street) (City/State/Zip)

Home:( )_____ E-mail Address:_____

Preferred Language:_____ Ethnicity: [ ] Hispanic/Latino [ ] Not Hispanic/Latino

Race: [ ] White [ ] Black [ ] Asian [ ] Middle Eastern [ ] Other:_____

_____

(Patients Employer Name) (Address) (City/State/Zip) (Telephone)

Person Responsible for Patient (Complete ONLY if Different from Patient):

Guarantor Name:_____ Social Security Number:_____

Relationship to Patient: (please check): [ ]Self [ ] Spouse [ ] Parent Date of Birth:_____

Address:_____ Phone Number: ( )_____

_____

(Employers Name) (Address) (City/State/Zip) (Telephone)

Emergency Contact:

_____

(Last Name, First Name) (Relationship) (Telephone Number)

Insurance Information:

Primary Insurance Comp:_____ Policy Number:_____

Group Number:_____ Plan Code:_____

Subscriber Name:_____ DOB:_____ SS No._____

Secondary Insurance Comp:_____ Policy Number:_____

Group Number:_____ Plan Code:_____

Subscriber Name:_____ DOB:_____ SS No._____

How did you hear about our clinic: (Please check to indicate which method?)

[ ] Newspaper [ ] Radio [ ] Media [ ]TV [ ] Employer [ ] Family/Friend [ ] Other:_____

My signature below hereby authorizes the absolved name, insurance company to pay for all medical service rendered. I, understand that I am financially responsible for all changes not covered by my insurance company. I authorized release of medical information to said insurance company. Additionally, my signature provides willing consent to procedures which may be performed including emergency treatment and services, and which may include but not to laboratory procedure, x-ray exams, medical or surgical treatment or procedures, anesthesia, or services rendered to the patient under the general and special instruction of the patient's physician or designate.

Signature: (If not Patient, Relationship) Date:

_____

Medication List:

Please list every prescription and over-the-counter drug you are currently taking. Be sure to include the strength and dosage of each medication, and how often it taken.

Medication Name and Strength	Direction, How Taking Medication
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	
21.	
22.	
23.	

Medical History:

Are you currently under a physician's care? [ ] YES [ ] NO If No, please explain:_____

Have you ever been hospitalized or has major operation? [ ] YES [ ] NO If Yes, please explain:_____

Have you ever had any surgeries? [ ] YES [ ] NO If Yes, please explain:_____

Have you ever had a serious head and neck injury? [ ] YES [ ] NO If Yes, please explain:_____

Are you on a special diet? [ ] YES [ ] NO If Yes, please explain:_____

Do you use controlled substance? [ ] YES [ ]NO

Do you use tobacco and/or smoke? [ ] YES [ ] NO If Yes, please explain:_____

Do you drink? [ ] YES [ ] NO If Yes, please explain (how much and how often):_____

WOMEN: [ ] Pregnant/trying to get pregnant? [ ] Nursing? [ ] Taking any type of contraceptives?

LAST PAP SMEAR?_____ LAST MAMMOGRAM?_____

LAST TENANUS VACCINATION?_____ **LAST INFLUENZA VACCINATION?**_____

Are You Allergic to Any of The Following?

[ ] Aspirin [ ] Penicillin [ ]Codeine [ ] Acrylic [ ] Metal [ ] Latex [ ] Local Anesthetics

[ ] other If Yes, please explain:_____

[ ] Any food allergy? If Yes, please explain:_____

Do you have, or have you had, any of the following?

☐ AIDS/HIV POSITIVE	☐ ALZHEIMERS DISEASE	☐ ANAPHYLACTIC	☐ ANEMIA
☐ ANGINA	☐ ARTHRITIS/GOUT	☐ ARTIFICIAL HEART-VALVE	☐ ARTIFICIAL JOINT
☐ ASTHMA	☐ BLOOD DISEASE	☐ BLOOD TRANSFUSION	☐ BREATHING PROBLEM
☐ CANCER	☐ CHEMOTHERAPY	☐ COLD SORES/FEVER BLISTERS	☐ CHEST PAIN
☐ CONTENGINAL HEART DISEASE	☐ CONVULSION	☐ DIABETES	☐ DRUG ADDICTION
☐ EASILY WINDED	☐ EPILEPSY OR SEIZURE	☐ EXCESSIVE BLEEDING	☐ EXCESSIVE THIRST
☐ FAINTING SPELLS/ DIZZINESS	☐ FREQUENT COUGH	☐ FREQUENT DIARRHEA	☐ FREQUENT HEADACHE
☐ GENITAL HERPES	☐ GLUCEMIA	☐ HAY FEVER	☐ HEART ATTACK/FAILURE
☐ HEART MURMUR	☐ HEART PACE MAKER	☐ HEART TROUBLE/DISEASE	☐ HEMOPHILIA
☐ HEPATITIS A	☐ HEPATITIS B OR C	☐ HERPES	☐ HIGH BLOOD PRESSURE
☐ HIVES/RASH	☐ IRREGULAR HEARTBEAT	☐ KIDNEY PROBLEM	☐ LEUKEMIA
☐ LIVER DISEASE	☐ LOW BLOOD PRESSURE	☐ LUNG DISEASE	☐ PAIN IN JAW JOINTS
☐ PARAMECIUM DISEASE	☐ RADIATION TREATMENT	☐ RECENT WEIGHT LOSS	☐ RENAL DIALYSIS
☐ RHEUMATIC FEVER	☐ SCARLET FEVER	☐ RHEUMATISM	☐ SHINGLES
☐ SICKLE CELL DISEASE	☐ SPINA BIFIDA	☐ SINUS TROUBLE	☐ STROKE
☐ SWELLING OF LIMBS	☐ THYROID DISEASE	☐ TONSILITIS	☐ TUBERCULOSIS
☐ ULCERS	☐ VENEREAL DISEASE	☐ YELLOW JAUNDICE	☐ HIGH CHOLESTEROL

☐ OTHER(NOT LISTED ABOVE):_____

TUBERCULOSIS (TB) RISK ASSESSMENT

Patient Name: DOB: Today Date:

Do you have any of the following symptoms? (please indicate YES or NO to each one that applies)

[ ]YES [ ] NO COUGH [ ]YES [ ] NO LOSS OF APPETITE

[ ]YES [ ] NO FEVER [ ]YES [ ] NO NIGHT SWEATS

[ ]YES [ ] NO COUGHING UP BLOOD [ ]YES [ ] NO FATIGUE

[ ]YES [ ] NO LOSS OF WIEGHT [ ]YES [ ] NO CHEST PAIN

Were you born in another county? (please indicate by circling YES or NO to each one that applies)

[ ] YES [ ] NO Please indicate the country: _____

Have you? (please indicate by circling YES or NO to each one that applies)

[ ]YES [ ] NO Had a recent contract with someone with active TB?

[ ]YES [ ] NO Recently or currently been homeless? (within the past 2 years)

[ ]YES [ ] NO Visited another country for 2 months or more?

Please indicate the country. _____

[ ]YES [ ] NO Lived in another country?

Please indicate the country. _____

[ ]YES [ ] NO Taken the BCG vaccine?

Are you? (please indicate by circling YES or NO to each one that applies)

[ ]YES [ ] NO A student who is entering the public or private school system and moved to WV within the past 4 months?

[ ]YES [ ] NO A volunteer or new personnel entering the WV school system for the first time ?

Patient Responsibility Form

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITIES
   a. *I understand that I am financially responsible for my health insurance deductibles, co-insurance or non-covered services. Co-payments are due at time of service.*
   b. *If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the cost of all service provided.*
   c. *If I am uninsured, I agree to pay for the medical services rendered to me at the time of services.*
2. *INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENIEFITS*
   a. *I hereby authorize and direct payment of my medical benefits to Shima Hadidchi, MD on my behalf of any services furnished to me by the provider(s).*
3. *AUTHORIZATION TO RELEASE RECORDS*
   a. *I hereby authorize Shima Hadidchi, MD to release to my insurer, governmental agencies, or any other financially responsible for my medical care, all information, including diagnosis(s) and the records of any medical care, all rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referrals to other medical provider(s)*
4. *MEDICAL REQUEST FOR PAYMENT*
   a. *I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Shima Hadidchi, MD*
   b. *I authorize any holder of medical or other information about me renewed to Medicare and its agents any information needed to determine these benefits for related services.*

_____

(Signature of patient, authorized representative or responsible party) **(Date)**

_____

(print name)

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information Pertaining to :

Patient Name: _____

Date of Birth: _____

Information may be disclosed or released by Shima Hadidchi MD, A Professional Group information includes (please check authorized information to be released):

[ ] Labs/Imaging Results
[ ] Prescriptions
[ ]Pick up Triplicates (hand written security scripts) from office
[ ] Appointments
[ ] Medical Records

Information may be disclosed or released to: (other than yourself)

Full Name	DOB	Relationship
Full Name	DOB	Relationship

This authorized is valid unless you specify a date of termination from the date signed or unless terminated by the patient or by the patient's authorized representatives. Specify expiration date (if needed) of termination _____. The patient may revoke or terminate this authorization submitting a written revocation to Shima Hadidchi MD, A Professional Group information disclosed under the authorization may be disclosed again by the person or organization to which it is sent. The privacy if this information, by signing, may not be protected under federal privacy regulation.

_____ Patient Signature

_____ Patient Representative (if Applicable)

_____ Date

_____ Relationship

Authorization to Release Medical Information:

To: _____ Date: _____

(PHYSICIAN,CLINIC,HOSPITAL, HOME HEALTH AGENCY, ATTENDING NURSE, PSYCHOLOGIST,COUNSELOR,THERAPIST, ETC.)

_____

(ADDRESS)

I, hereby authorize you to release any and all medical or confidential information contain in the record of:

_____ _____

(Name of Patient) (Date of Birth)

TO: **SHIMA HADIDCHI, MD**
12740 HESPERIA RD, SUITE A
VICTORVILLE, CA 92395
PHONE: 760-998-1999
FAX: 760-881-3555

THIS AUTHORIZATION SHALL EXPIRE ON: _____
(DATE)

RECORDS AUTHORIZED TO BE RELEASED:

[ ] ANY/ALL MEDICAL RECORDS
[ ] LAB REPORTS
[ ] RADIOLOGY REPORTS
[ ] DOCTOR/ PROGRESS NOTES
[ ] OTHER: _____

_____
(PATIENT OR AUTHORIZED REPRESENTATIVE)

_____
(RELATIONSHIP TO PATIENT ON WHOM INFORMATION IS REQUESTED)

_____
(ADDRESS)

NOTE:

1. THE PERSON WHO AUTHORIZED THIS RELEASE MAY REVOKE THIS AUTHORIZATION AT ANY TIME.
2. THE PERSON WHO AUTHORZED THIS RELEASE HAS RIGHT TO RECEIVE A COPY OF THE RELEASE.

PAIN CONTRACT:

I, _____ , understand and voluntary agree that

(initial each statement after reviewing):

_____ I will keep (and be on time for) all scheduled appointments with the doctor and the members of the treatment team.

_____ I will participate in all other types of treatment that I am asked to participate in.

_____ I will keep the medication(s) safe, secure and out of reach of children. If the medicine is lost or stolen, I understand it will not be replaced until next appointment and may not be replaced at all.

_____ I will take my medication as instructed and not change the way I take it without first talking to the provider or other members of the treatment team.

_____ I will not call between appointments or at night or on the weekend looking for refills. I understand that prescription will be filled only during scheduled office visits with the treatment team.

_____ I will make sure I have an appointment for refills, if I am having trouble making appointments, I will tell a member of the treatment team immediately.

_____ I will treat the staff at the office respectfully at all times. I understand that if I and disrespectful to the staff or disrupt the care of other patients my treatment will be stopped.

_____ I will not sell any of the medicine or share it with others. I understand that if I do so, my treatment will be stopped.

_____ I will sign a release for to let my doctor speak to all other doctors or providers, that I see.

_____ I will tell the doctor all other medication that I take and let him/her right away if I have a prescription for new medicine.

_____ I will use only one pharmacy to get my medications from:

_____

(Pharmacy Name, Telephone Number)

_____ I will Not get any opioids pain medication or any other medication that can be addictive, such as Benzodiazepines (KLONIPIN, XANAX, VALIUM) or stimulants (RITAIN, AMPHETAMINE)0 without telling a member of the treatment team before I fill that prescription. I understand that only exception to this is if I need pain medication for an emergency at night or on the weekend.

_____ I will NOT use illegal drugs such as, (but not limited to) heroin, cocaine, marijuana, or amphetamines. I understand that if I do, my treatment be stopped

_____ I will come in for drug testing (UDS) and counting of my pills within 24 hours of being called. I understand that I must make sure the office has my current contact information in order to reach me.

I will keep up-to-date with any bills from the office and tell the doctor or a member of the treatment team immediately if I lose my insurance or can't pay for treatment anymore.

I understand that I may lose my right to treatment in this office if I break any part of my agreement.

Pain Treatment Program Statement

We here at **Shima Hadidchi, MD** are making a commitment to work with you in your effort to get better. To help you in this work, we agree that:

We will help you schedule regular appointments for medication refills. If we have to cancel or change your appointments for any reason, we will make sure you have enough medication to last until you next appointments.

We will make sure that this treatment is a safe as possible. We will check regularly to make sure you are not having bad side effects.

We will keep track of your prescriptions and test for drug use regularly to help you feel like you are being monitored well.

We will help connect you with other forms of treatment to help you with your condition.

We will help set treatment goals and monitor you progress in achieving those goals.

We will work with any other doctors or providers you are seeing so that they treat you safely and effectively.

We will work with your medical insurance providers to make sure you DO NOT go without medication because of paperwork or other things that may ask for.

If you become addicted to these medications, we will help you get treatment and get off the medications that are causing you problems safely without getting sick.

Patient Name Printed: _____ Date: _____

Patient Signature: _____

Providers Name: MD Shima Hadidchi Date: _____

Provider's Signature: _____

ADVANCE DIRECTIVES EDUCATION

EXPLANATION:

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. If you use this form, you may complete all or any parts of it. You are free to use a different form.

INSTRUCTIONS:

Part 1: Of this form lets you name a person as "agent" to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name a different person to act for you if first choice is no: willing, able or reasonably available to make decisions for you.

Unless you state otherwise in this form, your agent will have the right to:

Consent or refuse consent to any care, treatment service, or procedures to maintain.

1. *Select or discharge health care providers and institutions.*
2. *Approve or disapprove diagnostic test, surgical procedures and program of medication.*
3. *Direct the provision, withholding, or withdraw of artificial nutrient and hydration and all other forms of health care, including cardiopulmonary resuscitation.*
4. *Donate your organs, tissue, and parts: authorize autopsy, and direct disposition of remains*

However, your agent will not be able to commit you to a mental health facility, or consent to convulsive treatment, psychosurgery, sterilization or abortion for you.

Part2: Of this form let you give specific instruction about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express you wishes regarding the relief. You also can add to the choices you have made or write down any additional wishes. If you are satisfied to allow your agent to determine what is the most in making your end-of-life decisions, you need not to fill out Part 2 pf this form.

Give a copy of this signed and completed form to your physician, to any other health care providers you may have, to any health care intuitions at which you are receiving care, and any health care agent you have named. You should talk to the person you have named as agent to make sure that he/she understands your wishes and willing to take responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

Name of Patient: _____

Date-of-Birth: _____

Advance Directive- this Patients Right to Decide Acknowledgment

Physicians: _____

Telephone: _____

Address: _____

_____

Patient name: _____

Date-of-Birth _____

Address: _____

_____

Telephone: _____

Advance Directive- The Patient's Right to Decide

This acknowledgment that the physician or one of his/her staff member, has provided me information concerning Advance Directive.

---

1. **I am age 18 years old or older.**
   (circle one) **[ ] YES** **[ ] NO**

2. **I realize that I have options of putting together Advance Directive for my healthcare. My physicians have provided me written information concerning these Advance Directive. I understand that it is my responsibility to provide my doctor(s) with any documents that are requires to carry out my Advance Directive.**
3. **I am aware that Advance Directive may be any one of the following:**

   a. **A DURABLE POWER OF ATTORNEY FOR HEALTH CARE.**
   b. **THE DECLARIATION IN THE NAUTRAL DEATH ACT-EX. A LIVING WILL**
   c. **I may write-down wishes on a piece of paper so that my family may use the documents, in deciding my medical treatment, in the sense I am unable to do so.**

This document will become part of my medical records.

_____

Patient Signature **Date**

Notice of Privacy Practices:

This notice of privacy practices("Notice") describes how we may use disclose your health information and how you can get access to such information. Please read it carefully.

Your "health information" for purpose of this Notice is generally any information that identities you and is crested, received and maintained or transmitted by us in the course of providing health care items or services to you referred to as :health information" in this Notice.)

We are required by the Health Insurance Portability and accountabilities of 1996 ("HIPPA") and other applicable law to maintain the privacy of your health information, to provide individua with this Notice of our legal duties and privacy practices with respect to such information and to abide by the term of this Notice. We are also required by the law to notify affected individuals following a branch of their unsecured health information.

USES AND DISCLOSURES OF INFORMATION WITHOUT YOU AUTHORIZATION

The most common reason why we use or disclose your health information are for treatment, payment or health are operation Example of how we use and disclose your health information for treatment purposes are setting an appointment for your testing or examine your eyes: prescribing glasses , contact lenses or eye medication and faxing them to filled: showing you low vision aides. referring you to another doctor or clinic for eye care or low vision aide or services or getting copies of your health information from another professional that you may have seen before us. Example of how we use or disclose your health information for payment purpose are: asking you about your health or vision care plans, or other courses or payment: preparing and sending bills or claims or collecting unpaided amounts ("either our self or through a collecting agency or attorney"). "Health care operation" means those administrative and manageable functions that we must carry out in order to run our office "example of how we use and disclosure your health information for health care operation: financial or billing audit: internal quality insurance: personal decisions: participation on manage care plans; declines of legal matter: business planning and outside storage of our records.

OTHER DISCLOUSURES AND USES WE MAY MAKE WOTHOUT YOU AUTHORIZATION OR CONSENT

In some limited situation the law allows or requires us to use or disclose your health information without you consenter authorization. Not all of these situations will apply to use some may never come up at our office at all. Such use disclosures are :

- **When a state or federal law mandates that certain health information be reported for specific purpose:**
- **For public health purposed such as contagious disease report, investigation or surveillances, and notice to and from the federal Food and Drug Administration regarding drug or medical devices**
- **Disclosure to government authorities about victims of suspected abuse neglect or domestic violence uses and disclosure for health oversight activities such as for licensing doctors, for audits by Medicare or Medi-Cal or for investigation of possible violation of health care laws:**
- **Disclosure for law enforcement purposes such as to provide information about someone who is suspected to be a victim of a crime: to provide information about a crime in office: or a crime somewhere else**
- **Disclosure to a medical examiner to identify a dead person or to determine the cause of death: or to funeral directors to aid in burial: or to organization handle organ and tissue donation**
- **Use and disclosure to prevent a serious threat to health or safety**
- **Use and disclosure for specialized government function such as for the prevention of the president or high-ranking government officials for lawful nation intelligence activities; for military purposes or for the evaluation and health of members of the foreign services**
- **Disclosure of de-identified information**
- **Disclosure relating to worker's compensation program:**
- **Disclosure of a "limited date set" for research, public health or health care operation:**
- **Disclosure to "business associates" and their subcontractors who perform health care operations for us and who commit to respect the privacy of your health information in accordance with HIPPA :(specify other uses and disclosure after by state law)**

Unless you object, we will also share relevant information about your care with any of your personal representatives who are helping you with eye care upon your death, we ay disclosure to your family members or to other persons who were involved in your care or payment for health care prior to your death (such as personal representative health

information relevant to their involvement in your care unless doing so is inconsistent with your preference as expressed to us prior to your death

SPECIFIC USES AND DISCLOUSES OF INFORMATION REQUIRING YOUR AUTHORIZATION

The following are some specific uses and disclosure we may not make of your health information without your authorization:

Marketing activities , we must obtain your authorization prior to using or disclose any other health information for marketing purposes unless such marketing communication take form face-to-face communication we may make with individuals or promotional gifts of normal value that we may provide. If such marketing involves financial payment to us from a third party your authorization must also include consent to such payment.

Sale of health information:

We do not currently ell or plan to sell your health information and must see your authorization prior to doing so

Psychotherapy note:

Although we do not create or maintain psychotherapy notes on your patients, we are required to notify you that we generally must obtain your authorization prior to using or disclosure any such note.

YOUR RIGHTS TO PROVIDE AN AUTHORIZATION FOR OTHER USES AND DISCLOUSE

- Other uses and disclosure of your health information that are not described in the notice will be made only with your written authorization
- You may give us written authorization on permitting use your health information or to disclosure it to anyone for any purpose.
- We will obtain you written authorization for uses and disclosure of your health information that are not identified in this Notice or are not otherwise permitted by applicable law
- We must agree to request to restrict disclosure of your health information to a health plan if the disclosure is for the purpose of carrying out payment or health care operation and is otherwise required by law and such information pertains solely to health care items or services for which you have paid in full for which another person other than the health plan has paid in full on your behalf.

Any authorization you provide to us regarding the use and disclosure of your Health information maybe we walk by you and writing at any time after you were woke your authorization we will no longer use or disclose her health information for the reason described in the authorization however we are generally unable to retract any disclosure that we may have already made with your authorization. We may also be required to disclose health information as necessary for purposes of payment for service received by you prior to revoked your authorization.

YOUR INDIVIDUAL RIGHTS

You have many rights concerning the confidentiality of your health information you have the rights:

- To request restrictions on the health information we may use and disclose for treatment payment and healthcare operations we are not required to agree to these requests. To request restrictions, please send a written request to us at the address below
- To receive confidential examinations of health information about you in any manner other than describing our authorization request form you must take such requested written to the address below however we reserve the right to determine if we will be able to continue treatment under some restriction authorization.
- The inspector copy your health information you want to make sure with quest is written to the address below if you request of your copy of your health information we may charge you a fee for the cost of copying, mailing or other supplies in certain circumstances we may deny your request inspector copy your health information subject to applicable law.
- To amend health information if you feel that health information we have about you is incorrect or incomplete you may ask to amend the information to request amendment you must write to us at the address below you must also give us a reason to support your request we may deny your request to amend your health information if it is not written or does not provide a reason to support your request we may also deny requested if the following health information.
    - Was not created by us unless the person that created information is no longer available to make the amendment
    - It's not part of the health information copy kept by or for us
    - It's not part of the information you will be permitted to inspect a copy or is accurate and complete.
- To receive an accounting of your health information you must make sure the request is written to the address below not all health information is subject to this request. Your request mistake a time, for the information you would like

- to review no longer than six years prior in the date of the request it may not include date before August 14, 2003 your request must state below you would like to receive report (paper, electronically.
- To designate another party to receive your health information, if you request for access of your health information, direct us to a transit a copy of the health information directly to another person to request must be made by you in writing to the address below and must clearly identify the designated recipient and where to send a copy of your health information.

Contact Person:

Our contact person for all questions request or for further information related to the privacy of your health is:

(Name) _____ (ADDRESS) _____

Complaints:

If you think that we have not properly respected the privacy of your health information you're free to complain to us or do United States department of health and human services office for civil rights we will not relate against you if you make a complaint if you want to complain to us send a written complaint to the office contact person at the address fax or email show me below if you prefer you can discuss your complaint in person or by phone.

Change on this Notice:

We reserve the right to change our privacy practice and to apply the reverse practice to health information about you that we already have any revision to our privacy practice will be described in a revised notice that will be posted properly in our facility copies of this notice are also available upon request at our reception area.

Notice Revised and Effective: _____

ACKNOWLEDGMENT OF RECEIPT:

I have knowledge that I have received a copy of: _____ Notice of privacy practices

Date: _____

_____

(Patient Name) (Signature)

SHIMA HADIDCHI MD,
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12740 HESPERIA RD, SUITE A
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FAX: (760) 881-3555

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to attribute it is understood that any dispute as a medical malpractice, that is asked to whether any medical service rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompletely rendered, Will be determined by submission to attribution as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review for attribution proceeding. Parties to this contract by entering into an argument of the constitutional rights to have any such dispute decided in a court of law before a jury, and instead are excepting to use of arbitrated Article 2: All claims must be attributed it is in intention of the parties the disagreement bind all parties who claims may arise out of or relate to treatment or services provided by the physician including any spouse or heirs of the patient any children whether born or unborn at the time of the occurrence given rise to any claim in the case of any pregnant mother the term "Patient" herein show me what and the mothers expected child or children. All claims for monetary damage exceeding the judicial limit the small claims court against the physician in the physicians partner associates, association, corporation or partnership, and the employees, agents and a state of any of them, must be attribute included, without limitations, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fees from the patient shall wave right to compel attribution of any malpractice claim Article 3: procedures and Application law: a demand for retribution must be communicated in writing to all parties. Each party shall select an arbitrator "party attribution" within 30 days any third arbitrator (neutral arbitrator) shall be selected by the attribute yours appointed by the party within 30 days of a demand for a neutral attribution by either parties. Each party to the arbitrator shall pay such party's pro rata share the expenses and fees of the neutral arbitrator, together with other expenses of attribution 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 attribute or has the immunity of a judicial office from civil liability when acting in the capacity of attribution under this contract. This immunity shall supplement, not supplant, any other applicable statuary or common-law. Either party shall have the absolute right to attribute separately the issues of liability and damages upon writing request to the neutral arbitrator. The parties consent to the intervention and joinder in this attribution of any person or entity in which what otherwise be a proper additional party in a court action, and up on such intervention and joinder any existing court action against heredity shall be stayed pending arbitration. The parties agree that provision of California law applicable to health care provides shall apply to dispute within this activation agreement, including, but not limited to, code of Civil Procedure section 340.5 and 667.7 in civil court section 3333.1 and 3333.2. Any party may bring before arbitrators a motion for summary judgment or summary arbitration in accordance with the code of civil procedures. Discovery shall be conducted pursuit to code of civil procedure section 1283.05, however the position may be taken without prior approval of the neutral arbitrator. Article 4: General provision: all claims based upon the same incident, the transaction or related circumstance shall be attribute it in one proceeding. A clean shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if assorted in a civil action, would be buried by the applicable California statute of limitations, or(2) the claimant feels to pursue that attribution claim in accordance with the procedure prescribed hearin with reasonable diligence. With respect to any matter not herein express provided for, the arbitrator shall be governed by the California code of civil procedures provision relating to arbitration. Article 5:Revocation: this agreement maybe revoked permit notice delivered to the physician within 30 days of signature. It is intended of this agreement to apply to all medical services rendered anytime for any condition. Article 6 Retroactive Effect: a 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 the first medical service:_____ Patients or patient representatives and initial: _____

If any provision of this arch vision agreement is held invalid running forcible, the remaining provisions shall remain in full force and should not be affected by the invalidating of any other provision. I understand that I have the right to receive a copy of this attribution agreement. By my signature below I acknowledge that I have received the copy.

Notice: By signing this contract you're agreed to have any issue of medical malpractice decided by the neutral attribution that you're giving up your right to jury core trail the article (1) of this contract

By:

_____

Patient or Patient Representative Signature Date

By:

_____

Positions or authorized representative signature Date

MD Shima Hadidchi

_____

Print or step name a physician dr. Shima Hadidchi

By:

_____

Patients Name Printed

By:

_____

is representative print name and relationship to patient

It signed copy of this documentation Is to be given to the patient. Originals to be filed in patient's medical record

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