**DAVID P. YAMINI, M.D.**
**2001 Santa Monica Blvd, 1286-W**
**Santa Monica, CA 90404**
**Phone: (310) 285-3005**
**Fax: (310) 935-1560**

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## PATIENT INFORMATION

**PLEASE PRINT ALL INFORMATION**

Legal Name: _____

Home Address: _____ No. _____

City: _____ State: _____ Zip Code: _____

Home No. (  ) _____ Work No. (  ) _____

Cell. No. (  ) _____ Fax No. (  ) _____

E-mail: _____ Sex: ☐ Male ☐ Female

Date of Birth: _____ Social Security No. _____ Driver's License No. _____

Employer: _____ Occupation: _____

Marital Status: _____ Spouse's Name: _____

**PRIMARY**

Insurance Co. _____ Name of Insured: _____

Relationship to Patient: _____ Insured's Date of Birth: _____

Member ID: _____ Insured's Employer: _____

**SECONDARY**

Insurance Co. _____ Name of Insured: _____

Relationship to Patient: _____ Insured's Date of Birth: _____

Member ID: _____ Insured's Employer: _____

**IS MEDICARE THE PRIMARY COVERAGE? ☐ YES ☐ NO**

**EMERGENCY CONTACTS:** Please identify three (3) people with whom the physicians or staff can speak to regarding your medical care, i.e., family member, friend, assistant:

Name _____ No. (  ) _____

Name _____ No. (  ) _____

Name _____ No. (  ) _____

**Referring Physician:** _____

**Referring Physician's Phone Number:** (  ) _____

**Please list below physicians you see on a regular or annual basis:**

Name _____ No. (  ) _____

**I give permission to share my medical information with above physician:** ☐ **YES** ☐ **NO**

Name _____ No. (  ) _____

**I give permission to share my medical information with above physician:** ☐ **YES** ☐ **NO**

Name _____ No. (  ) _____

**I give permission to share my medical information with above physician:** ☐ **YES** ☐ **NO**

**DO WE HAVE YOUR PERMISSION TO LEAVE RESULTS AND/OR A DETAILED MESSAGE ON YOUR HOME ANSWERING MACHINE OR WITH ANYONE WHO ANSWERS YOUR HOME PHONE?**

☐ **YES** ☐ **NO**

I HEREBY AUTHORIZE _____, M.D., TO FURNISH INFORMATION TO MY INSURANCE CARRIER AND HEREBY ASSIGN TO THE DOCTOR ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF.

I AUTHORIZE YOU TO GIVE ME REASONABLE AND PROPER MEDICAL CARE BY TODAY'S STANDARDS.

PATIENT'S SIGNATURE _____ DATE _____

# DAVID P. YAMINI, MD

**Board Certified, American Board of Gastroenterology & Hepatology**

**2001 Santa Monica Blvd, Suite 1286-W**
**Santa Monica, CA 90404**

**PH: 310.285.3005**
**Fax: 310.935.1560**


## FINANCIAL AGREEMENT

Thank you for choosing Dr. David P. Yamini as one of your health care providers. We are pleased to be able to render services in the evaluation and treatment of your condition.

We need a current copy of your insurance card in order to bill your insurance directly for the charges and services rendered. If you are unable to provide us with a current insurance card or do not have insurance, full payment is due at the time of service. We will submit your claims to your insurance as a courtesy and we will assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

Please understand that you will be financially responsible for charges that are not covered by your insurance. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. If we do not have a contract with your insurance company, you are responsible for payment in full regardless of any insurance companies' arbitrary determination of UCR rates.

If you do not have insurance, payment is due in full at the time of service.

Payment are for those known patient due amounts (deductibles, non-covered services) at the time of service. Full payment for any known outstanding balance may be due at the time of your visit. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. All other payments are expected within 30 days of receipt of our billing statement.

We are committed to providing the best diagnosis and highest quality of treatment possible for our patients. Our fees for services rendered are usual and customary for our geographic area.

If you have any questions regarding your financial account with our office, please contact our billing department during normal business hours at 310-448-2693.

SELF PAY
We expect full payment at the time of service unless prior arrangements have been made.

MEDICARE
We accept Medicare assignment. There are some services and supplies that are not covered by Medicare. We will advise you if there are any non-covered charges prior to that service being provided.

PPO
We are not contracted with PPO plans. Often times, your in network deductible may be as high as your out of network deductible. We will assist in checking your out of network benefits to let you know if you are responsible for anything, if at all. As a courtesy, we will bill your insurance on your behalf. If there are changes to your insurance eligibility, it is your responsibility to make sure we have your new insurance information or your services will be your responsibility. Deductibles are determined by your plan and are not something we can negotiate. If you're undergoing a screening colonoscopy that's covered under your plan & a polyp is removed, please note that your insurance company may not process it as a screening procedure and you may be responsible for any deductible or co-insurance due. Some out of network insurances, most notably Blue Cross and Blue Shield, may send the doctor's reimbursement check directly to you. If so, it is your

responsibility to directly mail that reimbursement check to Dr. Yamini. Failure to do so and cashing the check will be considered insurance fraud, and acted upon as so.

HOSPITAL AND SURGERY CENTER CHARGES

In the event that you undergo an endoscopic procedure in a hospital or outpatient surgery center, separate charges will be made by the facility. Please note that your Gastroenterologist at Westside Gastro Care is a minority partial owner of Linden/Spaulding Surgery Center where you might be having your surgery.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges not covered by my insurance. I guarantee that the balance will be paid by cash, check, or credit card. Past due balances may be subject to additional fees. I understand that if the office agrees to bill insurance as a courtesy, I must submit information as needed in a timely manner, to ensure that payment for services rendered. I understand that I am ultimately responsible for payment of all services.

MISSED APPOINTMENTS AND CANCELLATION FEE

*No Show Charge $50.00 if not notified within 24 hours prior to your appointment.
*Due to the amount of allotted time for scheduled endoscopic procedures, we do request at least 3 working days notice for cancellation of procedures. It is the Doctor's policy to charge a $250 procedure cancellation fee if given less than 3 working days notice. The charge for a late cancellation/no show for a procedure will be billed directly to you and not to your insurance. Please help us serve you better by keeping scheduled appointments.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize release of my medical information, pursuant to applicable federal and state laws, rules and regulations, to third party payers and other providers participating in my care, that agree to treat my information in a confidential manner in accordance with all applicable federal, state and local laws. I further authorize any other individual or entity that has provided health care to me to release to *David Yamini, MD INC*, any and all of my medical record information, whether in printed or electronic form, needed to provide me with informed care. I may revoke my consent for the release of this information at any time, except to the extent that action has been taken in reliance on the consent.

CREDIT CARD AUTHORIZATION

Our office requires that a credit card be kept on file for payment of any deductible or charge that may not be covered by your health insurance in the event of delinquency. This form will be kept confidential and only authorized staff has access to the information. The patient will receive 2 statements and a final notice. If these go unpaid or unanswered within 60 days, the patient will receive a courtesy phone call. If no payment is received, the balance on the account will be charged to the credit card on file.

I acknowledge and authorize Dr. David Yamini to charge the credit card on file for deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within 60 days after I receive statements. I agree to receive billing statements, invoices and receipts via the street address and or email I have provided to this office. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account.

**Patient Name (please print):** _____

*Patient's Guardian (if applicable, print):* _____

**Patient or Guardian Signature:** _____

**Date:** _____

# David P. Yamini, M.D.

*Gastroenterology & Hepatology*

Board Certified, American Board of Internal Medicine and Gastroenterology & Hepatology

## CREDIT CARD AUTHORIZATION FORM

Our office requires that a credit card be kept on file for payment of any co-payment, co-insurance, deductible, or charge that may not be covered by your health insurance in the event of delinquency. This form will be kept confidential and only authorized staff has access to the information. If, after a first statement is received with no payment made within 60 days, any balance under $100 will be charged to the below credit card. Courtesy calls will only be made for balances over $100.

PATIENT'S NAME: _____

NAME, AS IT APPEARS ON CREDIT CARD: _____

BILLING ADDRESS: _____

_____

EMAIL ADDRESS: _____

DISC/MC/VISA/# _____

EXPIRATION DATE: _____/_____ VERIFICATION CODE (3 or 4 DIGITS) _____

PLEASE PROVIDE THE CARDHOLDER'S DRIVER'S LICENSE

I acknowledge and authorize Dr. David Yamini to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within 60 days after I receive a statement. I agree to receive billing statements, invoices and receipts via the email I have provided to this office. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account.

_____ _____

Cardholder Signature Date

Physician's Copy

# PATIENT-PHYSICIAN ARBITRATION AGREEMENT

**ARTICLE 1:** 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 such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**ARTICLE 2:** I understand and agree that this arbitration agreement binds me and anyone else who may have a claim arising out of or related to all 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. This includes, but is not limited to, all claims for monetary damages exceeding the jurisdictional limit of the small claims court, including, without limitation, suits for loss of consortium, wrongful death, emotional distress or punitive damages. I further understand and agree that if I sign this agreement on behalf of some other person for whom I have responsibility, then, in addition to myself, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. I also understand and agree that this agreement relates to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and the employees, agents, and estates of any of them. I also hereby consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this Agreement, as set forth in the CMA/CHA Medical Arbitration Rules.

**ARTICLE 3:** I agree that the arbitrators have the same immunity from civil liability as that of a judicial officer when acting in the capacity of arbitrator under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

**ARTICLE 4:** I UNDERSTAND THAT I DO NOT HAVE TO SIGN THIS AGREEMENT TO RECEIVE THE PHYSICIAN'S SERVICES, AND THAT IF I DO SIGN THE AGREEMENT AND CHANGE MY MIND WITHIN 30 DAYS OF TODAY, THEN I MAY CANCEL THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED PHYSICIAN WITHIN THAT TIME STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT.

**ARTICLE 5:** On behalf of myself and all others bound by this agreement as set forth in Article 2, agreement is hereby given to be bound by the Medical Arbitration Rules of the California Healthcare Association (CHA) and the California Medical Association (CMA), as they may be amended from time to time, which are hereby incorporated into this agreement. A copy of these Rules is included in the pamphlet in which this agreement is found. Additional copies of the Rules are available from the California Medical Association, P.O. Box 7690, San Francisco, Ca. 94120-7690, Attention: Arbitration Rules. I understand that disputes covered by this Agreement will be covered by California law applicable to actions against health care providers, including the Medical Injury Compensation Reform Act of 1975 (including any amendments thereto).

**ARTICLE 6: OPTIONAL: RETROACTIVE EFFECT**
If I intend this agreement to cover services rendered before the date it is signed (for example, emergency treatment), I have indicated the earlier date I intend this agreement to be effective from and initialed below.

Earlier effective date:_____ Patient's Initials:_____

**ARTICLE 7:** I have read and understood all the information in this pamphlet, including the explanation of the Patient-Physician Arbitration Agreement, this Agreement, and the Rules. I understand that in the case of any pregnant woman, the term "patient" as used herein means both the mother and the mother's expected child or children.

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.

**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.**

_____ Dated:_____, 20_____
(Patient, Parent, Guardian or Legally Authorized Representative of Patient)

If signed by other than patient, indicate relationship:_____

**PHYSICIAN'S AGREEMENT TO ARBITRATE**
In consideration of the foregoing execution of this Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this agreement and in the rules specified in Article 4 above.

_____ Dated:_____, 20_____
(Physician or Duly-Authorized Representative)

_____ _____
Title—e.g., Partner, President, etc. Print name of Physician, Medical Group, Partnership or Association

# DAVID P. YAMINI, MD

**Board Certified, American Board of Gastroenterology & Hepatology**

2001 Santa Monica Blvd, Suite 1286-W

Santa Monica, CA 90404


**Medicare Assignment of Benefits:**

I request that payment of authorized Medicare benefits be made to or on my behalf to David Yamini, MD for any services furnished to me by one of its providers. I authorize any holder of information about me to the Centers for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health information" is indicated in item #9 of the CMS 1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductibles are based upon the charge determination of the Medicare carrier.

Print Name (First, Last): _____ Date _____ Signature (Patient or Parent, if minor) _____

**Medicare Supplement Insurance Lifetime Assignment of Benefits:**

I, the undersigned have Medi-gap or a Medicare supplemental insurance coverage and assign directly to David Yamini, MD all medical benefit payments on my behalf. I hereby authorize release of medical information necessary to secure benefit payments. I authorize the use of the signature on all insurance submissions whether manual or electronic. This assignment is in effect until revoked by me in writing.

Print Name (First, Last): _____ Date _____ Signature (Patient or Parent, if minor) _____

**Commercial Insurance Assignment of Benefits:** (For example: Blue Cross or Blue Shield, etc.)

**Authorization To Pay Benefits to Physician:** I authorize the release of medical or other information necessary to process health insurance claims. I permit a copy of the authorization to be used in the place of the original. I hereby authorize David Yamini, MD to apply for benefits on my behalf for covered services by him or by his order. I request that the payment from my insurance company be made directly to David Yamini, MD (or to the party who accepts assignment).

Print Name (First, Last): _____ Date _____ Signature (Patient or Parent, if minor) _____

# PHARMACY INFORMATION

**David Yamini, M.D.**
*Board Certified Gastroenterologist*

2001 Santa Monica Blvd, Suite 1286-W
Santa Monica, CA 90404

9400 Brighton Way, Suite 410
Beverly Hills, CA 90210

TEL 310.285.3005
FAX 301.935.1560
dyaminigastromd@gmail.com

Dr. Yamini's office is now E-prescribing to most pharmacies. The benefit to you is you no longer have to wait for your prescriptions to be filled. We will send them to your pharmacy electronically so they will be ready when you go to pick them up.

Please provide us with your pharmacy information:

PATIENT NAME: _____

MEDCIATION ALLERGIES: NONE YES (Circle One)
IF YES, SPECIFY _____

PHARMACY NAME: _____

PHONE # _____ FAX # _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

NOTE: If you are not sure of the address, please provide the cross streets of the pharmacy location

## Patient Questionnaire – Anorectal Health

Patient Name: _____

**Bowel & Dietary Habits**
*(Circle All That Apply)*

1. Do you suffer from Constipation? Y / N
2. Do you suffer from Diarrhea? Y / N
3. Do you have to strain when having a bowel movement? Y / N
4. Do you often feel like you're "still not done" after a bowel movement? Y / N
5. Time spent on toilet during average bowel movement? _____Minutes
6. Do you have to push any prolapsing tissue back into the rectum after a bowel movement? Y / N
7. Are you taking any fiber supplements? Y / N
   a. If yes, which ones? _____
8. On average, do you drink the equivalent of 6-8 glasses of water per day? Y / N

**Symptoms (In Rectal Area)**
*(Check all that apply)*

☐ Bleeding ☐ Itching ☐ Prolapse
☐ Pressure or Swelling ☐ Leaking or Soiling ☐ Pain ☐ Burning

**Additional Questions**
*(Circle All That Apply)*

1. Are you allergic to latex? Y / N
2. Are you pregnant? Y / N
3. Are you taking any erectile dysfunction medicine or any nitrates for chest pain? Y / N
4. Are you taking any anticoagulation medication (Coumadin, Plavix)? Y / N
5. Have you ever been diagnosed with Crohn's disease, proctitis, portal hypertension or anal/rectal cancer? Y / N
6. Are you taking immunosuppressant medication or undergoing radiation treatments? Y / N
7. Do you need to take antibiotics before having dental or other procedures? Y / N

**Additional Comments?**

_____

_____

# MEDICAL HISTORY

NAME _____ AGE _____ DATE _____

**What gastrointestinal problems are you currently having?**

_____

_____

_____

_____

**Are you experiencing?**

Indigestion or ulcer pain? _____

Abdominal pain? _____

Nausea, vomiting? _____

Heartburn? _____

Difficulty swallowing? _____

Change in bowel habits, constipation or diarrhea? _____

Blood in the stool? _____

Change in stool caliber? _____

Rectal pain or discharge? _____

Hemorrhoids? _____

Gas, belching or bloating? _____

Jaundice? _____

Food or milk product intolerance? _____

**Have you ever had:**

An ulcer? _____

Gallstones? _____

Liver disease or hepatitis? _____

Blood Transfusions? _____

Pancreatitis? _____

Ulcerative colitis or Crohn's disease? _____

Colon Polyps? _____

Rectal Problems? _____

Have you traveled in the past two years? _____ Where? _____

_____

Have you had any antibiotics in the past year? _____

_____

Any recent weight loss? _____

Weight now? _____ Weight one month ago? _____

Weight six months ago? _____ If yes, any change in appetite? _____

Please list any past medical problems for which you have been under treatment.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please list any prior Hospitalizations / Surgeries / Colonoscopies or Endoscopies done elsewhere.

| | YEAR | PROBLEM | OPERATION | HOSPITAL |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |

Please list all medications or pills that you take. List everything even if you only take it occasionally.

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

What medications are you allergic to? _____

_____

Any other allergies? _____

Any bleeding tendency or disorder of blood clotting? _____

Are you on blood thinners? _____ Which one? _____

Do you require antibiotics prior to dental work? _____

Any eye trouble? _____ Do you have Glaucoma? _____

Any mouth or throat trouble? _____

Any trouble with heart, lungs or blood vessels? _____

Heart murmur? _____

Rapid or irregular heartbeat? _____

Shortness of breath or trouble breathing? _____

Swelling of ankles or feet? _____

Persistent cough, or coughed up blood? _____

Pain or pressure in chest? _____

Lung disease? _____

Any skin problems? _____

Any fevers or chills? _____

Any trouble with kidneys / urinary system? _____

Pain or burning, or infection? _____

Blood (red or brown) in urine? _____

Difficulty passing urine? _____

Difficulty holding urine? _____

Any trouble with bones, joints? _____ Bursitis _____ Gout _____ Arthritis _____

Backache _____ Stiff neck _____

Any neurologic or muscular trouble? _____

Dizziness, fainting, loss of balance? _____

Tremor, paralysis, loss of strength? _____

Headache? _____

Psychiatric problems? _____

Is there a family history of:

Colon cancer? _____

Polyps? _____

Stomach cancer? _____

Other cancers? _____

Gallstones? _____

Ulcer disease? _____

Ulcerative colitis or Crohn's disease? _____

Other gastrointestinal disorders? _____

Do you have children? _____ How many? _____ Do they have any medical problems? _____

_____

Do you smoke? _____ If yes, how much? _____ How long? _____

Have you ever smoked? _____ Year quit? _____

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____