DAVID P. YAMINI, M.D.

Board Certified, American Board of Gastroenterology & Hepatology
2001 Santa Monica Blvd, Suite 1286-W Santa Monica, CA 90404
8920 Wilshire Blvd. Suite 310 Beverly Hills, CA 90211
TELEPHONE: 310-285-3005/ FAX: 310-935-1560
E: execassistant@westsidegastrocare.com

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. Depending on your deductible, 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 payment is due in full at the time of service regardless of any insurance companies' arbitrary determination of UCR rates. If you do not have insurance, it is your responsibility to determine any and all charges related to labs or imaging ordered, pathology, and procedure facility related cost-ambulatory surgery centers and/or hospitals as those costs are determined by your insurance plan and deductible, not by David Yamini, M.D. INC.

Payment is 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 patient. 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 **866-553-4486**.

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. If you do not have supplemental insurance, your financial responsibility will be 20% of the costs that Medicare does not cover for services rendered by David Yamini, M.D, INC.

PPO

We are not contracted with PPO plans. Oftentimes, 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 depending on your benefits. 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 for services rendered to you directly to you or the subscriber on your plan. If so, it is your responsibility to reimburse Dr. Yamini directly in a timely manner via credit card or mailing a separate check made out to "David Yamini, M.D INC". Failure to do so and cashing the check will be considered insurance fraud and acted upon as so. Once payment is received, you can cash the check the insurance company has sent you.

HOSPITAL AND SURGERY CENTER CHARGES

If 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 Beverly Hills Endosurgical Surgery Center where you might be having your procedure at..

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 is rendered. I understand that I am ultimately responsible for payment of all services.

"A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from patient furnishing any information related to this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."
Bill Text- SB-1061 Consumer dept: medical debt
Section 1785.27 is added to the Civil Code, to read:178.27.(a) A person shall not furnish information regarding a medical debt to a consumer credit reporting agency. (b) A medical dept is void and unenforceable If a person knowingly violates this section by furnishing information regarding the medical debt to a consumer credit reporting agency.(c) (1) On or after July 1, 2025, it is unlawful to enter into a contract creating a medical debt that does not include the following term: "A holder of this medical debt contract is prohibited by Section 1785.27 of the Civil Code from furnishing any information related to this debt to a consumer credit reporting agency. In addition to any other penalties allowed by law, if a person knowingly violates that section by furnishing information regarding this debt to a consumer credit reporting agency, the debt shall be void and unenforceable."(2) A contract entered into on or after July 1, 2025, that does not include the term described in paragraph (1) is void and unenforceable.(d) A violation of this section by a person holding a license or permit Issued by the state shall be deemed to be a violation of the law governing that license or permit.

MISSED APPOINTMENTS AND CANCELLATION FEES

*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 business 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 charged to your credit card on file 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, M.D. INC, 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 30 days, the patient will receive a courtesy phone call, text and/or email. 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, as well as for balanced reflecting checks that have gone to the patient or subscriber on the plan instead of the Doctor by the insurance company that have not been subsequently reimbursed to "David Yamini, M.D. INC" for services he has rendered. I acknowledge that my card will be run in the event payment is not received within 30 days after I receive statements. I agree to receive billing statements, invoices and receipts via the street address, text 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/Guardian Signature:_____Date:_____
INITIALS HERE:_____

INSURANCE REIMBURSEMENTS/CHECKS TO PATIENTS

To avoid any confusion, the following letter explains the Insurance Reimbursement policies of Dr. Yamini's practice.

Please note that some insurance companies- most notably Blue Cross and Blue Shield- play g ames and may send the doctor's reimbursement check for services rendered to y ou directly to you or the subscriber on your plan. If so, it is your direct responsibility to reimburse Dr. Yamini in a timely manner via credit card or mailing a separate check made out to "David Yamini, M.D INC." We reserve the right to charge your credit card on file for your balance reflecting checks that have been sent to you or the subscriber on the plan by your insurance company. Once payment is received, you can cash the check the insurance company has sent you.

Failure to clear your balance and cashing the check beforehand will be considered insurance fraud and acted upon as so. Please help us in making sure that balances are cleared immediately in such situations.

Dr. Yamini is contracted with Medicare,, and St. Johns Physician Provider's HMO only. Dr. Yamini is not contracted with commercial PPO insurance companies, but he does accept and take all PPO patients. Depending on your deductible, you may or may not be responsible for rendering payment up front for your consultation, procedure and/or follow up visits. Often times, your in network deductible may be as high as your out of network deductible, and there is minimal or no upfront cost.

We will assist in checking your out of network benefits to let you know if you are responsible for anything, if at all. Deductibles are determined by you and your insurance plan and are not something we can negotiate.

While a majority of other Specialists in the area who are out of network do not bill the insurances and leave this up to the patient, as a courtesy, depending on your deductible, Dr. Yamini will bill on behalf of his patients to help you meet your calendar year deductible.

In a particular situation where payment was obtained at the time of service and the insurance company ends up reimbursing Dr. Yamini the equal amount that was collected up front, you will be properly refunded once you have notified the office. Due to the comprehensive process of submitting bills for Dates of Service, length of time insurance companies take to issue payment and occasional denials of payment, please provide us at least 3-4 months to process and issue any refunds that may be due.

If you have any questions regarding your financial account with our office or possible pending refund, please contact our billing department- Arizon Billing- during normal business hours at 866-553-4486.

David Yamini, M.D. INC

Westside Gastro Care

INITIALS HERE ___

David P. Yamini M.D

2001 SANTA MONICA BOULEVARD, SUITE 1286-W, SANTA MONICA CALIFORNIA, 90404
8920 WILSHIRE BLVD, SUITE 310, BEVERLY HILLS, CA 90211
TELEPHONE: 310-285-3005/ FAX: 310-935-1560

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Birth Date: _____ Gender: ◯ Male ◯ Female SOCIAL SECURITY # _____

Address: _____

Cell No. _____ Home No. _____

Email: _____ Preferred Contact Method: ◯ Phone ◯ Email ◯ Text

Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Other

Spouse Name: _____

Occupation: _____ Phone: _____

Referred By: _____ Business name/ Address _____

Contact Information: _____
Phone Number Fax Number

Primary Care MD: _____
Phone Number Fax Number

Preferred Pharmacy: _____
Phone Number Address

INSURANCE INFORMATION- Must be completed for billing.

Primary Insurance: _____
Insurance Company Subscriber's Name

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other _____

Insurance Company Address: _____ Employer _____

Member ID: _____ Group: _____

Secondary Insurance: _____
Insurance Company Subscriber's Name

Insurance Company Address: _____ Employer _____

Member ID: _____ Group: _____

EMERGENCY CONTACT INFORMATION:

Name of Friend/ Guardian or Parent Relationship Phone Number

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize **David Yamini, MD** to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign to the doctor all payments for medical services rendered. I understand that I am financially responsible for all charges not covered by my insurance bills.

Patient Signature Insured Signature Date

Last Name First Name Middle Name Date of Birth

Chief Complaint- Main Reason for Visit

- ☐ Abdominal pain
- ☐ Colonoscopy screening
- ☐ Nausea, vomiting, or filling up quickly at meals
- ☐ Problems with liver, gallbladder, or pancreas
- ☐ Blood in the stool
- ☐ Weight loss or poor appetite
- ☐ Gas, bloating, or distension
- ☐ Reflux, heartburn,
- ☐ Regurgitation, ort indigestion
- ☐ Lactose or other food intolerance
- ☐ Hemorrhoids
- ☐ Constipation
- ☐ Diarrhea, urgency, or incontinence
- ☐ Difficulty in swallowing or painful swallowing
- ☐ Abnormal imaging blood test

What gastrointestinal problems are you currently having?

_____

_____

_____

_____

HEALTH CONCERNS:

Is there a particular test you would like? _____

Is there a particular diagnosis that you want to investigate? _____

Previous Testing- Please include dates.

- ☐ Blood tests
- ☐ CT scan
- ☐ Upper endoscopy
- ☐ Stool tests
- ☐ Consultation with other doctors or nutritionists (Please list)
- ☐ Urine test
- ☐ MRI
- ☐ Colonoscopy
- ☐ Sigmoidoscopy
- ☐ Breath test pelvic/ vaginal
- ☐ Ultrasound
- ☐ Wireless capsule endoscopy
- ☐ Hemorrhoids
- ☐ Other

Have you travelled in the past 2 years? _____ Where? _____

_____

Have you had any antibiotics in the past year? _____

_____

Any recent weight loss? _____ Height? _____ Weight _____

Are you on blood thinners? _____ Which one(s)? _____

Any blood tendency or disorders? _____ Blood cloths? _____

What are your food intolerances/ trigger foods? _____
(Sugar, caffeine, spicy, other)

Current & Past Medical Problems

- ☐ Anxiety/ depression
- ☐ asthma
- ☐ Atrial fibrillation/ other rythm disturbance
- ☐ Chronic bronchitis/ emphysema
- ☐ Colon polyp
- ☐ Congestive heart failure
- ☐ Coronary artery disease/ angina
- ☐ Diabetes mellitus
- ☐ Other
- ☐
- ☐ Other _____

- ☐ None
- ☐ Diverticulosis
- ☐ GERD (reflux)
- ☐ H. pylori/ gastritis
- ☐ Hemorrhoids
- ☐ High cholesterol/ triglycerides
- ☐ Hypertensio
- ☐ Inrritable bowel syndrome
- ☐ KIdney stones
- ☐ Other _____

- ☐ Kidney insufficiency
- ☐ Osteoporosis or osteopenia
- ☐ Peptic ulcer
- ☐ Seizure
- ☐ Sleep apnea
- ☐ SIBO
- ☐ Stroke/ TIA
- ☐ Thyroid problems
- ☐ Other
- ☐ Other _____

Past Surgical History

Surgery	Details/ Date/ Hospital	Surgery	Details/ Date/ Hospital
☐ Appendectomy	_____	☐ Other intestinal/ abdominal	_____
☐ Breast	_____	☐ Tonsillectomy	_____
☐ Gallbladder	_____	☐ Stomach/ duodenal ulcer	_____
☐ Hernia repair	_____	☐ Other	_____
☐ Hysterectomy/ ovaries	_____		

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

Details	Date
_____	_____
_____	_____
_____	_____

Most Recent Upper Endoscopy

Date	Physician	General Findings

Most Recent Colonoscopy

Date	Physician	General Findings

Allergies to Medications- Include latex/ tape, iodine and serous adverse reactions other than allergy.

Medication	Reaction

Medications- include over the counter, herbal products and if you take NSAIDs (i.e advil, naproxen)

	Medication	Dose/ Frequency/ Condition Being Treated		Medication	Dose/ Frequency/ Condition Being Treated
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		

Family History- Include age of diagnosis.

	FATHER	MOTHER	BROTHER	SISTER	GRANDPARENT/OTHER RELATIVE
Breast cancer					
Esophageal cancer					
Liver disease					
Hemochromatosis					
Gallbladder disease					
Stomach cancer					
Small bowel cancer					
Celiac disease					
Colitis/ Crohn's disease					
Colon cancer					
Colon polyp					
Uterine/ ovarian cancer					
Renal/ureteral cancer					
Other					

Social History

☐ Caffeine	☐ No	☐ Yes	How many per day? _____
☐ Smoking Status	☐ Never	☐ Current/Every day	How often per week?_____
☐ Alcohol Use	☐ No	☐ Yes	How many per week?_____
☐ Recreational Drug Use	☐ No	☐ Yes	
☐ Children	☐ None	Name(s) _____	Ages _____

Exercise _____ Type _____ Frequency _____

Occupation _____ Employer _____

Name of Specialist involve in your care

Cardiologist _____ Oncologist _____

Gynecologist _____ Other _____

Review of Systems- Check if you have any of the following and describe further in space below.

Gastrointestinal

- ☐ Heartburn/ regurgitation
- ☐ Difficulty swallowing
- ☐ Painful swallowing
- ☐ Filling up quickly at meals
- ☐ Nausea and vomiting
- ☐ Abdominal pain Irregular bowel habits
- ☐ Bloating/ gas
- ☐ Incomplete evacuation of bowels
- ☐ Symptoms improve with evacuation
- ☐ Blood in stool or on toilet paper
- ☐ Mucous in stool
- ☐ Loss of control of bowels
- ☐ Intolerance to other foods
- ☐ Jaundice
- ☐ Gallstones
- ☐ Hepatitis A,B,C,other
- ☐ Cirrhosis
- ☐ Fluid in abdomen (ascites)
- ☐ Pancreatitis
- ☐ History of ulcer
- ☐ Colon polyps
- ☐ Ulcerative colitis
- ☐ Crohn"s Disease
- ☐ Liver disease
- ☐ Hepatitis

Endocrine

- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Osteoporosis or osteopenia

Neurologic

- ☐ Headache
- ☐ Strokes/ CVA
- ☐ Seizures

Skin

- ☐ Rash
- ☐ Itching
- ☐ Unusual hair lost

Cardiovascular

- ☐ Chest pain, pressure, angina
- ☐ Coronary artery disease high
- ☐ Blood pressure swelling in feet or legs abnormal heart rhythm prostate cancer/ enlarged

Respiratory/ Lung

- ☐ Sleep apnea/ CPAP mask respiratory
- ☐ Complications w/ sedation
- ☐ Chronic bronchitis/ emphysema
- ☐ Difficulty breathing
- ☐ Persistent cough
- ☐ Asthma

Gynecology

- ☐ Pregnant now?
- ☐ Endometriosis
- ☐ Heavy periods

Psychiatry

- ☐ Depression
- ☐ Anxiety
- ☐ Suicide attempt

General

- ☐ Decreased appetite
- ☐ Unexpected weight loss
- ☐ Unexpected weight gain
- ☐ Fatigue
- ☐ Fever or chills

Eyes

- ☐ Blind field of vision
- ☐ Cataracts

ENT

- ☐ Hearing loss/ ringing
- ☐ Sore throat/ hoarseness
- ☐ Sinusitis/ sinus drainage

Musculoskeletal

- ☐ Joint pain/ arthritis back/
- ☐ Neck pain
- ☐ Muscle aching/ weakness

Blood/ Lymph

- ☐ Anemia
- ☐ Bruise easily
- ☐ Past blood transfusion
- ☐ Swollen/ tender lymph node
- ☐ Low platelets
- ☐ Coumadin or Lovenox

_____

_____

_____

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

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 change 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 $500 will be changed to the below credit card. Courtesy calls will only be made balances over $500 .

PATIENT 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 changes not covered by my health insurance provider. 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

DAVID P. YAMINI, MD
Board Certified, American Board of Gastroenterology & Hepatology
2001 Santa Monica Blvd, Suite 1286-W Santa Monica, CA 90404
8920 Wilshire Blvd #310 Beverly Hills, CA 90211

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 revolved 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 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) _____

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 the 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 ociation, to claims against the physician and any consenting substitute physician, as well as the physician's partners, associates, association, corporation or partnership, and to 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 arbitration under this Agreement. This immunity shall supplement, not supplant, any other applicable statutory or common law.

ARTICLE 4: 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 healthcare providers, including the Medical Injury Compensation Reform Act 1975 (including any amendments thereto).

ARTICLE 5: OPTIONAL: RETROACTIVE EFFECT

If I intend this agreement to cover services rendered before the data it is signed (for example, emergency treatment). I have indicated the earlier date I intend this agreement to be effective from and initiated 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 women, 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 provision 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 Patients)

If signed by other than patient, indicate relationship: _____

PHYSICIAN'S AGREEMENT TO ARBITRATE

In consideration of the foregoing execution of the Patient-Physician Arbitration Agreement, I likewise agree to be bound by the terms set forth in this agreement.

_____ Dated: _____, 20_____

(Physician or Duly- Authorized Representative)

_____ _____

Title e g: Partner, President, etc. Print Name of Physician, Medical Group, Partnership or Association