PLEASE COMPLETE AND SIGN **ALL** FORMS BEFORE YOU ARRIVE AT OUR OFFICE. THIS ALLOWS US TO SEE ALL PATIENTS PROMPTLY AT THEIR SCHEDULED APPOINTMENT TIMES.

ALL SECTIONS **MUST** BE COMPLETED. IF IT DOES NOT APPLY TO YOU, PLEASE WRITE "N/A"

IF YOU CANNOT KEEP YOUR SCHEDULED APPOINTMENT PLEASE CALL OUR OFFICE 24 HOURS PRIOR TO YOUR SCHEDULED APPOINTMENT. FAILURE TO DO SO WILL RESULT IN A $35 FEE WHICH IS NOT BILLABLE TO YOUR INSURANCE.

IF YOUR FORMS ARE NOT COMPLETED PRIOR TO YOUR ARRIVAL IT MAY RESULT IN THE RESCHEDULING OF YOUR APPOINTMENT.

THANK YOU FOR YOUR COOPERATION, WE LOOK FORWARD TO MEETING YOU.

Patient information (Picture ID and Insurance Card(s) required)

Last Name: _____ First: _____ Middle _____
As it appears on your insurance card

Birth Date: _____ Race (new billing requirement) _____

Referred by: _____

Social Security #: _____ Driver's License #: _____

Street Address: _____ Marital Status: M S D W

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance information

Insured, Responsible Party: _____ Relationship: _____
(If insured under someone other than yourself, we need their name and Date of Birth)

Birth Date: _____ Social Security #: _____

Insured's Employer: _____ City: _____ Work Phone: _____

Insurance Carrier: _____

Policy #: _____ Group #: _____ Effective Date: _____

Secondary Insurance Information

Insured, Responsible Party: _____ Relationship: _____

Birth Date: _____ Social Security #: _____

Insured's Employer: _____ City: _____ Work Phone: _____

Insurance Carrier: _____

Policy #: _____ Group #: _____ Effective Date: _____

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT/AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby give authorization for payment of insurance benefits to be made directly to Dr. Michelle A. Marine and/or Dr. Stuart J. Fischbein for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default I agree to pay for any courtroom and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I hereby agree that a photocopy of this agreement shell be as valid as the original.

Signature: _____ Date: _____

for Health & Midwifery Care

Name_____
(last) (first)
Date of Birth_____ Age_____
Married / Single / Separated / Divorced / Widowed
Occupation_____

FAMILY HISTORY

(grandparents, parents, siblings, children)
Cancer (type)_____
Heart disease_____
High blood pressure_____
Blood clots / Stroke_____
High cholesterol_____
Varicose veins_____
Diabetes_____
Respiratory disease_____
Tuberculosis_____
Kidney disease_____
Thyroid disease_____
Seizure disorder_____
Mental illness_____
Alcohol or drug abuse_____

YOUR MEDICAL & SURGICAL HISTORY

Asthma_____
Respiratory disease_____
Tuberculosis_____
Diabetes_____
High blood pressure_____
Heart disease/ murmur_____
Blood clots or stroke_____
Cancer_____
Liver disease_____
Kidney disease_____
Bladder infections_____
Thyroid disease_____
Epilepsy_____
Sickle cell anemia or trait_____
Hepatitis_____
Migraine headaches_____
Rheumatic fever_____
Blood transfusion_____
Anorexia / Bulemia_____
Collagen vascular disease (Lupus)_____
Arthritis_____
German measles (rubella)_____
Chicken pox_____
Recent weight change_____
Change in bowel or bladder habits_____
Unusual bleeding_____
Depression_____
Have you ever been hospitalized or had surgery?
When and why?_____
_____

PERSONAL HISTORY

Allergies_____
Current Medications / Hormones / Vitamins / Herbs
_____
Caffeine (cups per day)_____
Cigarettes (number per day)_____
Past cigarette use (number of years)_____
Alcohol (number of drinks per week)_____
Recreational drug use_____
Any treatment for drug or alcohol use_____
Exercise (type & frequency)_____
Do you perform breast self exam?_____
Is there violence in any of your relationships?_____
Explain_____
Have you ever been sexually abused?_____
Do you want to discuss it? _____

GYNECOLOGICAL HISTORY

Last menstrual period (first day)_____
Was it a normal period?_____
How long does your period last?_____
How often do you have your period?_____
Are your periods regular?_____
# of pads/ tampons you use in 24 hours_____
Are they soaked or spotted?_____
Do you have cramps?: none, mild, mod, severe
Age periods began_____
Date of last pap smear _____
Date of last mammogram_____
Do you have a history of:(include dates)
Abnormal pap smear_____
Colposcopy, cryo / laser surgery_____
Infertility _____
Endometriosis_____
DES exposure_____
Ovarian cysts_____
Fibroids_____
Breast lumps or tumors_____
Pelvic Inflammatory Disease (PID)_____
Gonorrhea_____
Chlamydia_____
Herpes_____
Syphilis_____
Genital Warts_____
Other gynecologic problems_____

SEXUAL ACTIVITY

Are you sexually active?_____
Sexual preference____men____women___both
Are you satisfied with your sexual relations?_____
Any pain or bleeding with intercourse?_____
Age of first intercourse_____
Frequency of intercourse _____
Number of partners in last 2 years_____

BIRTH CONTROL HISTORY

Are you using birth control now?_____
If so, what method?_____
Are you satisfied with that method?_____
Would you like a new method?_____
What methods have you used?:

Method	Problems
_____ Pili	_____
_____ IUD	_____
_____ Diaphragm	_____
_____ Cervical cap	_____
_____ Depo Provera	_____
_____ NuvaRing	_____
_____ Rhythm	_____
_____ Foam	_____
_____ Condom	_____
_____ Withdrawal	_____
_____ Sterilization	_____

PREGNANCY HISTORY

How many times have you been pregnant?_____
Number of children born alive_____
Number of miscarriages_____
Number of abortions_____
Number of tubal pregnancies_____
Number of children now living_____
Any problems with pregnancy or birth?_____
_____
Number of cesarean births_____
Do you plan on future pregnancies?_____

CURRENT PROBLEMS

Why are you here today?_____
_____
_____
_____
_____
_____

The Woman's Place

for Health & Midwifery Care

Name	Date of birth	
Address	Phone	

Date of last menstrual period_____Any problems with your periods?_____
Last pap smear_____Current birth control method_____
Have you or anyone in your immediate family had any changes in your health since your last visit? If so, what?

_____

_____

Do you have any allergies?_____Current medications?_____
Regular exercise?_____Vitamins or calcium supplements?_____
Do you smoke?_____ (per day) Use alcohol_____(oz/week) Drugs_____

WHY ARE YOU HERE TODAY?

_____

_____

_____

CLIENT HISTORY

DATE:

PATIENT RECORD OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided The right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home # _____

- ☐ O,K, to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication

- ☐ O.K. to mail to home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number

☐ Cell # _____

- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other Authorizations

☐ O.K. to discuss billing information with another person: _____
Name Relationship

☐ O.K.to discuss medical information with another person: _____
Name Relationship

_____ _____
Patient Signature Date

_____ _____
Printed Name Date of Birth

The privacy rule generally requires healthcare providers take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures. Information provided below if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

The Woman's Place for Health
Michelle A. Marine MD, Inc.
Stuart J. Fischbein MD
77 Rolling Oaks Dr. #306
Thousand Oaks, CA 91361
Phone 805/371-8775 FAX 805/379-3711

Advanced Beneficiary Notice

When we bill your insurance company, any deductible and co-insurance charges will apply. Any payment you make today will be credited to your account. Once the insurance company makes the payment, you will be responsible for any and all remaining balances. If there is a co-payment required, it must be paid at the time of service.

IT IS YOUR PRIMARY RESPONSIBILITY TO VERIFY YOUR INSURANCE BENEFITS AND CONFIRM IF OUR OFFICE IS A PROVIDER WITH YOUR INSURANCE COMPANY AT EACH VISIT.
We do not guarantee our provider status for your insurance plan.

Our practitioners only perform procedures which are deemed medically necessary for you and/or the health of your baby. They are discussed with you before they are performed.

You are responsible for any NON-COVERED expenses including 3D/4D ultrasound imaging, office visits, procedures deemed experimental or investigational, fetal cardiac ECHO evaluation with color & Doppler, etc.

As a courtesy, your insurance will be billed.

It is the **patient's responsibility** to obtain insurance authorization for any and all procedures and services for which they are referred, in addition to any services recommended by the consulting physician and/or accepted by the patient. If, at the time of your visit, the consulting physician recommends additional procedures, we will make every effort to advise you of any additional patient costs in advance.

I HEREBY AUTHORIZE **MICHELLEL A. MARINE MD, INC.** TO BILL MY INSURANCE COMPANY AND RECEIVE PAYMENT FROM THEM ON MY BEHALF. I ACKNOWLEDGE, HOWEVER, THAT I AM RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT AND ANY AND ALL CHARGES ACCOCIATED WITH ITS COLLECTION.

I ALSO AUTHORIZE **MICHELLE A. MARINE MD, INC.** TO PROVIDE MEDICAL TREATMENT FOR ALL OF MY VISITS ASSOCIATED WITH MY CURRENT PREGNANCY OR MEDICAL CONDITION AS REQUESTED BY MY REFERRING PHYSICIAN OR MYSELF.

Signature	Print Name	Date

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 rights 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 service 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 any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

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 of a demand for a neutral arbitrator by either party. 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. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

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 this 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 provisions 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. Discovery shall be conducted pursuant to Code of Civil Procedure Section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

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 arbitrators 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. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If 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 or Patient Representative'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 or Patient Representative's Signature Date

By: _____ _____
Physician's or Authorized Representative's Signature Date

By: _____
Print Patient's Name

_____
Print or Stamp Name of Physician,
Medical Group, or Association Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.