Kenneth Bermudez, MD
525 Spruce Street, Ste 2
San Francisco, California 94118
415.668.2122

Self-Pay Patient Registration Form

Referring Physician: _____ Primary Care Physician: _____

Patient Information: Email: _____ Male ☐ Female ☐

Name: _____ Date of Birth: _____
First M.I. Last

Address: _____
Street Number Street Name Apt# City State Zip Code

_____ _____ _____
Home Phone # Work Phone # Mobile/Cell #

Social Security #: _____ Driver's License #: _____
Patient ID Number

Patient's Occupation: _____ Employed by: _____

Emergency Contact Information:

Emergency Contact: _____ Relationship to Patient: _____
(Name of local relative or friend)

Emergency Contact Address: _____ Phone #: _____

Insurance Information:

Name of Insurance: _____ Insurance Phone #: _____

Name of Subscriber: _____ Relationship to patient: _____

Date of Birth: _____ Subscriber's Employer: _____ Employer Phone #: _____

Subscriber ID#: _____ Group number: _____ Effective date: _____

CANCELLATION POLICY:

This office has a policy of charging a fee for missing an appointment or canceling with less than two working day's notice. This policy is explained at the time of the first visit. The fee is $50.00. **NO EXCEPTIONS.** The purpose of this fee is to encourage our patients to take their appointments as seriously as we do. That time is reserved for you, and if you do not keep your scheduled appointment, then other patients who need to be seen are being obligated to wait longer than necessary. We remain available to discuss this policy in general, or individual circumstances. Thank you for understanding.

_____ _____ _____
Date Patient's signature Responsible Party's signature

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Patient Registration Form

Name: _____ Date of Birth: _____
First M.I. Last

Reason for Consultation: _____ Referred By: _____

Allergies: _____

Height: _____ Current Weight: _____

Do you smoke? Yes No Are you an ex-smoker? Yes No

Current Medications (INCLUDING NON-PRESCRIPTION DRUGS, VITAMINS AND HERBALS):

_____

List previous surgeries or major illnesses and dates (including any plastic surgery):

_____

Family History: Has any blood relative ever had any of the following:								
Breast Cancer	No	Yes	High Blood Pressure	No	Yes	Kidney Disease	No	Yes
Melanoma	No	Yes	Heart Disease	No	Yes	Depression	No	Yes
Stroke	No	Yes	Diabetes	No	Yes			

Past Medical History: Have you ever had the following:								
Heart Disease	No	Yes	Asthma	No	Yes	Stomach Ulcer	No	Yes
Stroke	No	Yes	Arthritis	No	Yes	Kidney Disease	No	Yes
Mitral Valve Prolapse	No	Yes	Tuberculosis	No	Yes	Thyroid Disease	No	Yes
High Blood Pressure	No	Yes	Rheumatic Fever	No	Yes	Bleeding Tendency	No	Yes
Cancer	No	Yes	AIDS/HIV+	No	Yes	Anemia	No	Yes
Diabetes	No	Yes	Hepatitis	No	Yes	Glaucoma	No	Yes
Substance Abuse Problems (Drugs or Alcohol)				No	Yes			

Review of Systems: Do you have now or have you had within the last year:								
Weight Change	No	Yes	Swollen Feet/Ankles	No	Yes	Seizures	No	Yes
Dry Eyes	No	Yes	Skin Rash	No	Yes	Joint or Muscle Pain	No	Yes
Chronic Cough	No	Yes	Chronic Diarrhea	No	Yes	Swollen Lymph Nodes	No	Yes
Chest Pain	No	Yes	Jaundice	No	Yes	Easy Bleeding	No	Yes
Rapid Heartbeat	No	Yes	Depression	No	Yes	Easy Bruising	No	Yes

Women Only:					
Date of last mammogram:	Breast lump	No	Yes	Breast Discharge	No Yes
Number of pregnancies:	Vaginal Issues/Concerns	No	Yes		

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

X_____ _____
Signature of patient or parent if minor Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment and/or dispute of payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we email you marketing materials? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we use your photographs and other audio-visual and graphic materials before, during, and after the course of your therapy for Dr Bermudez's before & after gallery on website, social media, medical, marketing, and education purposes. Although the photographs or accompanying material will not contain your name or any other identifying information, you are aware that you may or may not be identified by the photos. YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ 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.