ZENA H. GABRIEL, MD
DIPLOMATE, AMERICAN BOARD OF DERMATOLOGY
Medical Surgical Aesthetic

DR. ZENA H. GABRIEL, M.D.
DR. DONNA WEST, M.D.

359 SAN MIGUEL DRIVE STE. 300 NEWPORT BEACH, CA 92660

PLEASE PRINT

Patient Name _____ Age _____ M / F Birthdate _____

Home Address _____ Cell Phone _____

_____ Home Phone _____

Occupation _____ Email _____

SSN _____ CA Driver's License No _____ Medicare No _____

Primary Insurance Co Name_____ Phone number _____

Claims Address _____ID # _____ Group #_____

Name of Insured _____ SSN of Insured _____ Birthdate of Insured_____

Relationship to Patient □ Self □ Spouse □ Parent □ Other Employer _____

Name of Responsible Party for Minor _____ Relationship _____

Address _____ Cell Phone _____

_____ Home Phone _____

Spouse or Closest Relative Name _____ Relationship _____

Address _____ Phone _____

Name of Primary Care Physician _____ Phone _____

Referred by _____

_____

CONSENT + AUTHORIZATION FOR TREATMENT

By my signature below, I authorize evaluation and treatment by Dr. Gabriel and her staff.

I understand that many dermatological conditions are chronic and require ongoing care. All medications have side effects and there are risks to any medication prescribed.

Dermatologists frequently diagnose skin growths by performing a skin biopsy (sampling a small area of skin under local anesthesia) and treat skin growths by freezing, cauterization with a heated needle, and/or cortisone injection. I understand that there are risks to any procedure and that these risks include, but are not limited to:

- Temporary or permanent discoloration
- Scarring
- Pain
- Infection
- Bleeding
- Nerve damage.

I consent to having these procedures done as part of my care and treatment.

I understand that full skin examinations for cancer screening are performed if scheduled in advance.

I recognize that most visits are for consultation and evaluation of a specific condition and that surgeries, even minor removals, may need to be scheduled at a separate time. If time allows, the physician is happy to add this on to any appointment. This authorization and consent shall remain in force for this visit and all future visits to the office.

This consent will remain in effect until revoked by me in writing.

_____ _____

Signature **Date**

MEDICAL HISTORY

Reason for today's visit _____

Height _____ Weight _____

Medical Conditions: (please indicate with an "X" all that apply)

Skin
- □ Basal cell skin cancer
- □ Squamous cell skin cancer
- □ Melanoma
- □ Psoriasis
- □ Eczema
- □ Acne
- □ Scarring/keloids
- □ Other _____

Cardiovascular
- □ Heart attack
- □ Irregular heart beat
- □ Chest pain/tightness
- □ Heart murmur
- □ Shortness of breath
- □ High/Low blood pressure
- □ Pacemaker
- □ Stent or artificial valve

Hematologic/Metabolic
- □ HIV/AIDS
- □ Hepatitis C
- □ Anemia
- □ Bleeding disorders
- □ Autoimmune disease
- □ Thyroid disease
- □ Diabetes
- □ Kidney disease

Eye, Ear, Nose
- □ Blurry vision
- □ Dry eyes
- □ Glaucoma
- □ Ear disease
- □ Nasal allergies
- □ Nasal obstruction
- □ Nose bleeding
- □ Sinus Disease

Gastrointestinal
- □ Gastritis
- □ Ulcers
- □ Colitis
- □ Diverticulitis

Musculoskeletal
- □ Arthritis
- □ Fibromyalgia
- □ Arthritis
- □ Artificial joints

Pulmonary
- □ Asthma
- □ COPD
- □ Pneumonia
- □ Tuberculosis

Neurologic/Psychiatric
- □ Seizures
- □ Headaches
- □ Depression
- □ Schizophrenia/Bipolar

Do you use:				
	Alcohol	□ Yes	□ No	Frequency _____
	Tobacco	□ Yes	□ No	Frequency _____
	Aspirin	□ Yes	□ No	Frequency _____
	Illicit drugs	□ Yes	□ No	Frequency _____

Are you □ Pregnant □ Trying to conceive □ Breastfeeding

Family History (Indicate any conditions of immediate family members - mother, father, siblings, children)
- □ Heart disease
- □ Cancer (type) _____
- □ Melanoma
- □ Hypertension
- □ Autoimmune disease
- □ Non-melanoma skin cancer
- □ Stroke
- □ Eczema
- □ Asthma
- □ Diabetes
- □ Psoriasis
- □ Seasonal allergies/hay fever

Surgical/Procedure History (list all surgeries including cosmetic and laser procedures)

Date	Type	Physician	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you or anyone in your family had problems associated with surgery?
□ Bleeding □ General anesthesia □ Lidocaine allergy □ Poor scarring □ Other _____

Hospitalizations (Other than surgery)

Date	Reason/Illness	Physician	Complications
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medications (Include vitamins, diet pills, birth control, herbal supplements, etc.)

Name	Strength/Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies

Medication	Reaction
_____	_____
_____	_____
_____	_____

Are you allergic to: Latex □ Yes □ No

Adhesives □ Yes □ No

NOTICE OF PRIVACY PRACTICES

This notice describes how medial information about you may be used and disclosed and how you can get access to this information. Please review carefully.

The Health Insurance Portability and Accountability Act of a 1996 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, be kept confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse protected health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose this information. We may use and disclose your medical records only for each of the following purposes:

- **Treatment** - providing, coordinating or managing health care and related services by one or more health care providers.
- **Payment** - obtaining reimbursement for services, confirming coverage, billing collection activities, and utilization review.
- **Health care operations** - the business aspect of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost management analysis and customer service.

We may also create and distribute health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You have the following rights with respect to your protected health information, which you can exercise by sending a written request to the Privacy Officer.

- The right to request restrictions on certain use and disclosures of protected health information, including those related to disclosures to family members, close personal friends, or any other person identified by you. We are not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable request to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy with respect to protected health information. This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of the Notice of Privacy Practice and to make the new notice effective for all protected health information. We will post and you may request a written copy of this notice. If you have any questions about this Notice, or wish to exercise your rights, or file a complaint, please direct your inquiries to:

ZENA H. GABRIEL, M.D.
DONNA WEST, M.D.
ATTN: PRIVACY OFFICER
Address:

You may contact your Health Plan or the California Department of Managed Care with your concerns as well. You also have the right to directly complain to the Secretary of the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint against us.

PATIENT PRIVACY POLICY CONSENT

This consent will apply to all healthcare providers employed by and acting for the benefit of this office who conduct, plan and direct treatment and follow-up and may be involved in treatment, directly or indirectly. In the course of providing services to you, this office will create, receive and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for services and to conduct day-to-day health care operations. The Notice of Privacy Practices describes the uses and disclosures in detail. The use and disclosures of your health information may include care and services, follow-up care from another health professional, disclosure of your information for billing purposes or processing claims for obtaining payment, or submission of claims to a third-party or insurer. You have the right to restrict the use of disclosure made for purposes of treatment or health care operations, but this office is not obligated to agree to these restrictions. If this office does agree, however, the restrictions are binding. You may revoke this consent in writing at any time, except to the extent that this office has taken action relying on this consent.

I have read this document and understand it. I consent to the use and disclosure of my personal health information for purposes of treatment, payment and health care operations. I have received a copy of the Notice of Privacy Practices from this office.

Date: _____Patient Name:_____

_____
Signature of patient or legally authorized individual

_____ _____
Print name if signed on behalf of the patient Relationship - parent, legal guardian

Please initial and provide any additional information as required to enable us to appropriately use and disclose your protected health information for the following:

I agree to be contacted for appointments, biopsy/lab results, or follow up information regarding my care by:

□ Phone Preferred number _____ Initials _____

□ Ok to leave message/voicemail Initials _____

□ Email Initials _____

□ Text Initials _____

I agree to allow the practice to use and disclose information regarding my care as needed to family. Initials _____

These consents will remain in effect until revoked by me in writing.

_____ _____
Signature **Date**

CONSENT FOR USE OF PHOTOGRAPHS

I consent for medical photographs to be taken of me or my child (or for person whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching at Dr. Zena Dermatology, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future I may contact the staff at Dr.Zena Dermatology at 949-200-8222.

1. I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes at Dr.Zena Dermatology and to be used in my medical record.

Patient Signature _____ Date_____

2. I agree for my image to be shown for teaching purposes AND to be used for my medical record but NOT FOR medical publication.

Patient Signature _____ Date_____

3. I agree to the use of my image for medical records ONLY.

Patient Signature _____ Date_____

FINANCIAL POLICY

This is a fee-for-service medical practice that requires all services are paid on the day that the services are delivered. You will be expected to pay in full after your doctor's visit today.

We accept all major credit cards, check or cash.

We are not contracted with any insurance carriers. We do not submit claims to insurance companies. However, the procedures and treatment that you receive today will be coded onto a "superbill" which you may submit to your insurance carrier. This superbill and a completed claim form (provided by your insurance company) can be submitted to your insurance carrier for reimbursement of fees. Reimbursement is not guaranteed and the reimbursement rates depend on your insurance policy.

By signing below, you agree to pay the total charges for the services provided on the day care was delivered.

_____ _____

Signature Date

Physician –Patient/Client Arbitration Agreement

This Arbitration Agreement is entered into Leur Lab (hereafter "Leur Lab") and _____ (name of patient/client)

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 incompletely 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/client 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/client" 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, associated, 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/client shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any court action, shall be resolved by arbitration.

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 party) 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 such intervention and joinder any existing court of action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law application 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 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 arbitration agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this arbitration agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient/client intends this arbitration agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient/client should initial below:

Effective as of the date of first medical services Patient/client or Patient/client 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 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.

_____	_____	_____
Patient Signature	Printed Name	Date

_____

Physician's or Physician's Representative's Signature)