

Patient Questionnaire

Name _____ Date of Birth _____ Home Phone _____

Reason for visit _____ Primary Physician _____

Hospital Admissions/Surgeries

(Not including pregnancies. Please specify if surgery was preformed.)

Date	Reason

Medications & Supplements (list additional on back) **Dosage (MG)** **Frequency** **Prescribing Physician**

Medications & Supplements (list additional on back)	Dosage (MG)	Frequency	Prescribing Physician

Allergies

Reaction

Allergies	Reaction

Social

Please indicate quantity per day and duration in years.

Alcohol	
Tobacco	
Caffeine	
Illegal drug use	

Have you ever had a dependency to illegal or prescription drugs? _____

Have you ever been treated for drug dependency? _____

Medical History

Please list any symptoms or conditions you have a history of. (e.g., tremors or diabetes)

Family History

(Indicate 'D' if family member with condition is deceased)

Condition	Mother	Father	Brother	Sister

Signature _____

Date _____

NEURO PAIN MEDICAL CENTER, INC.

Perminder Bhatia, M.D.

David Baker, PA-C

736 Bullard, Suite 101, Fresno, CA 93710

(559) 437-9700 (559) 437-9799 Fax

Please read, initial and sign this form. A copy will be given to you upon request.

Please understand that our office is a specialty practice and our administrative procedures differ from that of your primary doctor. You have been referred to Dr. Bhatia by your primary care Physician for a consultation and evaluation. As a courtesy, we will bill your medical insurance, however; **it is your responsibility to pay for services rendered** in the event your insurance does not submit payment to us for any reason.

- _____ You must maintain a primary care physician while being treated by Dr. Bhatia.
- _____ After you are seen by Dr. Bhatia, an evaluation will be sent to your primary physician informing him/her of any follow-up treatments.
- _____ A letter will be sent to you advising you when to return to your primary physician.
- _____ Referrals for tests\procedures take 7 -14 working days for authorization & scheduling.
- _____ We charge \$10 - \$25 to fill out outside forms. Completed forms must be picked up. We do not fax or mail.
- _____ All medication refill requests must be called in to your pharmacy **72 hours prior** to Running out. Your pharmacy can fax us with a refill request. Call your pharmacy first for refill medications. **No refills will be done after hours/weekends/ holidays.**
- _____ We will not replace medication which has been lost or stolen.
- _____ **ALL NARCOTIC PRESCRIPTIONS MUST BE OBTAINED FROM OUR OFFICE.**
IF ANOTHER DOCTOR PRESCRIBES NARCOTIC MEDICATION, YOU MUST INFORM US AS SOON AS POSSIBLE, OR YOU WILL BE DISCHARGED.
- _____ If you are taking narcotic prescription medications, you hereby agree to submit to a random blood or urine test as requested. **If you are a cash paying patient, you will be charged \$35 for the test.**
- _____ If you are unable to keep your appointment, kindly give us a 24 hour notice or you shall be charged \$25 for the missed appointment.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION

Patient Signature: _____

Date: _____

Neuro Pain Medical Center

Perminder Bhatia, M.D.
736 E. Bullard, Suite 101
Fresno, CA 93710
(559) 437-9700 Office
(559) 437-9799 Fax

CHART # _____

Today's Date _____

Male _____ Female _____

Name _____

Birth Date: _____

Home Address _____

City _____ Zip _____

Home Phone _____

Work Phone _____

Social Security No: _____

Cell Phone _____

Driver's License No: _____

Single _____ Married _____ Widow _____ Divorced _____

Employer's Name _____

Employer's Address _____

Spouse's Name _____

Spouse's Social Security No: _____

Emergency Contact Name _____

Emergency Contact Phone _____

Primary Doctor _____

Phone _____

Referring Doctor _____

Phone _____

Primary Insurance _____

Policy /Group No. _____

Insured Name _____

Your relationship to Insured _____

Secondary Insurance _____

Policy/Group No. _____

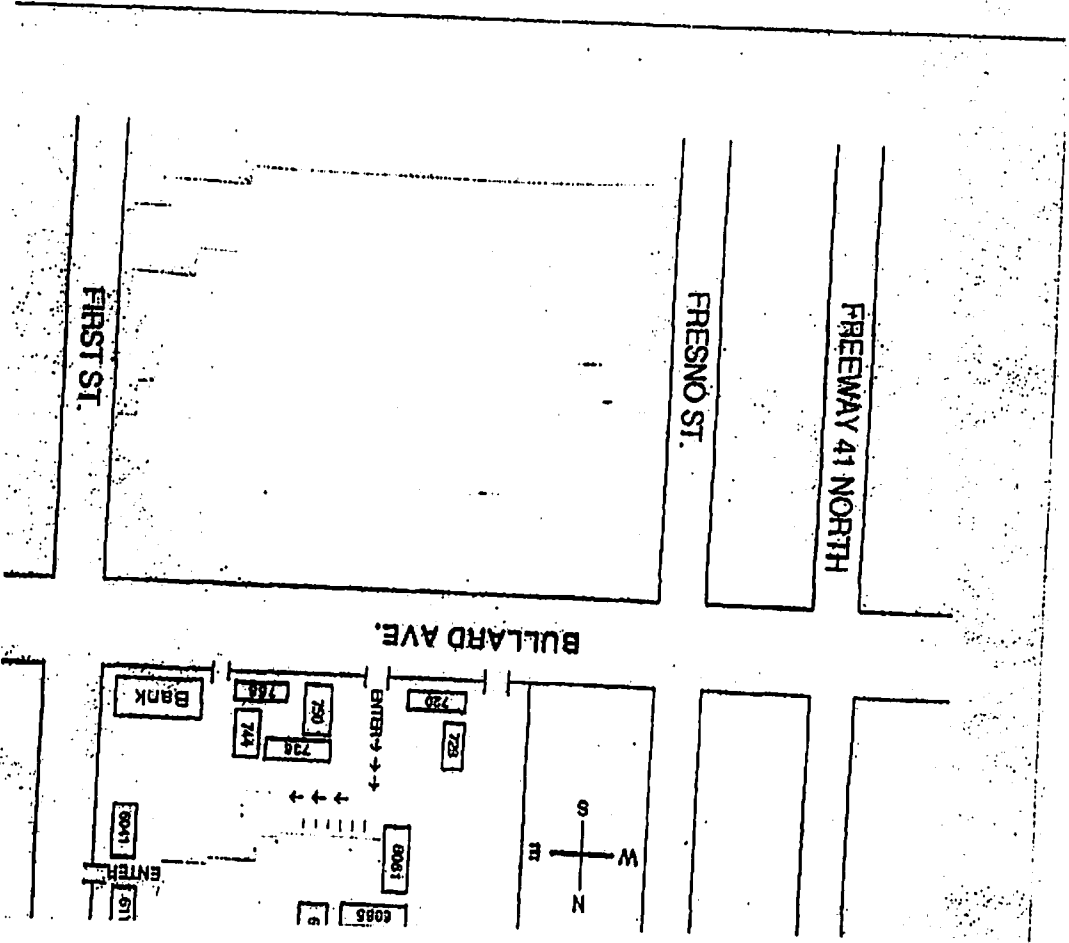
I hereby authorize direct payment of medical benefits to Neuro Pain Medical Center for any services rendered by Dr. Perminder Bhatia or any person under his direction. I understand that I am financially responsible for payment of any balance not covered by insurance.

I hereby authorize Dr. Perminder Bhatia to release any medical or incidental information that may be necessary for either my medical care or processing of medical insurance claims on my behalf. I certify that all information I provided on this form is correct. I authorize payment of any insurance benefits be made directly to Neuro Pain Medical Center on my behalf. A photocopy of these assignments shall be as valid as the original.

Signature: _____

Date: _____

IF UNDER 18, PATIENT'S PARENT/GAURDIAN SIGNATURE: _____



NEURO - PAIN MEDICAL CENTER

736 E. BULLARD #101

FRESNO CA 93710

(559) 437-9700

Welcome to Neuro- Pain Medical Center. We look forward to meeting your health care needs. Your time is important to us, so in an effort to minimize your wait time in the office please.

1. Complete all enclosed forms, before your appointment in black a ink and bring them with you on your appointment date on

_____ at _____ a.m. / p.m.

2. Bring your insurance card (s), fail to do so may result in re scheduling your appointment.

3. Be prepared to pay your co-pay at **TIME OF VISIT (if required by your insurance)**. We do not bill for co -pays.

Thank you for your attention to these details. If you have any questions please feel free to call our office Mon-Thurs. 8:00-5:00 and Friday 8:00 -12:00 and 2:00-4:00.

MAP →

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 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 with this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 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 judgement 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 with 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's 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: _____
Physician's Authorized Representative's Signature (Date)

By: _____
Patient or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

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