MOSHE H. WILKER M.D., INC.
11980 San Vicente Blvd. Suite 114
Los Angeles, CA 90049
Tel. 310.337.7463 Fax. 310.442.8336

Patient Name: ____

Who referred you to Dr. Wilker? ______________________________

Please check the payer responsible for this visit:

Medical Insurance ___ **Personal Injury Lien** ___ **Workers Comp** ___**Self**___

Are you seeing Dr. Wilker for an injury? Y/N

If yes, (Circle one)

1. I fell 3. I lifted a heavy object

2. I was hit by an object 4. I was assaulted 5.Other ____________________

-When? ______________________

Circle any of the following that you experienced at any time since your symptoms began:
*Fevers, *weight loss, *double vision, *sore throat, *dizziness, * seasonal allergies.
*shortness of breath,*burning in stomach, *burning on urination, *skin lesions,
*depression, *numbness, *frequent urination at night, *lightheadedness, *leg swelling

List any medical conditions you had/have: ______________________

List your medications: ______________________

Do you have any allergies to medications? Y/N

If yes, then what medication and what was the reaction? ______________________

____

List any surgeries you had stating the approximate year of surgery

1.______________________ 2.______________________

3.______________________ 4.______________________

What medical conditions do your parents have? ______________________

If your parent died before reaching 60 years old then what was the cause of death?

____

Who do you live with? ______________________

Do you smoke cigarettes? Y/N
Do you use drugs? Y/N

Do you drink more than one glass of alcohol per day? Y/N
Are you currently: working/ retired/ disabled? (Circle one)

What is/was your job position? ______________________

Signature & Date ______________________ _____/_____/2015

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PATIENT INFORMATION:

PatientLast Name: ____________________ **Patient Name:** ____________________

Date of Birth: ____/____/____ **SSN#** ______-_____-______ **Female:** ___ **Male:** ___

Address: ______________________________

City: ______________________________ **State:** _____ **Zip:** __________

Home Phone: (______) ______________ **Cell #:** (______) ______________

Married ___ **Single** ___ **Widowed** ___ **Divorced** ___

Email Address: ______________________________

REFERRING PHYSICIAN: ______________________________

Tel # (______) ______________________

Primary Care Physician: ____________________ *Tel# (______)* ______________

Employer Name: ______________________

Occupation: ____________________ *Work # (______)* ______________

Emergency Contact Name: ______________________________

Relationship: ______________*Emergency Contact Tel # (______)* __________

INSURANCE INFORMATION:(please provide the receptionist with a copy of your insurance card and ID)

***Medicare Number:**____________________ Part A _____ Part B _____

Effective Date: _____/_____/_____

Primary Insurance: ______________________________ PPO ___ POS___ HMO ___

ID# ______________________________

Insurance Telephone: (______) ______________

Group # ______________________Effective Date: ____/____/____

Subscriber Name (if patient is not the subscriber): ______________________________

Date of Birth: ____/____/____ SS # ______-_______-________

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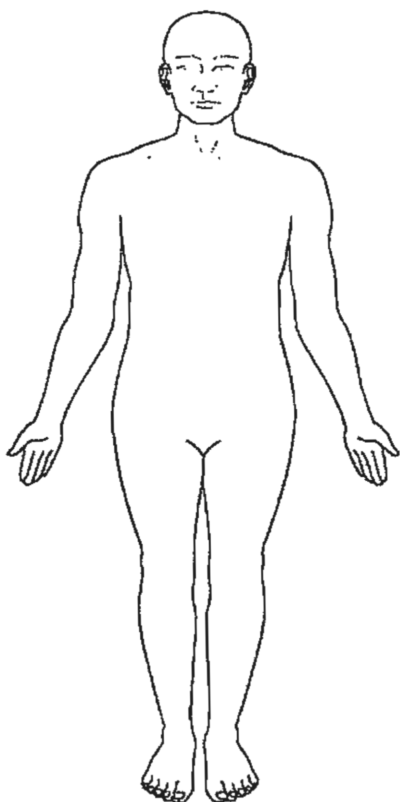
Patient Name ______________________________ Age______ Today's Date____ /___/_____

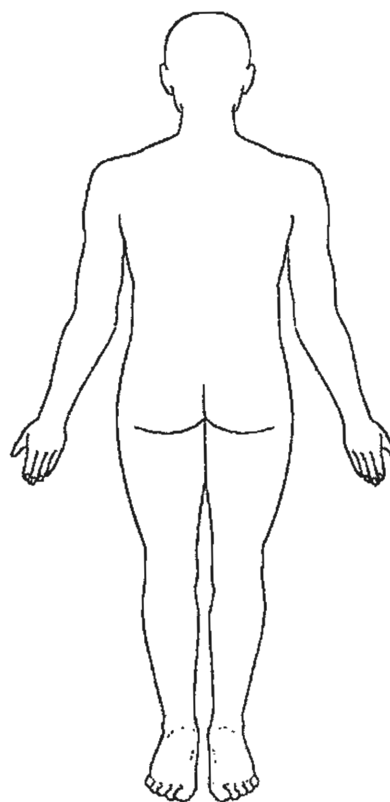
Mark the areas on your body where you feel the described sensations. Use the appropriate symbol.

PAIN=X	NUMBENESS=O

FRONT (RIGHT) (LEFT)

BACK (LEFT) (RIGHT)





PLEASE MARK ON THE LINE:

HOW BAD IS YOUR PAIN NOW?

1______2________3________4________5________6________7________8_______9_______10

NO PAIN INTERMEDIATE PAIN WORSTPAIN

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MEDICAL RECORDS RELEASE FORM

Patient Name (Print) ____

Date of Birth _____ / _____ / __________

Date _____ /______ /2015   Signature ___________________________

OFFICE USE ONLY:

I hereby authorize,

Providers Name or Facility: *MOSHE H. WILKER M.D., INC*

Address: *11980 San Vicente Blvd. Suite 114, Los Angeles CA 90049*

Phone Number: *310. 337.7463*   Fax Number: *310. 442. 8336*

Please release the following medical information regarding my previous healthcare.

- ____ *Physician Progress Notes*
- ____ *Diagnostic Reports*
- ____ *History and Physical Exam*
- ____ *Operative Reports*
- ____ *Discharge Summary*
- ____ *Consultation Report*
- ____ *Pothology Report*
- ____ *MRI/CT, X-RAY Films*
- ____ *Full Medical Records*
- ____ *Other* ____

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Notice of Privacy Practices

To Our Patients:This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Moshe Wilker, M.D. has a financial interest in Brentwood Orthopedic and Spine Surgery ambulatory surgery center.

Our Commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use of disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. of foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs

Your rights regarding your health information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests. You can request a restriction in our use or disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family member and friends. We are not required to agree to your request however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

2. You have the right to request and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, not including psychotherapy notes. You must submit your request in writing to Moshe H. Wilker, M.D. 310-33-Spine (77463)

3. You may ask to amend your health information if you believe it is incorrect or incomplete, and as long as the information is by our or for our practice. To request an amendment, your request must be made in writing and submitted to Moshe H. Wilker, M.D. 310-33-Spine (77463). You must provide us with a reason that supports your request for amendment.

4. Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice. Contact our front desk receptionist.

5. Right to file a complaint. If you believe your privacy right has been violated, you may file a complaint with our practice of with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Moshe H. Wilker, M.D. 310-33-Spine (77463). All complaints must be submitted in writing. You will not be penalized for filing a complaint.

6. *Right to provide* an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Moshe H. Wilker, M.D. at 310 -33-Spine (77463)

______________________	______________________	____/____/2015
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 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. Filling 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 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 the 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)
Effective as of the date of first medical services

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.

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.

By: ______________________ By: ______________________ ____/____/2015

Physician's or Authorized Representative's Signature — Patient's Signature — Date

MOSHE H.WILKER, M.D., INC
Print or Stamp Name of Physician,
Medical Group or Association Name

____
Print Patient Name

____
(If representative print Name and Relationship to Patient)

MOSHE H. WILKER, M.D., INC.

Patient Responsibility Disclosure Statement

Thank you for choosing Brentwood Orthopedic and Spine Surgery for you specialty care. We believe that good care for you and your family starts with good communication. We have created this policy to help our patients understand the responsibilities that they and their families have for payment of our services.

If at any time you have any questions or concerns with our fees or payment process, please don't hesitate to ask our receptionist or thebilling department.

We require that our patients promptly pay all charges that are present to them. In some cases, our fees may be adjusted, based on whether we participate in or accept insurance or government program payment, allowances or limitations. We will contact your insurance carrier to determine what your specific benefits are, and whether you have any deductible, or co-payments. We do request that any deductible or co-payments be paid in full at the time of your treatment.

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please remember that some or perhaps all of the services provided may not be covered by your plan. In this case you or the patient's responsibleparty is fully responsible for any payments. Also, should the insurance company fail to pay;you will be responsible for the balance remaining.

If you do not agree to with patient's responsibility amount or reimbursement amounts set by your insurance or government program, this is a matter between you and that program. We are happy to provide you with factual information about your care and billing to help you discuss this with them, but we still require you to promptly pay the entire charge we present to you, even if your issue with the program is not resolved.

Unless you are covered by Medicare or Workers Compensation, the following services are ***NOT COVERED*** by any insurance.

- Surgery cancelation $500
- Telephone conversation with the doctor $100 per 15min
- Penalty fee of $100 forNon-sufficient funds (NFS),Account closed (AC) or Refer to Maker (RTM)
- A fee of $ 200 will be charged for an office visitno show if a 24 hour notice is not provided.

It is the patient's responsibility or the Responsible Party to verify with the insurance company if Dr. Wilker is a preferred provider with your specific plan.

Please be advised that your insurance company may send payments directly to you for the services provided by Moshe H. Wilker, M.D. and fully understand that is your responsibility to mail the payment together with the Explanation of Benefits (EOB) to the doctor's office within (14) days. Any unpaid balance will be accessed at 18% a year, 1.5% monthly interest and the account will be turned over to our collection agency.

I understand and accept the terms that if ***I DO NOT*** forward the insurance payment together with the EOB (Explanation of Benefits) to Moshe H. Wilker, M.D. my credit card on file will be immediately charged in the amount of the check provided to me by my insurance.

I understand that it is my responsibility to alert Dr. Wilker if any changes arise in my condition while I am under his care. I understand that Dr. Wilker cannot be held responsible for any poor outcome that arise from my failure or delay in reporting changes in my medical condition to him.

By signing below, you agree to accept full l responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above statement, understand your responsibilities and agree to these terms.

PatientSignature ______________________________ Date: ____/____/______

Patient Name (Please Print) ______________________________

Responsible Party Signature ______________________________ Date: ____/____/______

Responsible Party Name (Please Print) ______________________________