800 Fairmount Ave, Suite 210
Pasadena CA 91105

Amy Savagian, M.D., Inc

Name:					Date:
PATIENT INFORMATION (please print)					
Gender:	DOB:	SSN:	Driver's License Number:	Expiration Date:	State:
Home Phone:		Work Phone:	Mobile Phone:	Email:	
Address:			City:	State:	Zip Code:
Ethnicity: (please only indicate non-Hispanic or Hispanic)			Preferred Language: (if not English)	Race(s):	
INSURANCE INFORMATION (please give your insurance card(s) to the receptionist					
Occupation:		Employer:	Employer Address:		Employer Phone:
Primary Insurance:			Secondary Insurance: (if applicable)		
Policy Holder's Name: (as it appears on insurance card)			SSN:		DOB:
Group Number:			Policy Number:		Co-Pay:
IN CASE OF EMERGENCY					
Emergency Contact: (local friend or relative)			Relationship to Patient:	First Phone Number:	Second Phone Number:
Referred to Dr. Savagian					
SURGERIES					
1.	Date:		2.		Date:
3.	Date:		4.		Date:
DRUG ALLERGIES (please indicate exact type of reaction)					
1.			2.		
3.			4.		

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Name:	Date:

PAST/PRESENT MEDICAL PROBLEMS

☐	Acid Reflux	☐	Emphysema/Chronic Bronchitis	☐	Kidney Disease, Type:
☐	Allergies/Hay Fever	☐	Epilepsy/Seizures	☐	Kidney Stones
☐	Anemia	☐	Gallstones	☐	Liver Disease, Type:
☐	Anxiety/Panic Attacks	☐	Glaucoma	☐	Migraines
☐	Asthma	☐	Gout	☐	Obesity
☐	Autoimmune Disease	☐	Headache	☐	Osteoarthritis
☐	Back Pain	☐	Heart Attack	☐	Osteoporosis
☐	Bleeding from Bowels	☐	Heart Murmur	☐	Prostate Problems
☐	Bleeding Problems, Type:	☐	High Blood Pressure	☐	Skin Problems, Type:
☐	Blood Clot	☐	High Cholesterol	☐	Stroke
☐	Cancer, Type:	☐	Irregular Heart Beat	☐	Thyroid Problems
☐	Congestive Heart Failure	☐	Irritable Bowel Syndrome	☐	Urinary Incontinence
☐	Depression	☐	Insomnia	☐	Other:
☐	Diabetes/High Blood Sugar	☐	Joint Pain	☐	Other:

PLEASE LIST ALL PHYSICIANS WHOSE CARE YOU ARE CURRENTLY UNDER

1.	Location:	2.	Location:
3.	Location:	4.	Location:

FAMILY HISTORY

☐	Alcohol/Drug Addiction	☐	Glaucoma	☐	Osteoporosis
☐	Anxiety or Depression	☐	Heart Attack	☐	Stroke
☐	Asthma	☐	High Blood Pressure	☐	Thyroid Problems
☐	Bleeding Problems	☐	High Cholesterol	☐	Tuberculosis
☐	Cancer, Type:	☐	Kidney Disease, Type:	☐	Other:
☐	Diabetes/High Blood Sugar	☐	Liver Disease, Type:	☐	Other:
☐	Epilepsy/Seizures	☐	Migraines	☐	Other:

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Name:			Date:
PREVENTATIVE CARE			
Vaccinations With Date: (i.e. Flu, Hepatitis A/B, Pneumococcal) **1.**		**2.**	
3.		**4.**	
WOMEN		**MEN**	
Colonoscopy Last Date:	**Have you ever had an abnormal result? If so, please indicate date:**	**Colonoscopy Last Date:**	**Have you ever had an abnormal result? If so, please indicate date:**
Mammogram Last Date:	**Have you ever had an abnormal result? If so, please indicate date:**	**Prostate Exam Last Date:**	**Have you ever had an abnormal result? If so, please indicate date:**
Breast Exam Last Date:	**Have you ever had an abnormal result? If so, please indicate date:**	**PSA Level Checked Last Date:**	**Have you ever had an abnormal result? If so, please indicate date:**
PAP/Pelvic Exam Last Date:	**Have you ever had an abnormal result? If so, please indicate date:**		
Last Menstrual Period:	**Pregnancies:** **Deliveries:**		
Current Form of Birth Control if Sexually Active:		**Current Form of Birth Control if Sexually Active:**	

LIFESTYLE			
Exercise:	**Frequency:**	**Duration: (in Minutes)**	**Type:**
Smoking Status:	**Frequency: (in Packs)**	**Duration: (in Years)**	**Past Attempts to Quit:**
Alcohol:	**Frequency:**	**Duration:**	**Type:**
Drug Use:	**Frequency:**	**Duration:**	**Type:**

CURRENT MEDICATIONS INCLUDING SUPPLEMENTS, WITH DOSAGE AND FREQUENCY	
1.	**2.**
3.	**4.**
5.	**6.**

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Amy Savagian, M.D., Inc

The following outline of financial responsibilities and consent policies have been established to assist us in providing the highest quality medical care and outline possible disclosures of health information for treatment, payment, and patient healthcare options.

Insurance: It is your responsibility to know and understand your coverage and benefits. As a courtesy, we file your insurance forms from our office. Please make sure your insurance and demographic information is kept up to date with our office. This includes any change of information such as address, phone numbers, and insurance changes. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security number, and relationship to the patient to file all claims. Patients are responsible for all fees that are not covered by insurance, including co-payments, coinsurance, deductibles and non-covered services or items received. At every visit, please make sure you have all insurance card(s) and photo identification as well as any other forms that may assist us in processing your claims correctly.

No Insurance: If you are not covered by insurance at the time of service, please be advised that you will be responsible for all charges incurred at the time of service. Cash, PayPal, or credit card is accepted.

Returned Check: There will be a thirty dollar ($30.00) charge assessed for any check returned by your bank for any reason.

Collections: Accounts that are not paid within sixty (60) days from the date of service may be sent to our collections department. If acceptable terms cannot be reached to satisfy the past due balance, the patient may be dismissed from our practice.

Medical Records: We will provide a digital or analog copy of your medical records upon request for a twenty-five dollar ($25.00) administrative fee. You will be required to sign a medical record release form and pay the medical record fee in full prior to having your medical records copied. Please allow up to one (1) week for this request to be processed.

Dismissal Process: There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

- Failure to keep scheduled appointments
- Being verbally abusive or physically abusive to staff
- Failure to meet financial obligations

A certified letter will be sent to your last known address notifying you that you are being dismissed from Dr. Savagian's practice. If you have a medical emergency within thirty (30) days of the date of the letter, Dr. Savagian will see you. After the thirty (30) days, you will no longer be seen by Dr. Savagian or her practice. A copy of your medical record may be forwarded to your new doctor after a formal request is made and appropriate fees are paid.

Patient Acknowledgement:

I,_____(print name) have read and agree to the Patient Financial Responsibilities and Policies.

I agree to pay at the time of service. I also understand that Amy Savagian MD Inc. reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections. I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations, and tests results, dignoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

Patient Signature (Date)

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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 or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on 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 related 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 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 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 communicate 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 Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations 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 once 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, or 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 Effective as of the date of first medical services.

Patient Initials: _____

If any provision if this arbitration agreement is held invalid of 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 THE CONTRACT.

Physician Signature	Patient Signature (Date)
Amy Savagian, MD	
Name of Physician	Name of Patient

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

Amy Savagian, M.D., Inc
800 Fairmount Ave, Suite 210
Pasdena CA 911105

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Federal regulations developed under the Health Insurance Portability and Accountability Act (HIPAA) requires that the practice provide you with this notice regarding privacy of personal health information. This Notice describes (1) how the practice may use and disclose your protected health information, (2) your rights to access and control your protected health information in certain circumstances, and (3) the practice's duties and contact information.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED

This notice describes information about privacy practices followed by our employees, staff, and other office personnel. The practices described in this notice will also be followed by healthcare providers you consult with by telephone (when your regular healthcare provider from our office is not available) who provide "call coverage" for your healthcare provider.

Protected Health Information

"Protected Health Information" is health information created or received by your health care provider that contains information that may be used to identify you, such as demographic data. It includes written or oral health information that relates to your past, present, or future physical or mental health; the provision of health care to you; and your past, present, or future payment for health care.

The Use and Disclosure of Protected Health Information in Treatment, Payment, and Health Care Operations

Your protected health information may be used and disclosed by the practice in the course of providing treatment, obtaining payment for treatment, and conducting health care operations. Any disclosures may be made in writing, electronically, by facsimile, or orally. The practice may also use or disclose your protected health information in other circumstances if you authorize the use or disclosure, or if state law or the HIPAA privacy regulations authorize the use or disclosure.

Treatment

The practice may use or disclose your protected health information in the course of providing or managing your health care as well as any related services. For the purpose of treatment, the practice may coordinate your health care with a third party. In addition,
the practice may disclose protected health information to other health care providers for treatment activities of those other parties.

Payment

When needed, the practice may use or disclose your protected health information to obtain payment for its services. Such uses or disclosures may include disclosures to your health insurer to get approval for a recommended treatment or determine whether you are eligible for benefits or whether a particular service is covered under your health plan. When obtaining payment for your health care, the practice may also disclose your protected health information to your insurance company to demonstrate the medical necessity of the care of utilization review when required to do so by your insurance company. Finally, the practice

may also disclose your protected health information to another provider where that provider is involved in your care and requires the information to obtain payment.

Operations

The practice may use or disclose your protected health information when needed for the practice's health care operations for the purpose of management or administration of the practice and of offering quality health care services. Health care operations may include: (1) quality evaluations and improvement activities; (2) employee review activities and training programs; (3) accreditation, certification, licensing, or credentialing activities; (4) reviews and audits such as compliance reviews, medical reviews, legal services, and maintaining compliance programs; and (5) business management and general administration activities. The practice may disclose your protected health information to another provider or health plan for their health care operations.

Other Uses and Disclosure

As part of treatment, payment, and healthcare operations, the practice may use or disclose your protected health information to: (1) remind you of an appointment including the leaving of appointment reminder information on your telephone answering machine; (2) inform you of potential treatment alternatives or options; or (3) inform you of health related benefits or services that may be of interest to you.

Additional Uses and Disclosures Permitted without Authorization

In addition to treatment, payment and healthcare operations, the practice may use or disclose your protected health information without your permission or authorization in certain circumstances, including:

When Legally Required

The practice will comply with any federal, state or local law that requires it to disclose your protected health information.

Public Safety

The practice may use or disclose your protected health information to prevent or lessen a serious threat to the health or safety of another person or to the public.

Abuse, Neglect, or Domestic Violence

As required, or authorized by law, or with the patients agreement, the practice may inform government authorities if it is believed that a patient is the victim of abuse, neglect, or domestic violence.

Health Oversight Activities The practice may use or disclose your protected health information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation, and/ or intervention. The practice may disclose your protected health information to a health oversight agency for oversight activities authorized by law including audits, investigations, inspections, licensure, or disciplinary actions, administrative and/ or legal proceedings.

Legal Proceedings

The practice may disclose your protected health information in the course of certain judicial or administrative proceedings.

Law Enforcement

The practice may disclose your protected health information for law enforcement purposes or other specialized governmental functions.

Coroners, Medical Examiners, and Funeral Directors

The practice may disclose your protected health information to a coroner, medical examiner or a funeral director.

Organ Donation

If you are an organ donor, the practice may disclose your protected health information to an organ donation and procurement organization.

Disaster Relief

The practice may disclose your protected health information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

Disclosure to Department of Health and Human Services

The practice may disclose your protected health information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

Family and Friends

Unless you object, the practice may disclose your protected health information to family members, other relatives, or close personal friends, when the health information is directly relevant to that person's involvement with your care.

Notification

Unless you object, the practice may disclose your protected health information to notify a family member, a personal representative or another person responsible for your care of your location, general condition, or death.

Authorizations

Other than the circumstances described above, the practice will not disclose your protected health information unless you provide written authorization. You may revoke your authorization in writing at any time.

Your Rights Regarding Your Medical Information

You have the following rights with respect to your protected health information:

The Right to Request Confidential Information

You have the right to receive communication from this practice in a confidential manner.

The Right to Request a Restriction on Uses and Disclosures of Your Protected Health Information

You may ask the practice to restrict certain uses and disclosures of your protected health information. Your request should be directed to the practice's Privacy Officer. The practice may choose to deny your request for a restriction, in which case the practice will notify you of its decision. Once the practice agrees to the requested restriction, the practice may not violate that restriction unless use or disclosure of the relevant information is needed to provide emergency treatment.

The Right to Inspect and Copy Your Protected Health Information

Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.

The Right to Request an Amendment of your Protected Health Information

You may ask the practice to amend your protected health information. The practice may deny your request for certain specific reasons. If denied, the practice will provide you with a written explanation for the denial and information regarding further rights you may have at that point.

The Right to Request an Accounting of Certain Disclosures

You have the right to receive an accounting of the disclosures of your protected health information made by the practice during the last six years, except for disclosures for treatment, payment, or healthcare operations, disclosures that you authorized and certain other specific disclosure types. The practice is not required to provide an accounting for disclosures that took place prior to April 14, 2003. The practice will not charge you for the first accounting you request of any 12-month period. Subsequent accounting may require a fee based on the practice's reasonable costs for compliance of the request.

The Right to Obtain a Paper Copy of This Notice

You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.

The Right to File a Complaint

If you believe that your privacy rights have been violated, you have the right to relate complaints to the practice and to the Secretary of the Department of Health and Human Services. You may provide complaints to the practice verbally or in writing. Such complaints should be directed to the practice's Privacy Officer. This practice encourages you to relate any concerns you may have regarding the privacy of your information and you will not be retaliated against in any way for filing a complaint.

Privacy Officer

If you would like further information regarding your rights or regarding the uses and disclosures of your protected health information, you may contact:

Privacy Officer
Amy Savagian, M.D., Inc
800 Fairmount Ave, Suite 210
Pasdena CA 911105