

PLEASE FILL OUT ALL AREAS. DO NOT LEAVE BLANK.

Name:	Date:
Reason for Visit:	
Have you been treated by another gastroenterologist? Y N	
If so, who?	When?
Reason for changing gastroenterologists?	

Past Medical History: Have you had:

Diabetes	Y	N
Heart Disease	Y	N
High Blood Pressure	Y	N
Stroke	Y	N
TB	Y	N
Cancer	Y	N

If yes, type _____

Ulcer or H.Pylori infection	Y	N
Hemorrhoids	Y	N
Hepatitis A, B, C	Y	N
Jaundice	Y	N
Internal Bleeding	Y	N
Blood Transfusion	Y	N

If yes, when? _____

Other Medical Problems / Conditions:
Please list:

Past Surgical History:

Please list any medications you are currently taking:

MEDICATION	DOSAGE	FREQUENCY	REASON FOR TAKING	DATE STARTED

Review of Systems: Do you have any of the Following:

Skin lesions	Y	N
Eye trouble	Y	N
Recent weight changes	Y	N
Sleeping troubles	Y	N
Fever	Y	N
Nose bleeds	Y	N
Enlarged glands	Y	N
Palpitations	Y	N
Chest pain	Y	N
Chills	Y	N
Shortness of breath	Y	N
Spitting up blood	Y	N
Phlegm	Y	N
Cough	Y	N
Blood with urination	Y	N
Frequent urination	Y	N
Pain on urination	Y	N
Headaches	Y	N
Dizziness	Y	N
Joint pain	Y	N

FAMILY History: Have any blood relatives had: Relations?

Colon Cancer	Y/N	-----
Colon polyps	Y/N	-----
Gastric cancer	Y/N	-----
Pancreatic Cancer	Y/N	-----
Uterine cancer	Y/N	-----
Ovarian cancer	Y/N	-----
Kidney cancer	Y/N	-----
Ureter/bladder cancer	Y/N	-----
Gall bladder cancer	Y/N	-----
Breast Cancer	Y/N	-----
Thyroid cancer	Y/N	-----
Parathyroid cancer	Y/N	-----
Liver cancer or disease	Y/N	-----
H.Pylori infection	Y/N	-----
Heart disease	Y/N	-----
Diabetes	Y/N	-----
Genetic disorders	Y/N	-----
Blood clot disorder	Y/N	-----

PONEH RAHIMI, M.D.

27800 Medical Center Rd, Suite 318

Mission Viejo, CA 92691

Phone: (949)364-2536

Fax: (949)388-8848

Cancellation Policy

Time has been specifically reserved for your office visit and procedures. Due to our high patient volume, you are required to give us 72 hour (3 days) notice if you cancel your procedure (EGD, Colonoscopy or Capsule Endoscopy) and 24 hour (1 day) notice for all in office appointments. This will enable us to schedule another patient and follow the required procedure preparation. If you fail to cancel before the 72 hour or 24 hour time period, you will be charged a cancellation fee of \$75 for procedures and \$40 for office visits.

We make every effort to confirm procedures 2-3 days before scheduled date as a reminder to start your preparation. We confirm office visits 1-2 days before scheduled appointments. This is a courtesy call only. It is your responsibility to call us 3 days before your procedure or 1 day before your office visit if you are unable to keep your scheduled appointment. If an emergency arises and you need to cancel your procedure after hours, we ask that you call our office and have the doctor on call paged for notification.

Cancellation Agreement:

Effective: October 1, 2008

I understand Dr. Rahimi's Cancellation Policy above and agree to follow Dr. Rahimi's office policy.

Patient Name (Please Print)

Patient Signature

Witness

Date

PATIENT INFORMATION SHEET

FIRST NAME: _____ MIDDLE INT: _____ LAST NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME # _____ WK# _____ CELL# _____

BIRTHDATE: _____ SS# _____ E-MAIL _____

AGE: _____ SEX: F M MARITAL STATUS: S M W D OTHER

REFERRED BY: _____ FAMILY DOCTOR: _____

EMPLOYER: _____ OCCUPATION: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SPOUSE/NEAREST RELATIVE: _____ PHONE: _____

SPOUSES EMPLOYER: _____ BIRTHDATE: _____ SS# _____

EMERGENCY CONTACT: _____ RELATION/PHONE: _____

PRIMARY INSURANCE

SECONDARY INSURANCE

COMPANY: _____

COMPANY: _____

ID# _____

ID# _____

GROUP# _____

GROUP# _____

INSURED: _____

INSURED: _____

CO-PAY: _____

CO-PAY: _____

The undersigned hereby authorized the release of any information related to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, or services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents.

- I guarantee payment to Poneh Rahimi, M.D. I authorize my insurance company(ies) to pay any/all charges rendered on my behalf directly to Poneh Rahimi, M.D. I will be responsible for, and will guarantee payment on any and all charges, which may not be paid or covered by my insurance company(ies). I understand payment in full may be required at the time of service (for your convenience we accept money orders, checks, cash.)
- I have read and understand Dr. Rahimi's cancellation fee policy for office visits as well as scheduled procedures.
- A service charge of 1 ½% per month (18% per annum) (but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 90 days of treatment.
- I understand if my account is submitted for collection I will be charged a 30% fee of the balance that is transferred to the collection agency. I understand the returned check fee is \$25.00.



SIGNATURE _____ DATE _____

Poneh Rahimi, MD

27800 Medical Center Road, Suite #318, Mission Viejo, CA 92691
Phone: 949-364-2536 Fax: 949-388-8848

I have read and agree with the following office policies:

1. A 72hr notice must be given prior to the request for medication refills.
2. After hour phone calls are limited only to urgent medical calls. Please use a phone that receives blocked numbers. Otherwise, she will not be able to call you back.
3. No phone consultation will be performed by Dr. Rahimi. All medical issues must be discussed in the office including the results. Dr. Rahimi will only call the critical results or if she has indicated a call back.
4. It is the patient's responsibility for colon cleansing prior to the colonoscopy.
5. It is patient's responsibility to read and review the prep instruction and driving directions given at the time of consultation.
6. It is the patient's responsibility to update the medication list and new medical events on each office visit.
7. Facility and pathology fees (if any biopsy has been done) are separately charged by the facility and pathologist. These are not related or set by Dr. Rahimi. Fees are dependent on the insurance plans and benefits. You have a choice to go to any of the three facilities that the procedures are done if authorized by your insurance. Dr. Rahimi has no ownership in any of these facilities.
8. If a patient seeks medical care with another gastroenterologist in the interim since the last office visit, it is considered as a prompt discharge from this practice.
9. There is a charge of \$30 for any forms that need to be filled out with at least 72hr prior notice.
10. There is a charge of \$30 for photocopying the records.
11. I have read and agree with cancelation policy and understand there is no exception.
12. I have received a copy of instructions and office policy.

Signature

Print Name

Poneh Rahimi, MD

27800 Medical Center Road, Suite #318, Mission Viejo, CA 92691

Phone: 949-364-2536 Fax: 949-388-8848

Patient Consent for Disclosure and Use of Procedure Health Information

I hereby give my consent for Poneh Rahimi, MD to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). The notice of Privacy Practices provided by Poneh Rahimi, MD describes such uses and disclosures more completely. I have the right to review the notice of Private Practices prior to signing this consent. Poneh Rahimi, MD reserves the right to revise the notice of Private Practices at any time. A revised Notice of Private Practices may be obtained by forwarding a written request to the receptionist. I am aware that Poneh Rahimi, MD is licensed and regulated by the Medical Board of California (www.mbc.ca.gov 800-633-2322). By signing this form, I am consenting to allow Poneh Rahimi, MD to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made a disclosure based upon my prior consent. If I do not sign this consent, or later revoke it, Poneh Rahimi, MD may decline to treat me.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER:

(CHECK ALL THAT APPLY.)

Home Phone _____

OK to leave message with detailed information

Leave message with a call-back number only

Work Phone _____

OK to leave message with detailed information

Leave message with a call-back number only

Cell Phone _____

OK to leave message with detailed information

Leave message with a call-back number only

Written communication: Okay to mail to my home address

Okay to mail to my work/office address



Signature

Print Name

RECORDS RELEASE

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

I AUTHORIZE THE USE/ DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW.



Patient's Name _____
Date of Birth _____ Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information:

- Poneh Rahmi, M.D.
- Insurance Carrier _____
- ~~Other~~ Primary Care Doctor: _____

B. Person(s) or Organization(s) authorized to receive this information:

- Poneh Rahmi, M.D.
- Insurance Carrier _____
- ~~Other~~ Primary Care Doctor: _____

C. Specific description of the information that may be used or disclosed (including date(s)):

D. Description of how the information will be used or disclosed:

- To provide you with our professional services
- To disclose/share with other health care professionals who provide treatment/services to you
- To seek payment for services we provide to you
- To assist in the notification of a family member or anyone responsible for your care in case of an emergency

- 1) I understand that this authorization will expire in 1 year.
- 2) I understand that I may revoke this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying Poneh Rahmi, M.D., in writing.
- 3) I understand that I can refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
- 4) I may inspect or copy any information used or disclosed under this agreement.
- 5) I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal regulations, the information described above may be re-disclosed and would no longer be protected by these regulations.



_____ Patient's Signature or Patient's Representative	_____ Date
_____ Printed Name of Patient's Representative	_____ Relationship to Patient

Note: You have the right to know and specifically what information you are authorizing for release (e.g., "results of a lab test performed on 1/4/03" or, if your entire medical record is included, "all health information")
 You have the right to know the name(s) of other identification of the person(s) or organization(s) authorized to release information (e.g. the names of your health care provider(s))
 You have the right to know who is going to use it and what it is going to be used for (e.g., John Smith, PhD/Research)

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free and understandable prescription directly to a pharmacy from the point of care. E-Prescribing greatly reduces medication errors, and enhances convenience for the patient while maximizing patient safety. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- Formulary and benefit transactions – Gives the prescriber information about which drugs are covered by the patient's drug benefit plan.
- Medication history transactions – Provides the physician with information about medications the patient is already taking to minimize adverse drug events.
- Fill status notification – Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription needs to be refilled, has been picked up, not picked up, or partially filled.

By signing this consent form, you are agreeing that Poneh Rahimi, M.D., can electronically transmit your prescriptions directly to your pharmacy.

E-Prescribing is an optional service and you may choose to decline. Please note that consenting to E-Prescribing also permits the use of your prescription medication history from other healthcare providers and/or third-party benefit payors (i.e., your insurance company) for treatment purposes only.

Understanding all of the above, I hereby provide informed consent to Poneh Rahimi, M.D. to enroll me in the E-Prescribe Program.

Signature of Patient (or Guardian)

Date of Birth

Print Patient Name

Relationship to Patient

If you choose to participate in E-Prescribing, please list your preferred pharmacy information below.

Pharmacy Name

Location-(City and Street Name)

Pharmacy Telephone Number

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. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also 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 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

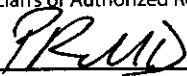
Patient's or Patient Representative's Initials

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:  _____
Physician's or Authorized Representative's Signature (Date)


Print or Stamp Name of Physician, Medical Group, or Association Name

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

By: _____
Print Patient's 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.