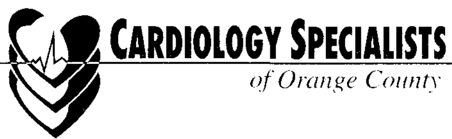


NEW PATIENT INFORMATION

(PLEASE PRINT)

DATE ____________________

PATIENTS NAME	MARITAL STATUS: S / M / W / D / SEP	DATE OF BIRTH	AGE	S.S.#
STREET ADDRESS — PERMANENT — TEMPORARY	CITY AND STATE	ZIP CODE	HOME PHONE #	
PATIENTS OR PARENTS EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED	BUS PHONE #	
EMPLOYERS STREET ADDRESS	CITY AND STATE	ZIP CODE		
DRUG ALLERGIES, IF ANY	DRIVERS LIC. #			
SPOUSE OR PARENTS NAME	S.S. #	NUMBER OF CHILDREN AND AGES		
SPOUSE OF PARENTS EMPLOYER	OCCUPATION (INDICATE IF STUDENT)	HOW LONG EMPLOYED	BUS. PHONE #	
EMPLOYERS STREET ADDRESS	CITY AND STATE	ZIP CODE		
SPOUSE DATE OF BIRTH				

IN CASE OF EMERGENCY, PERSON TO NOTIFY (Not living at same address)

NAME ____________________ PHONE ____________ RELATIONSHIP ____________

PERSON RESPONSIBLE FOR PAYMENT, IF NOT ABOVE	STREET ADDRESS, CITY, STATE & ZIP CODE	HOME PHONE #		
BLUE SHIELD (GIVE NAME OF POLICY HOLDER) ☐	EFFECTIVE DATE	CERTIFICATE #	GROUP #	COVERAGE CODE
OTHER (WRITE IN NAME OF INSURANCE COMPANY) ☐	MAILING ADDRESS	POLICY #		
OTHER (WRITE IN NAME OF INSURANCE COMPANY) ☐	MAILING ADDRESS	POLICY #		
MEDICARE (PLEASE GIVE NUMBER) ☐	RAILROAD RETIREMENT (PLEASE GIVE NUMBER)			
INDUSTRIAL ☐	WERE YOU INJURED ON THE JOB? ☐ YES ☐ NO	DATE OF INJURY	INDUSTRIAL CLAIM #	
ACCIDENT ☐	WAS AN AUTOMOBILE INVOLVED? ☐ YES ☐ NO	DATE OF ACCIDENT	NAME OF ATTORNEY	
HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY BEEN TREATED BY OUR PHYSICIAN(S) BEFORE?				
REFERRED BY	STREET ADDRESS, CITY, STATE, AND ZIP CODE	PHONE #		

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

INSURANCE AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE CARDIOLOGY SPECIALISTS OF ORANGE COUNTY TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. <u>I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.</u>

DATE ____________________ SIGNATURE ____________________

CARDIOLOGY SPECIALISTS
of Orange County

BILLING POLICY

CO-PAYMENTS AND/OR DEDUCTIBLE BALANCES WILL BE COLLECTED AT THE TIME OF SERVICE. Co-payments and deductibles are the responsibility of the patient. If you do not pay your co-payment at the time of your office visit or lab test, we will charge a $25.00 "Statement Fee" to your account. Extended unpaid balances for deductibles and/or co-payments will be forwarded to our collection agency.

We will bill your insurance company as a courtesy to you. However we are not responsible for following up with the insurance company to ensure that they provide reimbursement, this is the patient's responsibility. **Payment for all services billed to the insurance company will be due in full within 45 days from the date of service.**

<u>Patients with HMO/Managed Care insurance plans:</u> You will need to provide proof of eligibility or sign a waiver of eligibility at the time of service. **Prior authorizations must be on file in writing prior to all scheduled appointments and tests.** While our Business Office will attempt to obtain all authorizations prior to your appointment, it would be helpful and possibly expedite the process if you contact your Primary Care Physician two weeks before your appointment to insure an authorization is in progress.

By signing this form, you are certifying that you are eligible with the insurance company listed on the card you presented at the time of each of your appointments. " I, the patient, understand that if the above is not true or if I am not eligible under the terms of my Medical and Subscriber Agreement, I am liable for any and all charges for services rendered. Also, if the above is not true, I agree to pay in full for all services rendered, within thirty days (30) of receiving a bill from *Cardiology Specialists of Orange County."*

<u>No Show Policy:</u> Patients who do not show up for a scheduled office or lab visit, or who do not cancel the appointment the day before, will be charged a $25.00 fee.

Any checks returned by the bank will be subject to a $25.00 service fee.

A patient will be considered a cash patient once the account has been sent to collection due to a delinquent balance. *<u>Any future services, after a patient has been sent to the collection agency, will need to be paid at the time of service</u>*. Our office will not bill your insurance, but we will give you the necessary form so you may request reimbursement from your insurance. The patient will be responsible for any extraordinary costs associated with collection of funds owed to the practice, including but not limited to, collection agency fees, attorney's fees and court costs.

Payment arrangements can be made in advance of services rendered in cases involving cash patients and/or financial hardship. Please ask to speak to a representative of the Business Office.

I have read, understand, and agree to comply with the above information.

Signature of Patient/Guardian

Date

Verified by: _______________

Printed Name

MEDICAL HISTORY

(To be filled in by patient)

NAME ______________________________ DATE ______________________ AGE__________

REASON FOR VISIT OR CHIEF COMPLAINT: ____

____

REFERRED BY: ____

PRESENT ILLNESS: *(to be filled in by physician)*

MEDICAL HISTORY

(To be filled in by patient)

I. Have you had any reactions, allergies or bad effects from any of the following:

	Yes	No		Yes	No
Serum	☐	☐	Aspirin	☐	☐
Penicillin	☐	☐	Morphine	☐	☐
Other antibiotics	☐	☐	Other drugs *(specify)* ____________		
Codeine	☐	☐	______________________________		
Sulfa Drugs	☐	☐	______________________________		

II. Have you ever had any of the following: *(If Yes, please check)*

1. Measles ☐
2. Mumps ☐
3. Chicken pox ☐
4. Whooping cough ☐
5. Scarlet fever ☐
6. Diptheria ☐
7. Rheumatic fever ☐
8. Glaucoma ☐
9. Migraine headaches ☐
10. Stroke or paralysis ☐
11. Fits or epilepsy ☐
12. Cancer or tumor ☐
13. High blood pressure ☐
14. High cholesterol ☐
15. Heart attack ☐
16. Other heart disease ☐
17. Tuberculosis, asthma or emphysema ☐
18. Ulcer or colon problems ☐
19. Gallbladder disease ☐
20. Kidney or bladder problems ☐
21. Arthritis or gout ☐
22. Anemia ☐
23. Sugar diabetes ☐

Have you had illnesses other than those listed above? ☐ Yes ☐ No *(If Yes, please list)*

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Relation	Age if living	If dead — cause of death	Age at death
Father			
Mother			
Brothers			
Sisters			
Wife or Husband			
Children Male			
Female			

IV. List any significant family illnesses other than listed above:

____

____

____

V. OPERATION: Have you had any surgical treatment or operations? *(If Yes, list below)*

____

____

____

VI. Have you had serious accidents or injuries? *(If Yes, list below)*

____

____

VII. Menstrual History:

1. Number of pregnancies? ______________ 2. Number of living children ______________
3. Did you have any miscarriages? ______________ 4. If yes, how many? ______________
5. Have your menstrual periods stopped? ______________ When ______________
6. Did you have any difficult deliveries? ______________
7. Did you have heart or kidney trouble during pregnancy? ______________

VIII. Habits:

Do you now or have you ever smoked? ☐ Yes ☐ No ☐ Cigars ☐ Cigarettes ☐ Pipe

If yes, how much ________ How long ________ *(years)* If you have stopped, how long ago ________ *(years)*

Do you follow a regular exercise program? ______________

Do you drink alcoholic beverages? ☐ Never ☐ Occassionally ☐ Almost daily ☐ More than above

Do you drink coffee? ☐ Yes ☐ No ☐ Less than 5 cups per day ☐ More than 5 cups per day

IX. Do you take any of the following medicines or drugs regularly?

Digitalis (Medicine for the heart)	☐	Insulin	☐
Anticoagulants	☐	Aspirin	☐
Diuretics (to remove fluid)	☐	Thyroid	☐
Tranquilizers	☐	Sleeping Pills	☐
Drugs to lower high blood pressure	☐	Nitroglycerine	☐

Please list all other medications currently taking ____

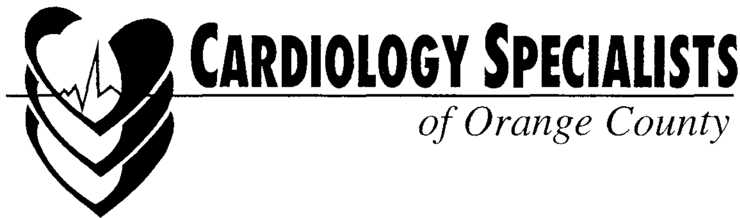
____

Please bring all medications or current list to your appointment.

X. Have you ever had or do you now have any of the following: *(If Yes, please check)*

Headaches	☐	Hemorrhoids	☐
Dizziness or blackouts	☐	Rupture or hernia	☐
Goiter or thyroid trouble	☐	Blood in urine	☐
Hearing or ear condition	☐	Red blood or black tarry	
Hay Fever	☐	bowel movements	☐
Eye or vision problems	☐	Excessive thirst	☐
Frequent sore throats	☐	Trouble starting or stopping urine	☐
Pain or difficulty in swallowing	☐	Frequent or painful urination	☐
Frequent hoarseness	☐	Skin cancer	☐
Chronic cough	☐	Shingles more than once	☐
Coughed up blood	☐	Alcoholism	☐
Severe or recurrent pain in chest	☐	Narcotic or drug habit	☐
Pneumonia or pleurisy	☐	Car, air or sea sickness	☐
Heart murmer	☐	Tremor or palsy	☐
Shortness of breath on climbing		Difficulty sleeping	☐
flight of stairs	☐	Frequent or terrifying nightmares	☐
Swelling of ankles	☐	Attempted suicide	☐
Irregular, palpitation or fast		Frequent depression	☐
heartbeat	☐	Urinate more than once a night	☐
Pain or cramps in legs with walking	☐	Dribbling of urine	☐
Varicose veins or phlebitis	☐	Prostrate troubles	☐
Recent change in appetite	☐	Disabling back pain	☐
Change in weight	☐	Bone, joint or other deformity	☐
Vomiting of blood	☐	Neuritis	☐
Frequent vomiting	☐	Pain after drinking	☐
Recurrent burning in stomach	☐	alcohlic beverages	☐
Frequent diarrhea or constipation	☐	Blood disorder	☐
Yellow jaundice	☐	Chronic skin condition	☐
Chronic abdominal pain	☐	Ulcer of legs or feet	☐
Frequent belching or bloating	☐	Hives	☐

Are you on any special diet? *(Please specify)* ____



700 N. Tustin Ave.
Santa Ana, CA 92705
(714) 245-1444
Fax (714) 953-6604

1140 W. La Veta, Suite 845
Orange, CA 92868
(714) 543-5555
Fax (714) 543-5585

16300 Sand Canyon Ave, Suite 801
Irvine, CA 92618
(949) 753-9150
Fax (949) 753-9152

NOTICE OF PRIVACY PRACTICES

HIPAA, the Health Insurance Portability Act of 1996 has recently been formalized and will help govern the relationship between patients and their providers of Health Care to provide all entitled Medical Services in the most efficient way.

THIS NOTICE DECSRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU, AS THE PATIENT, MAY GET ACCESS TO THIS INFORMATION.
Please Read and Review it Carefully

If you have any questions about this notice, please contact Phyllis A. Kasparian, our Practice Administrator at our Santa Ana office, (714) 245-1444 ext. 223.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are requited by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1 Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services, which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose the information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our " business associates", such as our billing service that performs administrative services for us. We have a written contract with each of these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law

does not protect health information, which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. If you are part of a health plan, we may also share medical information about you to all the other health care providers [health care clearinghouses] [and health plans] who participate in your plan for any health care operations activities.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. How may we contact you and still provide privacy and security you require as we protect your health and personal information?

Please check:
________ Telephone and message to your answering machine.
________ Telephone and message to another person (Please name________________________)
________ Mail.
________ Contact you at work (Please give number____________________________________)
________Leave a message at your work. (Please give number _____________________________)
________Designated caregiver, legal guardian or relative (Please specify___________________)

5. Sign in sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and communication with family. We may disclose health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate the notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. We may contact you to give you information about products ore services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information without your written authorization.

8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

9. Public Health. We may and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

11. Judicial and administrative proceedings. We may and are sometimes required by law to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or tissue donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

15. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

16. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

17. Worker's compensation. We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by worker's compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or worker's compensation insurer.

18. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/ record will become property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

19. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information, which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have the right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. Right to Accounting of Disclosures. You have the right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment) 3, (health care operations), 6 (notification and communication with family) and 16 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. You have a right to a paper copy of this Notice Of Privacy Practices , even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made. The revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and will offer you a copy at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.
If you are not satisfied with the manner in which this office handles a complaint, you may submit formal complaint to:

Department of Health and Human Services
Office of Civil Rights
Hubert H. Humphrey Bldg.
200 Independence Avenue, S.W.
Room 509 F HHH Building
Washington, DC 20201

You will not be penalized for filing a complaint.

Acknowledgement of Receipt of Notice Of Privacy Practices
Cardiology Specialists of Orange County

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: ____

Signed: ______________________ Date: ______________________

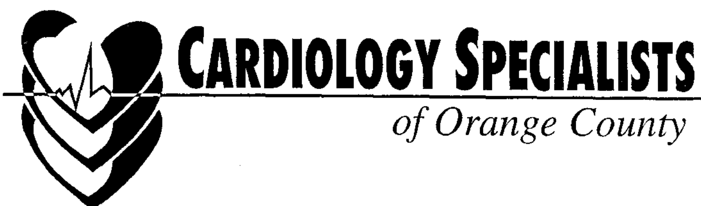
Print Name: ____________________ Telephone: ____________________

If not signed by the patient, please indicate:

Relationship:

- ❑ Parent or guardian of minor patient
- ❑ Guardian or conservator of an incompetent patient
- ❑ Beneficiary or personal representative of deceased patient.

Name of Patient: ______________________________________



JAMES M. PAGANO
M.D., F.A.C.C.

BAHRAM ESLAMI
M.D., INC., F.A.C.P., F.A.C.C.

WARREN D. JOHNSTON
M.D., F.A.C.P., F.A.C.C.

PAUL MELTZER
M.D., INC., F.A.C.C.

STEPHEN A. COHEN
M.D., F.A.C.C.

DONALD J. MAHON
M.D., INC., F.A.C.C.

TYSON C. COBB
M.D., INC., F.A.C.P., F.A.C.C.

THOMAS C. KIM
M.D.

MAHMOUD ESLAMI-FARSANI
M.D.

SUZANNE A. FEIGOFSKY
M.D.

PHYLLIS A. KASPARIAN
ADMINISTRATOR

A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached contract is an Arbitration Agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court.

Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that this method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by California courts.

By signing this agreement, you are changing the place where your claim will be presented. You can still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then selects a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. This is because the time it takes to conduct an arbitration hearing is far less than that for a jury trail. Further, both parties are spared some of the rigors of trial and the publicity, which may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

1140 W. La Veta
Suite 845
Orange, California
92868

714-543-5555
FAX 714-543-5585

700 N. Tustin Ave.
Santa Ana, California
92705-3508

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16300 Sand Canyon Ave.
Suite 801
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949-753-9150
FAX 949-753-9152