

## New Patient Registration Information

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Wilshire Aesthetics

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ male/female

Address \_\_\_\_\_  
street city state zip

Phone #'s \_\_\_\_\_  
home cell work

SSN \_\_\_\_\_ email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Primary Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

Address \_\_\_\_\_  
street city state zip

Emer. Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

### How did you hear about us? *please check the primary influence below*

- My friend/relative \_\_\_\_\_ suggested you.
- My primary physician referred me to you.
- I found you in the search results of  Google  Yahoo!
- I found you listed on my Health Provider's  website  printed catalogue
- I saw your ad in New Frontiers in LA Magazine

\_\_\_\_\_  
Name - printed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**What you need to know...**

When Wilshire Aesthetics (WA) bills your Insurance Carrier (IC) for the services we have provided you, your IC pays for a portion of your bill and you pay for a portion of your bill. Generally, your portion covers your:

- Deductible ( varies with each plan )
- Co-pay ( an up front charge per visit, usually between \$15 - \$50 )
- Co-insurance ( the amount your IC delegates to you, usually 20% )
- Other ( miscellaneous services your IC considers “not medically necessary” )
- Sometimes, your IC may require you to pay for the entire bill

Your IC will send you and us an Explanation of Benefits (EOB) which tells you how much your portion is.

**What you need to know about paying for your portion**

- WA does not send out Billing Statements. It is a costly, futile, and ineffective system that is quickly becoming obsolete.
- WA simply charges to your credit card the amount you owe for each visit, the same amount that is printed on your EOB.
- WA sends you a copy of the charge receipt for your personal records.
- Credit card authorizations are kept completely safe and secure.
- Co-pays are collected at the time of visit.

*For those patients who choose not to leave their credit card information...*

- WA does not send out Billing Statements.
- WA requires a service deposit ( retainer ) to cover your payment obligations for the services you received. The deposit covers your deductible, medical service co-insurance, non-covered services.
- Deposit amount - “In Plan” patients is \$200 “Out of Plan” patients is \$300
- When payment comes in from your IC, we deduct your payment obligation from the deposit you have left us. *We’ll contact you if your obligation is more than your deposit.*
- We keep the balance of the deposit for six months to cover future visits to our office. After six months, we will return the balance to you at your request.

**Patient Declaration**

I have read and understand all of the above.

\_\_\_\_\_  
Name - printed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Cancellation – “No Show” Agreement

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Wilshire Aesthetics

**Overview** When you schedule an appointment at Wilshire Aesthetics, we block out time specifically for you. We reserve staff, exams rooms, equipment, and an appropriate amount of time so that we can provide you with the best medical care possible. The amount of resource we reserve for you depends on the type of appointment you make.

We realize that sometimes circumstances require you to cancel or reschedule an appointment. We ask that you provide us with at least 48 hours notice when you cancel or reschedule an appointment.

**Our Promise to You** We will call you 72 hours before your appointment to remind you of your appointment.

If you call us at least 48 hours prior to your appointment, then we will not charge you a cancellation fee. If you call us less than 48 hours prior to your appointment, **we promise** to do all we can to fill the opening your cancellation has created.

**Your Promise to Us** **I promise** to call Wilshire Aesthetics if I cannot keep my appointment. If I notify Wilshire Aesthetics more than 48 hours ahead of time, I will not be charged for my cancellation. If I call Wilshire Aesthetics less than 48 hours and Wilshire Aesthetics cannot fill my appointment [ or if I do not call to cancel ], I authorize Wilshire Aesthetics to charge my credit card on file. I understand that the charge will be between \$75 and \$150 depending upon the type of appointment that I have made.

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Name – printed

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Signature

Date

*Please note: 48 hours does not include weekend hours*

# Credit Card / Debit Card Authorization

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Wilshire Aesthetics

## Card Information

Card Number: \_\_\_\_\_ Exp. Date \_\_\_\_\_ V Code \_\_\_\_\_

Card Holder Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Billing Address \_\_\_\_\_  
Street City State Zip

## Our Commitment to You

- We keep your card Information **locked** safely away.
- Your information is always kept **confidential** and **private**.
- We **do not share** your card information with anyone.
- We only charge your card for services provided to you or to those you designate below.
- You will **always** receive a **receipt** when we charge your card.

## Patient Authorization

I authorize Wilshire Aesthetics to charge my card for services provided to me and the following patients:

Patient 1 \_\_\_\_\_

Patient 2 \_\_\_\_\_

Patient 3 \_\_\_\_\_

I understand that I will incur an additional \$25 service fee if my card transaction/charge is denied.

\_\_\_\_\_  
Name - printed

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



### PATIENT'S BILL OF RIGHTS

The patient has the right to:

1. Considerate and respectful care.
2. Knowledge of the name of the physician who has primary responsibility for coordinating the care and the names and professional relationships of the other physicians and non-physicians who will see the patient.
3. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person who will carry out the procedure or treatment.
4. Participate actively in any decisions regarding medical care. To the extent permitted by the law, this includes the right to refuse treatment.
5. Full consideration of privacy concerning the medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual.
6. Confidential treatment of all communications and records pertaining to his/her care.
7. Reasonable continuity of care and to know in advance the time and location of appointment as well as the identity of persons providing the care.
8. Be advised if the physician proposes to engage in or perform human experimentation affecting care or treatment. The patient has the right to refuse to participate in such research projects.
9. Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
10. Have complaints forwarded to administrative personnel for appropriate response.
11. Know that all the clinic/office personnel will observe these patient's rights.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

### PATIENT'S RESPONSIBILITIES

The care that a patient receives depends partially on the patient. In addition to these rights, a patient has certain responsibilities.

1. The patient has the responsibility to provide accurate and complete information concerning his/her present complaints, past medical history, and other matters relating to his/her health
2. The patient is responsible for making it known whether he/she clearly comprehends the course of medical treatment and what is expected of him/her.
3. The patient is responsible for following the treatment plan established by his/her physician, including the instructions of the nurse or other health professionals as they carry out the physician's orders.
4. The patient is responsible for keeping appointments and for notifying the office when he/she is unable to.
5. The patient is responsible for his/her actions should he/she refuse treatment or choose not to follow his/her physician's orders.
6. The patient is responsible for assuring that the financial obligations of his/her care are fulfilled.
7. The patient is responsible for being considerate of the rights of the other patients and office personnel.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**PRINTED NAME** \_\_\_\_\_



5757 Wilshire Boulevard, Promenade 2  
Los Angeles, CA 90036  
(323) 936-1245  
(323) 936-0887 Fax

PATIENT NAME:	DATE:
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## 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 were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right 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 also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relation to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with serving as a back-up for the health care provider, including those working at the health care provider clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims of loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

**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 thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. 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, witness fees, or other expenses incurred by a party of such party's own benefit.

**Article 4: General Provision:** 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) of the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

**Article 5: Revocation:** This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

**Article 6: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. \_\_\_\_\_. Effective as the date of first professional services.

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.**

PATIENT SIGNATURE	X
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(Or Patient Representative)

(Indicate relationship if signing for patient)

OFFICE SIGNATURE:	X
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## **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.**

### *USES AND DISCLOSURES*

**Treatment.** Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

**Payment.** Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

**Health Care Operations.** Your health information may be used as necessary to support the day-to-day activities and management of Wilshire Aesthetics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

**Law Enforcement.** Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

**Public Health reporting.** Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

**Other uses and disclosures require your authorization.** Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

### *ADDITIONAL USES OF INFORMATION*

**Appointment reminders.** Your health information will be used by our staff to send you appointment reminders.

**Information about treatments.** Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

### *INDIVIDUAL RIGHTS*

You have certain rights under the federal privacy standards. These include:

- ◆ the right to request restrictions on the use and disclosure of your protected health information
- ◆ the right to receive confidential communications concerning your medical condition and treatment
- ◆ the right to inspect and copy your protected health information
- ◆ the right to amend or submit corrections to your protected health information
- ◆ the right to receive an accounting of how and to whom your protected health information has been disclosed
- ◆ the right to receive a printed copy of this notice



*WILSHIRE AESTHETICS DUTIES*

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

*RIGHT TO REVISE PRIVACY PRACTICES*

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

*REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION*

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting Marilyn or H. J. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

*COMPLAINTS*

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Privacy Officer  
Wilshire Aesthetics Medical Associates, Inc.  
5757 Wilshire Blvd., Promenade 2  
Los Angeles, CA 90036

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

*CONTACT PERSON*

The name and address of the person you may contact for further information concerning our privacy practices is:

Privacy Officer  
Wilshire Aesthetics Medical Associates, Inc.  
5757 Wilshire Blvd., Promenade 2  
Los Angeles, CA 90036  
(323) 936-1245 ext. 0

*EFFECTIVE DATE*

This notice is effective on or after April 15, 2003.