ADVANCED ORTHOPEDIC CENTER

☑WC ☐PPO ☐AUTO ☐PI ☐MEDI ☐CASH ☐QME/AME/IME Clinic: ☐PW ☐BH ☐SB ☐EV ☐GV ☑PS

Patient Name Florcen Rooks DOB 6/20/49 Date: 6/21/17

DIAGNOSTICS:

X-ray:
☑ Cervical Spine (w/w out contrast)
☐ Thoracic Spine (w/w out contrast)
☑ Lumbar Spine (w/w out contrast)
☑ Ankle R L ☐ Elbow R L
☐ Wrist/Hand R L ☐ Hip R L
☐ Knee R L ☑ Shoulder R L
☐ Other _____

MRI: ☐ Obtain Reports for:_____ ☐Boxes checked below
☐ Cervical Spine (w/w out contrast)
☐ Thoracic Spine (w/w out contrast)
☐ Lumbar Spine (w/w out contrast)
☐ Ankle R L ☐ Elbow R L
☐ Wrist/Hand R L ☐ Hip R L
☐ Knee R L ☐ Shoulder R L
☐ Other _____ ☐*OPEN_____
☐CT: _____

DIAGNOSTIC ULTRASOUND:
☐ Ankle R L ☐ Elbow R L
☐ Wrist/Hand R L ☐ Hip R L
☐ Knee R L ☐ Shoulder R L
☐ Other _____

ELECTRODIAGNOSTIC TESTING:
☐B/L ☐ Upper Extremities ☐ R/O CTS ☐R/O Cubital tunnel
☐B/L ☐ Lower Extremities ☐ Obtain Report ☐UE ☐ LE

☐ Bone Density ☐ Total Body Scan
☐ MANUAL THERAPY/ MASSAGE THERAPY
☐ CHIRO ☐ PHYSICAL / ACTIVE ☐ ACUPUNCTURE
Frequency of Treatment:
☑ 2 ☐ 2-3 ☐ 3 X/Wk For ☐ 4 ☐ 6 Wks
Treatment Areas:
☐ Cervical Spine ☐ Ankle/Foot R L
☐ Thoracic Spine ☐ Shoulder R L
☐ Lumbar Spine ☐ Elbow R L
☐ Sacroiliac ☐ Wrist R L
☐ Hip R L ☐ Hand R L
☐ Knee R L ☐ TMJ/CMD
Goal: ☐ Decrease Pain ☐ Increase ROM ☐Passive only
☐ Neers protocol only.
Precautions:_____

☐ Attention VICKI (Nurse)
☐ Cane
☐ Open Patella Brace R L
☐ Wrist Brace R L
☐ Thumb Spica Brace R L
☐ Tennis Elbow Brace R L
☐ Sacro Lumbar Corsett
☐ Cam Walker
☐ Custom Brace:_____

DME
☐ Interferential Unit
☐ Tens Unit
☐ Electrodes / Tens Pads
☐ In office procedure
☐ *Mail to patient
☐* Outside DME CO
☐*Dispensed at_____

MEDICATIONS:

☑ Naproxen 550mg 1 tab bid #60 ☐Omeprazole 20mg #60
☐ Pantoprazole 20mg 1tab bid #60 ☐ Pennsaid 2%
☐ Cyclobenzaprine 7.5mg #90 ☐ Duexis 1 tab TID #90
☐ Gabapentin 300 mg #60 ☐Vimovo 500/20 mg #60
☐ Zofran 4mg #30 ☐ Diclofenac 100mg #60
☐ Bupropion ER 150 mg #30
*Mail meds to pt /Fill out Super bill w/ mailed date .

COMPOUND MEDICATIONS:
☐ Flurbiprofen ☐ Amitriptyline ☐Capsaicin
☐*Mail creams to pt /Fill out super bill w/ mailed date.

RESTRICTIONS:

☐Full Duty ☑ TTD ☐ Sedentary work only
☐Other/ Return to work on: _____
☐ Weight lifting restrictions _____lbs.
☐ No prolonged standing or walking
☐ No overhead use right / left arm
☐ No climbing, bending, or stooping
☐ No repetitive use of: _____
☐ Avoid bending or twisting at waist
☐ Limited use of right / left hand
☐ Right / left handed work only

REFERRAL:

☐ Consult Pain: F/UP *Pt has films
☑ LESI 1 2 3 ☐ CESI 1 2 3 F/UP ☐ Facet Injection
☐ Consult Podiatry Phil / Arnie:_____
☐ Consult Spine Specialist: _____
☐ Other Dr._____*Patient has films Y / N
☐ Consult Internal Medicine:☐Marshak ☐ Bortz F/UP
(Reason)_____
☑Psyche (Reason) anxiety + Opthalmology
☐ Functional Capacity Evaluation and P&S afterward.
☐ ESWT
☐ Functional Restoration Program

SURGERY

Type of Surgery:

_____

_____

☐ Equipment Needed:_____
☐ Nursing Home ☐ Home Heath

Location:
☐ Inland Valley Surgical Center - Poway
☐ Inland Valley Surgical Center - Los Angeles
☐ Rancho Bernard Surgery Center- Rancho Bernard SD
☐ Cedars Sinai Hospital- Los Angeles
☐ St. Johns Hospital- Santa Monica

Jonathan Nissanoff, M.D.

Additional Doctor Notes:_____

DATE OF EVALUATION: 6/21/17 Doctor Seen: J. Nissanoff ☒ Dictated

PATIENT INFORMATION

FIRST NAME FLOREEN MI: LAST NAME: ROOKS

DATE OF BIRTH: 6-20-49 AGE: 68

☐ MALE ☒ FEMALE

SOCIAL SECURITY NO: 130-38-8510 DRIVER'S LICENSE NO: N9778713

ADDRESS: 125 N. Allen Ave CITY/STATE: Pasadena ZIP CODE: 91106

HOME PHONE: 626-354-4900 WORK PHONE: N/A CELL PHONE: 626-354-4900

EMAIL ADDRESS: flohappy@yahoo

Who referred you to our office?
☐ Doctor ☐ Insurance company ☒ Attorney ☐ Friend ☐ Internet

If you were referred by a doctor, please provide doctor's address, phone/fax #s to allow us to provide them with a report of your evaluation.

Today's evaluation is:
☒ Work Related ☐ Auto Accident/Personal Injury ☐ Private Insurance ☐ Medicare ☐ Cash

EMPLOYER NAME:

EMPLOYER ADDRESS:

EMPLOYER PHONE NUMBER:

ATTORNEY NAME (if applicable): Natalia Folia, Esq.

ATTORNEY ADDRESS/PHONE/FAX:

INSURANCE COMPANY NAME:

INSURANCE COMPANY ADDRESS:

INSURANCE COMPANY PHONE NUMBER:

NAME OF INSURED/POLICY HOLDER:
Relationship to patient:

POLICY NUMBER: GROUP NUMBER:

PRESENT COMPLAINTS

Are you having pain? ☐ No ☑ Yes If yes, where?

☑ Neck ☐ Upper Back ☑ Lower Back ☐ Buttocks (Left) (Right) ☐ Head pain/Jaw pain

☑ Shoulder (Left) (Right) ☑ Upper Arm (Left) (Right) ☐ Elbow (Left) (Right) ☐ Forearm (Left) (Right)

☑ Wrist (Left) (Right) ☐ Hand (Left) (Right) ☐ Thumb (Left) (Right) ☑ Finger(s) (Left) (Right) 2 3 4 5

☐ Hip (Left) (Right) ☐ Thigh (Left) (Right) ☑ Knee (Left) (Right) ☐ Calf/Shin (Left) (Right)

☑ Ankle (Left) (Right) ☑ Foot (Left) (Right) ☐ Toe(s) (Left) (Right) 1 2 3 4 5 –circle

☐ Other: _____

Do you have any difficulty sleeping secondary to pain? ☑ Yes ☐ No

Do you get headaches related to the injury? ☐ Yes ☐ No Sometimes

If the pain radiates, state direction of pain (from where to where) Left foot to Left Knee

Do you have: Numbness ☐ No ☑ Yes. Tingling ☐ No ☐ Yes. Burning ☐ No ☐ Yes

Do you have: Stiffness ☐ No ☑ Yes Swelling ☐ No ☑ Yes

Do you have: Locking ☒ No ☐ Yes Giving Way ☐ No ☐ Yes Clicking/Popping/Grating ☐ No ☐ Yes

Do you have weakness of joints or muscles ? ☐ No ☑ Yes in Left leg & Back

Do you have full motion of your joints? ☒ No ☐ Yes in _____

Rate the intensity of your pain with 0 being no pain and 10 being the worst pain:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☒ 9 ☐ 10

Describe frequency of pain: ☒ Constant ☐ Frequent ☐ Intermittent ☐ Infrequent

What makes your pain worse? ☑ Sitting ☑ Standing ☑ Walking ☑ Stooping ☑ Twisting ☑ Lifting

☐ Pushing/pulling ☐ Repetitive hand motions ☑ Overhead reaching ☑ Stair climbing/descending

☑ Kneeling ☑ Bending ☐ Lifting

What improves your pain? ☐ Lying down ☐ Sitting ☐ Standing ☑ Medication ☐ Chiropractic

☐ Physical Therapy ☑ Rest ☑ Use of cane/crutches ☑ Braces ☐ Injections

Do you lose control of bladder (urine) or bowels (stools)? ☐ No ☐ Yes Sometimes

WORK HISTORY/JOB DUTIES

Name of Employer at the time of injury D'Veal Family & Youth Services

Job Title: Marriage & Family Counselor Therapist

How long did you work for this employer at time of injury?: 12 years

Job duties at time injury? accumulative

Did you do any lifting? [ ] No [ ] Yes ~~sometimes~~

Heaviest weight lifted was _____ pounds _____ times per hour _____ hours per day.

Did you do any keyboarding (computer, typing, mouse, or repetitive or rapid tasks)? [X] Yes [ ] No

How many minutes per hour 45 and how many hours per day depends - average 3-4

Did you do any [X] Sitting [ ] Standing [X] Walking [ ] Lifting [X] Climbing [ ] Kneeling

[ ] Squatting [ ] Bending [ ] Crawling [ ] Pushing [ ] Pulling [ ] Reaching

When hired, did you have any restrictions? [ ] No [X] Yes List moving furniture

At the time of your injury, were you working two jobs? [X] No [ ] Yes

If yes, name of second employer:

Hours per day: Days per week:

CURRENT WORK STATUS

Are you working now? [X] No [ ] Yes.

If yes, are you working for same employer where injury occurred? [ ] Yes [ ] No
If yes, give date you started working after the injury?

If no, were you □ Laid-off [X] Terminated □ Unable to work secondary to pain

Are you working with any restrictions or limitations? [ ] No [ ] Yes N/A

List current work restrictions: N/A

Are you currently working for a different employer? [X] No [ ] Yes

HISTORY OF PRESENT INJURY

Date of Injury/Accident/Onset of symptoms: accumulative

Describe the injury/accident: What were you doing? How did it occur? What part or parts of the body were hurt?

Did you report your injury? ▫ No ▫Yes If yes, ▫ Immediately ▫ Later date: _____

When did you first receive medical treatment? Date: _____ ▫Never

Where did you receive treatment? [ ] None [ ] Company Doctor [ ] Emergency Room [ ] Chiropractor [ ] Family Doctor [ ] Walk In Clinic [ ] Other

I received the following tests after my injury: **(Please bring all prior studies with you for your visit)**

[ ] X-rays of _____ Where performed? _____

[ ] Nerve Tests/EMG/NCS) [ ] Upper Extremities [ ] Lower Extremities Where performed? _____

[ ] CT scan of _____ Where performed? _____

[ ] MRI of _____ Where performed? _____

[ ] Other: _____

Were you admitted to the hospital? [ ] No [ ] Yes If yes, what hospital?

I have had the following treatment/response to treatment:

▫ Physical Therapy ▫ Improvement ▫ Little or no improvement ▫ Worsening of symptoms

▫ Chiropractic Treatment ▫ Improvement ▫ Little or no improvement ▫ Worsening of symptoms

▫ Injections ▫ Improvement ▫ Little or no improvement ▫ Worsening of symptoms

▫ Surgery ▫ Improvement ▫ Little or no improvement ▫ Worsening of symptoms

(Please bring copies of any operative reports with you for your visit)

IF AUTO ACCIDENT:

Were you a: □ Driver □ Front seat passenger □ Rear-seat passenger □ Pedestrian □ Bike/motorcycle

Were you wearing a seatbelt? [ ] Yes [ ] No

Did you lose consciousness: □ No □ Yes

Were you... □ Rear-ended □ T-boned □ Hit head-on □ Other:

Did you file a police report? □ No □ Yes

Estimated dollar damage to your vehicle: $_____

PRIOR INJURIES/PROBLEMS

Prior to the injury in question, have you ever had similar problems with injuries to the body part or parts involved in this claim? [ ] No [X] Yes. If yes, give details.

Had your symptoms resolved completely at the time of this new injury? [ ] Yes [X] No
If no, explain

IF WORK RELATED: Have you had any other work or non-work injuries since the injury involved in this claim? □ No □ Yes

If yes, explain:

_____

_____

Date of Injury: 2007

How did injury occur; work; non-work; body parts; treatment

Did you get completely well? [ ] Yes How long did it take?

If no, explain Continue to have problems w/knee + ankle

Have you had any prior or subsequent automobile/motor vehicle accident(s)? [X] No [ ] Yes

If yes, explain

_____

_____

Prior to this injury, did you participate in any outdoor/recreational activities? [ ] No [ ] Yes

[ ] Gardening	[ ] Sewing	[ ] Arts/Crafts	[ ] Cooking	[ ] Computer
[ ] Sports	[ ] hiking	[ ] Biking	[ ] Hunting	[ ] Fishing
[ ] Golf	[ ] Tennis	[ ] Softball	[ ] Basketball	[ ] Soccer
[ ] Water Sports	[ ] Dancing	[ ] Skiing	[X] Walking	[ ] Other

Are you able to participate in any of these activities now? [ ] No [X] Yes. with pain
If yes, which activities can you participate in now?

SOCIAL HISTORY

HEIGHT: 5 WEIGHT: 5 ☐ RIGHT-HANDED ☐ LEFT-HANDED

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

TOBACCO USE: ☐ NONE ☐ ½ pack/day ☐ 1 pack/day ☑ other 3-cigs per day

ALCOHOL USE: ☐ NONE ☒ SOCIALLY ☐ OTHER

DRUG USE: ☒ None ☐ Marijuana ☐ Cocaine ☐ Other:

FAMILY HISTORY

Mother: ☐ Alive ☒ Deceased ☐ High blood pressure ☐ Diabetes ☐ Heart Disease ☒ Cancer
List any other diseases:

Father: ☐ Alive ☒ Deceased ☐ High blood pressure ☐ Diabetes ☐ Heart Disease ☐ Cancer
List any other diseases:

REVIEW OF SYSTEMS

PLACE AN "X" IN BOX NEXT TO ANY CONDITIONS THAT APPLY TO YOU:

☒ GENERAL (fatigue, weight gain/loss)	☐ ENT (nose bleeds, sinus/throat pain)
☐ LUNGS (asthma, wheezing, cough)	☒ HEART (high blood pressure, cardiac condition)
☐ ENDOCRINE (diabetes, thyroid, hormone problems)	
☐ GI (diarrhea,constipation)	☐ BLOOD (anemia, bleed easily)
☒ PSYCHIATRIC (depression,anxiety)	☐ SKIN (rash,lesion,itching) need further
☒ NEUROLOGIC (seizure,numbness,dizziness)	☒ ARTHRITIS (rheumatoid,lupus)
☐ URINARY (frequency, incontinence,burning)	
☐ Other (Explain)	

ALLERGIES TO MEDICATIONS: ☐ No known allergies to medicat ons
☒ Allergic to: LEN

CURRENT MEDICATIONS:

Have you had any surgery? ☐ NO ☐ YES

If yes, please provide date, body part & type of surgery:

ASSIGNMENT OF INSURANCE RIGHTS AND BENEFITS

I authorize and direct payment to:

Advanced Orthopedic Center, Inc. (DBA Inland Valley Surgery Center), and

Orthopedic Specialists of Southern California, Inc.

for any and all services, treatment, and products provided by the above. I authorize my insurance companies, self funded plans, Medicare, Medi-Cal, Cal Optima or other third party payer(s) to furnish to any agent, designee, or representative of my insurance company any and all information pertaining to my medical coverage, benefits, and status of claims submitted by above entities, for treatment or products rendered or applied to me.

I assign to **Advanced Orthopedic Center, Inc. (DBA Inland Valley Surgery Center), and Orthopedic Specialists of Southern California, Inc.**, any and all of my rights to pursue any remedy that might accrue to me as a result of the failure of my insurer(s) or third party payer(s) to reimburse **Advanced Orthopedic Center, Inc. (DBA Inland Valley Surgery Center), Orthopedic Specialists of Southern California, Inc., and Integrated Surgery Center #107,** for the services, treatment and/or products rendered to me under the Agreement; including without limitation to the right to investigate, appeal and seek reconsideration of denied claims, prosecute and file lawsuits, prosecute administrative hearings or take other necessary and appropriate actions on my behalf in order to recover payment, benefits or insurance proceeds.

SIGNATURE: Florence Porter Date 6-21-17

HEALTHCARE LIEN

Advanced Orthopedic Center, Inc., DBA Inland Valley Surgery Center, and Orthopedic Specialists of Southern California, Inc.,

Patient authorizes Provider(s) to furnish his/her Attorney and Insurance Carrier with a full report of examination, diagnosis, course of treatment, prognosis, and any other relevant information concerning his/her care and treatment for the aforementioned injury. Patient further authorizes his/her Attorney and Insurance Company to furnish Provider(s) with information concerning the merits, viability, and status of Patient's injury claim.

Patient hereby gives this Lien to Provider against all proceeds, whether by settlement, judgment or award, including all Med-Pay advances, derived from Patient's injury claim to secure payment of all fees owed Provider(s) by Patient for treatment furnished Patient for aforementioned injury. This Lien, regardless of when executed, shall apply retroactively to all care and treatment furnished Patient by Provider(s) arising out of aforementioned injury.

Patient understands and agrees that this Lien attaches against all proceeds derived from Patient's injury claim as soon as the proceeds are received, by either Patient or his/her Attorney. Patient authorizes and directs his/her Attorney and Insurance Carrier to withhold from any settlement, judgment or award all funds necessary to fully and completely satisfy this Lien. Patient further authorizes and directs his/her Attorney to honor this Lien and make full payment thereon as soon as possible and prior to and in advance of distributing any of the proceeds derived from Patient's injury claim to Attorney or Patient. It is understood and agreed that payment shall be tendered without regard to setoff, unresolved claims against other third parties, or apportionment or pro-rata distributions to other Heath Care providers.

Patient and Attorney understand that this Lien is offered for the protection of Provider and in consideration for Provider agreeing to await payment for services rendered to Patient. Patient understands and agrees that payment of Provider's fees is not contingent on Patient's receipt of a favorable settlement, judgment or award, and that he/she remains directly and fully responsible to Provider for all services rendered him/her. Patient agrees that if no suit on the injury claim is filed by Attorney within the statutory period provided, that all Provider's fees shall become due and payable immediately upon expiration of the statutory period.

Attorney and Patient hereby agree to immediately notify Provider(s) in the event Patient retains new or different legal counsel. Patient directs his/her new counsel to execute a new copy of this Lien and otherwise honor the terms hereof.

Attorney agrees that his/her status as trustee for those funds recovered on Patient's behalf will change from trustee to debtor if Attorney: 1) does not directly and fully and completely pay Provider for services furnished Patient that is subject to this Lien (absent a written agreement signed by Provider accepting a compromised amount in lieu of full payment), or 2) releases/forwards the funds from Patient's settlement, judgment or award from his/her trust account prior to satisfaction of this Lien, or 3) refuses to withhold that amount owed Provider from the funds obtained on Patient's behalf by way of settlement, judgment or award.

Patient, Attorney and Provider agree that if enforcement of this Lien or any portion therefore is required, all disputes for less than $5,000 will be submitted to Small Claims Court for resolution, while all disputes in an amount in excess therefore will be submitted to binding arbitration with any award therefrom confirmed by a court of competent jurisdiction. Patient, Attorney and Provider further agree that if enforcement of this Lien or any portion therefore is required, that the prevailing party shall be entitled to recover Attorney's fees, arbitration fees and costs, jointly and severely from the non-prevailing part(ies).

I/we have read and fully understand this Lien and agree to be bound by its terms.

SIGNATURE: Noreen Lorta Date 6-21-17

INSURANCE AGREEMENT

Advanced Orthopedic Center, Inc.,dba Inland Valley Surgery Center and Orthopedic Specialists of Southern California, Inc.

ASSIGNMENT OF BENEFITS: I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due me under my insurance plan. I agree to pay the balance of expenses not paid under this plan. I also hereby authorize this provider to use and disclose any of my personal medical information for treatment and payment, including my insurance company. Should the account be referred to any attorney for collection, the undersigned shall pay actual attorney's fees and collection expenses. IF I AM UNINSURED, I understand I am fully responsible for ALL charges.

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize this medical provider to use and disclose any of my personal health information, treatment, payment and healthcare operations purposes requested by the insurance necessary to collect benefits under the policies in effect at the time of treatment of any polices which I subsequently make claim against for hospital services including related physician's services on this or related date of service. Unless noted below, this authorization includes but is not limited to the release of information related to drug, alcohol, HIV antibody and or psychiatric treatment and/or testing. I further authorize any physician or institution that attended this patient previously to furnish medical records or information which may be requested by this provider.

CONSENT FOR MEDICAL AND SURGICAL TREATMENT: I authorize this provider to furnish the necessary medical or surgical treatment or procedures, including diagnostic x-ray and laboratory procedures, anesthesia, drugs, and supplies as may be ordered by the attending physician, his assistants or designees. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatment. I recognize that the physicians for this provider are independent physicians. This provider may delegate to those independent physicians those services physicians normally provide, and any questions relating to care that my physician has given or ordered should be directed to him. Please be aware that Dr. Nissanoff may have financial interest in the ancillary services to which you are being referred including but not limited to physical therapy, surgery center, x-ray and MRI. You have the right to change facilities and physicians. I understand this and accept this without any reservation.

LIFETIME MEDICARE B SIGNATURE AUTHORIZATION: I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services or its intermediaries or carriers, or to the billing agent of this provider any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignments on my behalf. I understand that I am responsible for any deductible and coinsurance.

SIGNATURE: Flora Rook

Date 2-17-21

FINANCIAL POLICY AND PATIENT AGREEMENT

Advanced Orthopedic Center, Inc., (DBA Inland Valley Surgery Center), and Orthopedic Specialists of Southern California, Inc.

We are committed to giving you the best care possible. We expect in return that you have the same commitment to your medical and financial responsibility to us.

CUSTOMER SERVICE If you need assistance with insurance or referral problems, or wish to discuss your account and/or set up financial arrangements, please contact our billing department. We accept cash, checks, or credit cards (Visa, MasterCard) as payment. There will be a $25 service charge on any returned checks.

APPOINTMENT Even if you are an established patient with us, it is advisable to arrive 5-10 minutes before your scheduled appointment time for updating your record and/or paying your copayment. We understand that emergencies arise necessitating changing your appointment date and/or time. If you fail to cancel or reschedule, we will excuse your first failed appointment, however any subsequent failed appointments will be charged to you, $45/per failed appointment.

WORKERS' COMPENSATION We need the name of your workers' compensation insurance carrier, their address, your claim number, as well as your name, name of employer at the time of the injury, phone number, and a contact person. If that information is unavailable on your first visit, you are responsible for the bill until we receive that information.

MOTOR VEHICLE ACCIDENT We have 30 days to file our claim with your insurance carrier and must have your billing information to do so. If that information is unavailable, you are responsible for the bill.

PPO If we have an agreement with your insurance carrier, we will receive direct payment for covered services. Copayments are due at the time of service. Deductible and coinsurance amounts applied to the claim will be due from you. Any and all services not covered or deemed not to be medically necessary by your insurance plan will be billed to you.

INDEMNITY TYPE INSURANCE Your insurance may or may not agree with the usual and customary and reasonable charges for our local area. Your benefit plan may not cover all services or may even deny payment for services. Should there remain a balance on your account for any reason after your insurance has been processed, you will be responsible for payment.

LIENS We accept liens, although this must be with approval of the office administrator and/or Doctor. A deposit of $100 is required.

BILLING We will file your primary and supplemental insurance claims for you if you provide us with the billing information and a copy of your insurance cards.

COPIES OF RECORDS If you are in need of copies of your records, we must have a completed release form, and allow enough time for this to be completed. There is a $15 copying fee.

DISABILITY FORMS There is a $15 charge for completion of one page forms and $25 for forms up to three pages. If you need a letter to be written by the physician, please allow 5-7 working days for completion.

PRESCRIPTIONS Please give our office at least 24 hours notice if you need a refill on your prescription during the work week. Please call by noon on Friday for refills needed over the weekend. No refills after hours.

As a patient, you have the choice between obtaining a prescription from our office or obtaining the prescription at a pharmacy of your choice. The patient hereby acknowledges that, prior to dispensing any prescription or device, the patient has been offered the right to have a written prescription which the patient may elect to have filled by the prescriber or by any pharmacy.

Our practice may be a non contracted provider with your insurance carrier. You are responsible to pay the entire bill regardless of what your insurance carrier pays. The total amount owed is due at time of service. If for some reason you don't receive a statement from the office, the explanation of benefits will serve as the statement and any amount not paid by the insurance carrier to the provider will be considered due at that time.

Both the provider and the patient agree that the venue for any dispute arising out of or associated with or related to treatment including fee disputes including and not limited to any other dispute between the patient and the provider will be held in Los Angeles, California

This Agreement constitutes the entire agreement between the parties with respect to the subject matter hereof, and supersedes all prior oral or written agreements, commitments, or understandings with respect to such matters. There are no conditions affecting this Agreement that are not found in this Agreement.

SIGNATURE: Flora Park Date 2-21-17

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: AGREEMENT TO ARBITRATION: 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 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 the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or services 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 thereafter. 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.

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 healthcare 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 arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure.

Both parties agree that the venue for any arbitration or court action will be in the City of Los Angeles, State of California.

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 arbitration shall be governed by the California Code of Civil Procedures provisions relating to arbitration.

Article 5: REVOCATION: This agreement may be revoked by written notice delivered to the physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: RETROACTIVE EFFECT: The patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) the effective date is the first medical 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 4 OF THIS CONTRACT.

Advanced Orthopedic Center, Inc. (DBA Inland Valley Surgery Center), and Orthopedic Specialists of Southern California, Inc. 2080 century Park East Suite 1111 Century City Ca 90067 15525 Pomerado Road, Suite E-6, Poway, CA 92064

SIGNATURE: Steve Lee Locke **Date** 2-21-17