

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)

VINCENT M. FORTANASCE, M.D.

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.

Fortanasce Neurology Center

ONLINE MEDICATION REFILL CONSENT FORM

I _____ understand that prescriptions will be filled and refilled using an
Patient's Name

online service. I have been made aware that in utilizing this service they will have access to view all of the medications I am taking at the present time; including medications prescribed by my other doctors.

Patient's Signature

Date

Local Pharmacy Information:

Name: _____

Street Address: _____

City: _____

Or Phone Number: () _____

Mail Order Pharmacy Information:

Name _____

Hand Used for Writing: Right Left

Why are you seeking help now? _____

Health Prior to present illness _____

Approximate date of onset and present type of onset?

Sudden (within 24 hours) Specify _____

Gradual (more than 1 day) Specify _____

Progression of illness: Worsening Same Improving

Name of previous doctors seen for the above illness

Their treatment for the problem _____

Previous Special Examinations

Date of Examination (Approximate)

- EEG (Brainwave)
- Spinal Tap
- Brain Scan
- Angiogram
- Skull X-Ray
- Cat Scan
- Other

Lawsuit or Compensation Pending?

Yes No Explain _____

Have You Had or Do Have:

Eye Pain

Yes No Explain _____

Sinus Problems

Yes No Explain _____

Dental Problems

Yes No Explain _____

Ear Problems

Yes No Explain _____

Serious Respiratory Illness (TB, Asthma, Emphysema)

Yes No Explain _____

Heart Attack

Yes No Explain _____

High Blood Pressure

Yes No Explain _____

Gastrointestinal Illness

Yes No Explain _____

Venereal Disease

Yes No Explain _____

Menstrual Difficulties

Yes No Explain _____

Onset of Menses

Yes No Explain _____

Bone or Joint (Arthritis, Fracture)

Yes No Explain _____

Low Back Pain

Yes No Explain _____

Neck Pain

Yes No Explain _____

Sleep Disturbances (Insomnia, early Awakening)

Yes No Explain _____

Sexual Difficulties

Yes No Explain _____

AIDS Risk

Yes No Explain _____

Seizures

Yes No Explain _____

Dizziness

Yes No Explain _____

Blackouts

Yes No Explain _____

Headaches

Yes No Explain _____

Cancer

Yes No Explain _____

Fever in the Past 3 Months

Yes No Explain _____

Current Weight _____ Usual Weight _____

Weight Loss in Past 3 Months

Yes No Explain _____

PAST MEDICAL HISTORY _____

Medical Illness

Yes No Explain _____

Hospitalization and Surgeries

Yes No Explain _____

Mental Illness

Yes No Explain _____

Accidents

Yes No Explain _____

Head Injury

Yes No Explain _____

Allergies

Yes No Explain _____

Medications you are currently taking (including birth control pills and Vitamins)

Yes No Explain _____

Recent Infections

Yes No Explain _____

Immunizations

Yes No Explain _____

Foreign Travel

Yes No Explain _____

Animal Bites

Yes No Explain _____

FAMILY HISTORY _____

	Age	Status Health
Mother	_____	_____
Father	_____	_____
Brothers	_____	_____
Sisters	_____	_____
Daughters	_____	_____
Sons	_____	_____

Family Illness? (Including particular illness that runs in your family I.E Muscular Dystrophy, Diabetes, Hypertension)

WORK HISTORY

Occupation _____

Exposure to Toxins: Yes No

Previous Occupation _____

Highest Level of Education _____

HABITS

Coffee

Yes No Explain _____

Tea

Yes No Explain _____

Alcohol

Yes No Explain _____

Recent Infections

Yes No Explain _____

Have you ever or do you now smoke?

Yes No Explain _____

Self-Assessment (Please use one sentence that you feel best describes you?)

What type of person do I feel I am now?

How would my (pick one) husband, wife, mother, best friend answer the above question?

Thank You

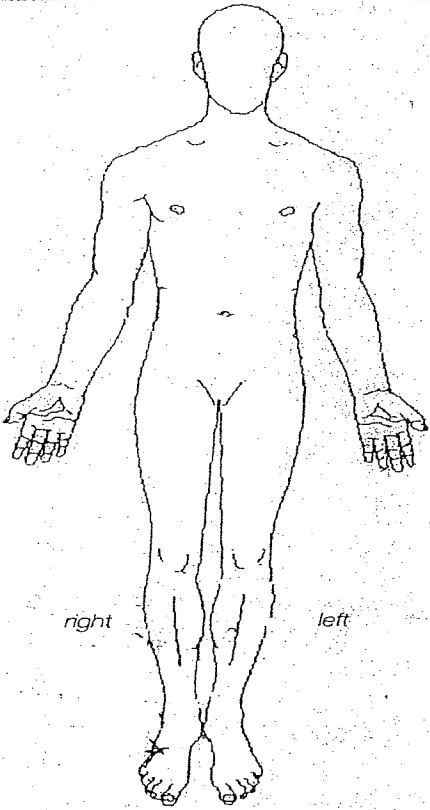
Pain Location Radiation Quantity and Quality

Patient's Name: _____ Date: _____

Age: _____

Where is Your Pain Now? Please mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation using the symbols indicated below. Include all affected areas. Just to complete the picture, please draw your face.

Active Pain ^^^^^ ^^^^^	Numb OOOOO OOOOO	Pins & Needles +++++ +++++	Burning XXXXX XXXXX	Radiating Pain ///// /////
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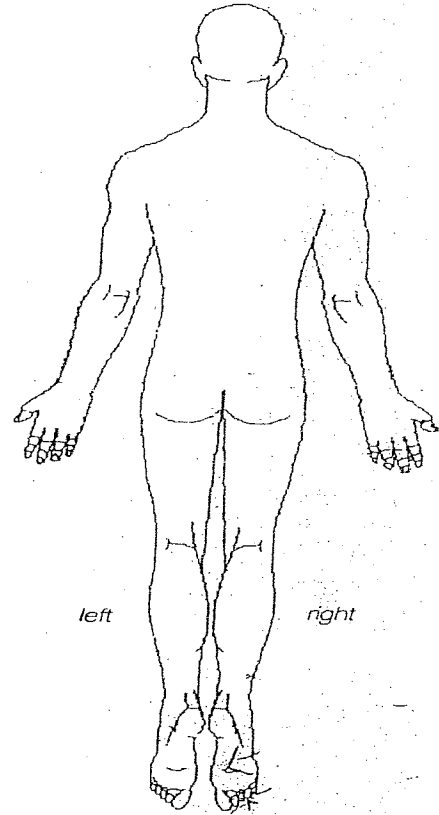
Neck Pain: %

Arm Pain: %

Back Pain: %

Leg Pain: %

Total: %



How Bad Is Your Pain Now? (1 = No Pain 10 = Worst Pain)

1 2 3 4 5 6 7 8 9 10

How Consistent is your pain?

Continuous Positional INTERMITTENT (ON/Off) Unable to Rate

Fortanasce Spine Center

Dr. Vincent M. Fortanasce, M.D.

665 W. Naomi Avenue, Suite 201

Arcadia, California 91007

Bus: (626) 445-8481 Fax: (626) 574-9669

Chief complaint today (i.e.) (neck and right arm, back, back and left leg, mid-back, etc.)

When did the symptoms originally begin? Neck/arms _____

Back/legs _____

Thoracic (mid-back) _____

Did your pain start gradually? _____ Suddenly? _____ Was it due to an injury? _____

How did the injury occur? If there is injury to both neck and back, please be specific as to how many injuries occurred and when. _____

Are your symptoms now worse? _____ Better? _____ Or no change? _____

What is your neck pain to arm pain ratio? (i.e. 100% back/0% arm)

_____ 100/0	_____ 90/10	_____ 80/20	_____ 70/30
_____ 60/40	_____ 50/50	_____ 40/60	_____ 30/70
_____ 20/80	_____ 90/10	_____ 0/100	

What is your back pain to leg pain ratio? (i.e. 100% back/0% leg)

_____ 100/0	_____ 90/10	_____ 80/20	_____ 70/30
_____ 60/40	_____ 50/50	_____ 40/60	_____ 30/70
_____ 20/80	_____ 90/10	_____ 0/100	

(Note: how much more does your back or neck hurt than your leg or arm?)

Do you have numbness in your upper extremities? _____ yes _____ no

If yes, where? (i.e. neck, right arm, left arm, hand, fingers, etc.) _____

Do you have numbness in your lower extremities? _____ yes _____ no

If yes, where? (i.e. upper back, mid back, right leg, left leg, thigh, foot, etc.) _____

Do you have weakness in your upper extremities? _____ yes _____ no

If yes, where? (i.e. neck, right arm, left arm, hand, fingers, etc.) _____

Do you have weakness in your lower extremities? _____ yes _____ no

Do you have numbness in your lower extremities? yes no
If yes, where? (i.e. upper back, mid back, right leg, left leg, thigh, foot, etc.) _____

Do you have bowel or bladder problems?
 none incontinence constipation
 hesitancy dribbling frequency

What is your pain in your neck/arms on a scale of 1-10, 10 being the worst pain? _____

What is your pain in your back/legs on a scale of 1-10, 10 being the worst pain? _____

What treatments in the past have made your neck/arm pain better? (i.e. ice, medication, physical therapy, acupuncture, etc.) _____

What treatments in the past have made your back/leg pain better? (i.e. ice, medication, physical therapy, acupuncture, etc.) _____

What treatments in the past have made your neck/arm pain worse? (i.e. ice, medication, physical therapy, acupuncture, etc.) _____

What treatments in the past have made your back/leg pain worse? (i.e. ice, medication, physical therapy, acupuncture, etc.) _____

What diagnostic studies have you had to your neck/arms and the dates you had them?
(i.e. MRI, CT Scan, myelogram, EMG/NCV, Contrast CT, bone scan, discograms, tomogram, SSEP) If you have not had studies, please write none.

1. Have you had spinal surgery? Yes No
2. If yes: When was the surgery performed? _____
Where was the surgery performed? _____
Who performed the surgery? _____
3. Did you experience a pain-free interval after surgery? Yes No
4. If yes: How long were you pain-free? _____
5. Did you have a second or third spine surgery? Yes No
6. If yes: When was the surgery performed, by whom, and what was the pain-free interval? _____
7. Have you ever been treated for a staph infection? Yes No

Review of Symptoms

SYMPTOMS	IMPROVED	WORSE	UNCHANGED
Cough or sneeze			
Straining			
Sitting			
Driving			
Bending forward			
Lying flat prone (on back)			
Lying flat supine (on front)			
Lying on right side			
Lying on left side			
Walk 1 block			
Walk 2-3 blocks			
Walk 3-6 blocks			
Walk more than 6 blocks			
Standing			
Twisting			
Twist and bend forward			
Lifting			
Morning pain			
Day pain			
Night pain			
Working overhead			
Stiffness in morning			
Weather			
Menstrual			

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = would never doze 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

SITUATIONS:

- Sitting and reading: _____
- Watching TV: _____
- Sitting inactive in public place (i.e., a theatre or meeting): _____
- As a passenger in a car for an hour without a break: _____
- Lying down to rest in the afternoon when circumstances permit: _____
- Sitting and talking to someone: _____
- Sitting quietly after a lunch without alcohol: _____
- In a car, while stopped for a few minutes in the traffic: _____

TOTAL _____

PRIMARY SLEEP COMPLAINTS

- | | | | |
|--|-----------------------------|------------------------------|---------------------------------------|
| Do you snore at night? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Occasionally |
| Have you been told you have pauses in your breathing while asleep at night? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Occasionally |
| Do you have difficulty falling asleep at the beginning of the night? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Occasionally |
| Do you have difficulty staying asleep throughout the night? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Occasionally |
| Have you been told you make kicking and/or twitching movements while asleep? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Occasionally |
| Do you experience excessive tiredness during the day? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Occasionally |
| Do you awaken feeling paralyzed? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Occasionally |
| Do you experience sudden loss of strength in your arms or legs during the day? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Occasionally |
| If yes, are these brought upon by a sudden frightening event or laughter? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Occasionally |
| Do you experience morning headaches? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Occasionally |
| Do you experience choking/gasping episodes? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Occasionally |
| Do you experience chest pain? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> Occasionally |

CPAP/BIPAP

CPAP or BiPAP machine? No Yes If Yes for How Long _____

Pressure settings: _____ cmH₂O

Use Supplemental Oxygen? No Yes

Equipment Supplier _____

Fortanasce Neurology Center

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Patient's Name

online service. I have been made aware that in utilizing this service they will have access to view all of the medications I am taking at the present time; including medications prescribed by my other doctors.

Patient's Signature

Date

Local Pharmacy Information:

Name: _____

Street Address: _____

City: _____

Or Phone Number: () _____

Mail Order Pharmacy Information:

Name _____

NOTICE OF PRIVACY PRACTICES

Your Individual Rights

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

1. The right to receive a printed copy of this notice
2. The right to receive an accounting of how and to whom your protected health information has been disclosed.
3. The right to receive confidential communications concerning your medical condition and treatments.
4. The right to inspect and copy your protected health information.
5. The right to amend or submit corrections to your protected health information.
6. The right to request restrictions on the use and disclosure of your protected health information.
- 7.

Duties of Vincent M Fortanasce M.D., Inc

We are required by law to maintain the privacy of your protected health information and to give this notice of privacy practices. We are also required to abide by the privacy policies that are outlined in the notice.

Revising Privacy Practices

We reserve the right, as legally permitted, to amend or modify our privacy policies and practices. These changes in our policies and practices may be required because of changes in federal and state laws and regulation. Upon request, we will provide you the revised notice at the time of your office visit. These 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 request access to your records by contacting our receptionist or privacy official. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

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.

Signature of Patient (or responsible party, if minor)

Date

Please print the name of the Patient

Patient Current Phone contact and/or E-mail



Vincent M Fortanasce MD., Inc.
665 W Naomi Ave Suite 201
Arcadia, CA 91007 Phone: 626 445-8481 Fax 800 507-0633

PATIENT CONSENT TO TREATMENT

I understand that, under the Health Insurance portability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

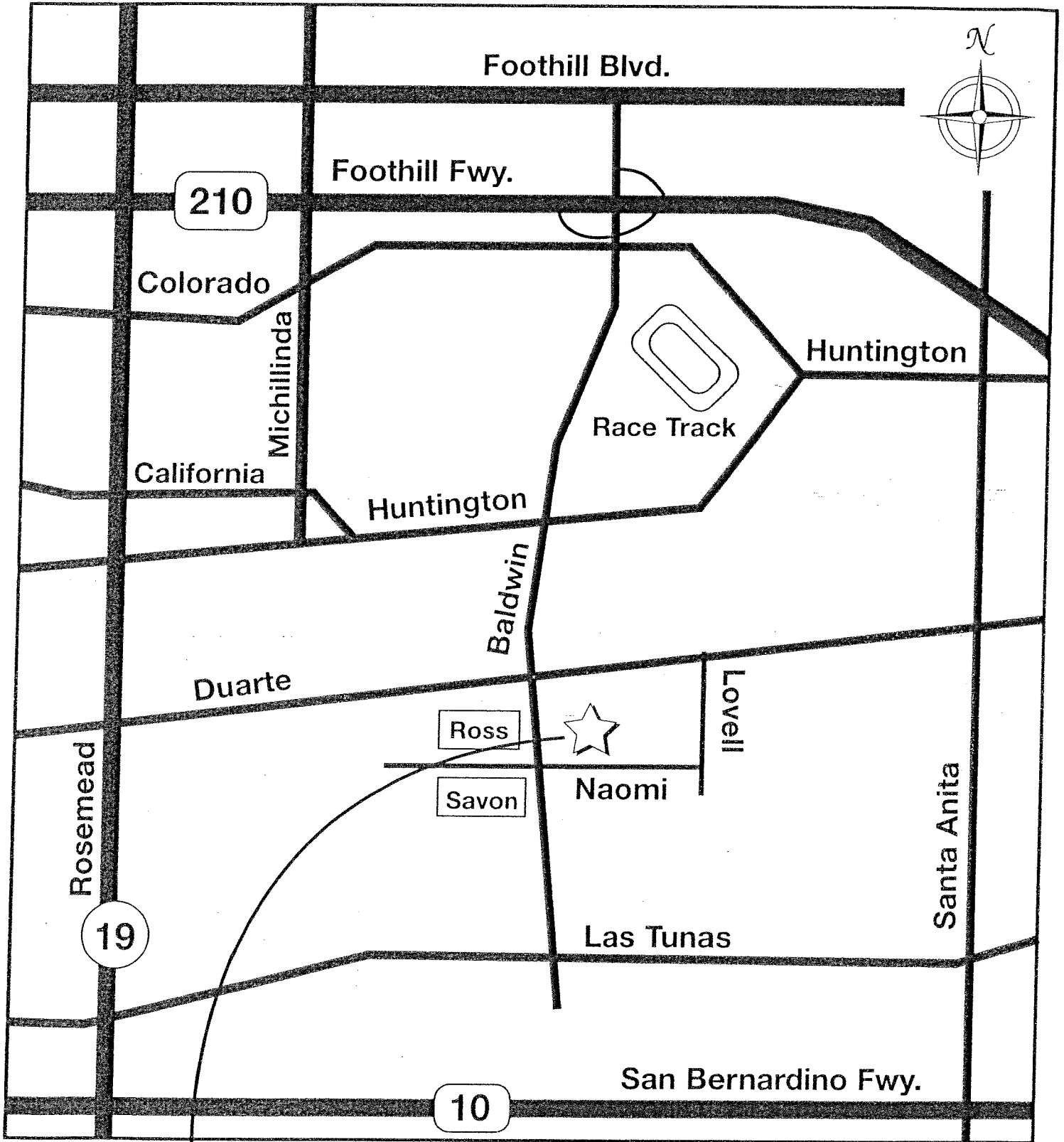
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand your are not required to agree to my requested restrictions, but if you agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Signature (or responsible party, if minor)

Date

Please Print Patient signature



Fortanasce Neurology Center
665 W. Naomi Ave Suite, 201
ARCADIA, Ca 91007
(Formerly Fortanasce Imbus Neurology -
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