PATIENT REGISTRATION RECORD
BEACH CITIES MIDWIFERY AND WOMEN'S HEALTH CARE
PATIENT INFORMATION

PATIENT

NAME (LAST / FIRST / MIDDLE) — DATE OF BIRTH — AGE

PRESENT ADDRESS: (STREET (AND APT NO) / CITY / STATE / ZIP CODE) — HOME/MESSAGE PHONE

MAILING (IF DIFFERENT) ADDRESS: — DRIVER'S LICENSE NO

FOR ADDRESS CHANGE ONLY — WORK/CELL PHONE #:

SOCIAL SECURITY NUMBER: — CHECK ONE: ☐ MARRIED ☐ SINGLE ☐ PARTNERED ☐ SEPARATED ☐ UNMARRIED ☐ WIDOWED — EMAIL ADDRESS

EMPLOYER AND/OR SCHOOL: (NAME OF FIRM (OR SCHOOL) AND DEPARTMENT / CITY) — POSITION — HOW LONG:

IF PATIENT HAS EVER BEEN KNOWN UNDER A DIFFERENT NAME, LIST _____

HAS ANY MEMBER OF THE PATIENT'S HOUSEHOLD BEEN UNDER THE CARE OF BEACH CITIES MIDWIFERY & WOMEN'S HEALTH CARE? ☐ YES ☐ NO

REFERRED BY: (FULL NAME / ADDRESS / PHONE) _____

INSURANCE

PATIENT INSURANCE OR OTHER COVERAGE: ☐ YES ☐ NO

NAME OF MEDICAL COVERAGE/ADDRESS — INSURANCE NUMBERS MEDICARE: _____ MEDICAL: _____ GROUP NO: _____ POLICY NO: _____

SUBSCRIBER'S NAME (IF OTHER THAN PATIENT)

OTHER INSURANCE NAME/ADDRESS — INSURANCE NUMBER

SUBSCRIBER — DATE OF BIRTH

REFERRING PHYSICIAN: _____

INSURANCE NOTES: _____

PARTNER

(IF APPLICABLE) SPOUSE/PARTNER OF PATIENT

NAME: (LAST / FIRST / MIDDLE) — DATE OF BIRTH

ADDRESS: (STREET (AND APT NO) / CITY / STATE / ZIP) — SOCIAL SECURITY NUMBER — DRIVER'S LICENSE NO

EMPLOYER: (NAME OF FIRM AND DEPARTMENT / CITY / POSITION) — HOW LONG? — PHONE NUMBER

FAMILY

(IF PATIENT IS A DEPENDENT CHILD) FATHER/MOTHER OF PATIENT

NAME: (LAST / FIRST / MIDDLE) — DATE OF BIRTH

ADDRESS: (STREET (AND APT NO) / CITY / STATE / ZIP)

EMPLOYER: (NAME OF FIRM AND DEPARTMENT / CITY / POSITION) — HOW LONG? — PHONE NUMBER

CONTACT

PERSON TO CONTACT IF UNABLE TO REACH YOU DIRECTLY

NAME OF FRIEND OR NEAREST RELATIVE: (NOT LIVING WITH YOU) (LAST / FIRST / MI) — PHONE NUMBER — RELATIONSHIP

ADDRESS: (STREET (AND APT NO) / CITY / STATE / ZIP)

AUTHORIZATION

I AUTHORIZE, BEACH CITIES MIDWIFERY AND WOMEN'S HEALTH CARE TO RELEASE ANY MEDICAL INFORMATION WHICH MAY BE REQUIRED TO PROCESS CLAIMS FOR PAYMENT OF MEDICAL SERVICES THROUGH INSURANCE CARRIER PREPAID MEDICAL PLAN, OR GOVERNMENT AGENCY WHEN APPLICABLE. I AUTHORIZE ASSIGNMENT OF SURGICAL, MEDICAL BENEFITS TO BEACH CITIES MIDWIFERY AND WOMEN'S HEALTH CARE.

PATIENT'S SIGNATURE _____ **DATE:** _____

OR

SIGNED BY: _____ ☐ **PARENT** ☐ **GUARDIAN** ☐ **OTHER, SPECIFY** _____

Patient Consent for Use and Disclosure of Protected Health Information

With your consent, Beach Cities Midwifery & Women's Health Care may use and disclose protected health information about you to carry out treatment, payment and health care operations. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We have the right to revise our Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to our Privacy Officer at 24902 Moulton Parkway, Suite 120, Laguna Hills, CA 92637.

With your consent, Beach Cities Midwifery & Women's Health Care may call your home or office and leave a message in reference to any items that assist the practice in carrying out treatment, payment, and health care operations such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent, Beach Cities Midwifery & Women's Health Care may mail or email to your home or office any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminder cards and patient statements.

I give my consent to electronically send or fax my records for the purpose of treatment, payment, or healthcare operations and understand that I may withdraw this consent any time in writing. I understand that my medical records may be transmitted electronically or by fax and may be received in error by a third party. In the event that this should occur, I absolve Beach Cities Midwifery & Women's Health Care or all liability.

You have the right to request that we restrict how we use or disclose your protected health information to carry out treatment, payment, and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we have already made disclosures in reliance upon your prior consent. If you decline to sign this consent, we may decline to provide treatment for you.

Signature of Patient or Legal Guardian _____ Date _____
This authorization will remain standing until revoked in writing.

Patient Name _____ Date of Birth _____

Print Name of Parent or Legal Guardian _____ Date _____

ONLY SIGN BELOW IF YOU ARE DECLINING THIS CONSENT

I, _____, decline to the use and disclosure of my protected health information to carry out treatment, payment, and health care operations.

Nurse-Midwife/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 related to treatment or service provided by the nurse-midwife 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 nurse-midwife and the nurse-midwife's partners, associates, consultant's, 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 nurse-midwife to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

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 Cold 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 or 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 nurse-midwife 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 signature Date

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: _____
CNM or Authorized Representative's Signature

Beach Cities Midwifery & Women's Health Care
Print Name of CNM or Practice

By: _____ **Date:** _____
Patient or Patient Representative's Signature

_____
Print Patient's Name

_____
If Representative, Print Name and Relationship to Patient

Revised: 4/2009

NOTICE OF PRIVACY PRACTICES:

Acknowledgement of Receipt

By signing this form, you acknowledge receipt of the ***Notice of Privacy Practices*** of Beach Cities Midwifery & Women's Health Care. Our ***Notice of Privacy Practices*** provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our ***Notice of Privacy Practices*** is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting our Privacy Officer at 949-215-7575.

I acknowledge receipt of the ***Notice of Privacy Practices*** of Beach Cities Midwifery & Women's Health Care.

Signature: _____ Date: _____

Print Name Here: _____

FOR OFFICE USE ONLY

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reason why the acknowledgement was not obtained:

Signature of provider representative: _____ Date: _____

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgement

( ) An emergency situation prevented us from obtaining acknowledgement

( ) Other (Please Specify)

_____

_____

_____