Rubinstein
Plastic Surgery Center

Cosmetic, Plastic & Reconstructive, and Micro Surgery
Hand and Wrist Surgery
Board Certified, Plastic and Reconstructive Surgery
Board Certified, Hand/Upper Extremity Surgery

NEW PATIENT REGISTRATION FORM

NAME (first, middle, last): _____ DATE: _____

DOB: _____ AGE: _____ SEX: _____ MARITAL STATUS: _____ NICKNAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ EMAIL: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

PLEASE CHECK IF YOU ARE TAKING ANY OF THE FOLLOWING MEDICATIONS:

☐ **WEGOVY** ☐ **TRULICITY** ☐ **BYETTA** ☐ **OZEMPIC** ☐ **VICTOZA** ☐ **ADLYXIN** ☐ **RYBELSUS**

☐ **MOUNJARO** **or** ☐ **OTHER:** _____

HEIGHT: _____ WEIGHT: _____ SSN _____

INSURANCE: _____ ID#: _____ GROUP#: _____

NAME OF INSURED (if not self): _____ DOB: _____

EMERGENCY CONTACT: _____ RELATION: _____ PHONE: _____

PREFERRED PHARMACY: _____ ALLERGIES _____

REFERRED BY MD _____ OTHER: _____

WHAT IS THE REASON FOR YOUR VISIT?: _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE. I REALIZE THAT ANY OMISSIONS OF FALSE INFORMATION MAY NEGATIVELY IMPACT THE OUTCOME OF MY SURGERY AND/OR RESULT IN SERIOUS ADVERSE MEDICAL CONSEQUENCES.

_____ _____

Patient Signature **Date**

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 or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on 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 physician including any spouse or heirs of the patient and any children, whether bron 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 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 if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician 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 communicate 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, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti 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 Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations 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 once 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, or 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 Effective as of the date of first medical services.

If any provision if this arbitration agreement is held invalid of unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

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 Date

_____

Patient Name (please print)

Cancellation /No Show Policy regarding Doctor Appointments and Surgery

1. Cancellation/No Show Policy for Doctor Appointment

We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be unwittingly limiting other patients' access to medical care. To optimize our appointment calendar and provide care for patients, failure to appear for a scheduled appointment is subject to a penalty.

Please call us at 805-379-9353 by 2:00pm on the day PRIOR to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00 pm on Friday. If prior notification is not given, within the time frame, you will be charged a fifty dollar ($50) fee for the missed appointment. This charge is not covered by insurance.

2. Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patients and doctor on time. Please arrive on time for your appointment to avoid surrendering your appointment and rescheduling. We have a 15-minute grace period.
We urge you to please plan accordingly, especially if you are arriving from out of town.

3. Cancellation/No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 14 days in advance you will be charged a one hundred dollar ($100) fee. The cancellation fee for surgery duration of 2 or more hours is one thousand dollars ($1000). This will not be covered by your insurance.

4. Account balances

We require that patients clear account balances to $0 (zero) prior to receiving further services by our practice.
Patients who have questions about their bills or who would like to discuss a payment plan option may call and request a review of their account. Patients with balances over $100 must make payment arrangements prior to future appointments being made. Account credits will be applied to any outstanding balances prior to refund. There will be $40.00 charge for returned checks.

5. Forms

The fee to complete and distribute disability certification (SDI), FMLA or any other insurance forms is $25.00 for each.

_____	_____	_____
Patient Signature	Patient Name (please print)	Date

PATIENT FINANCIAL RESPONSIBILITY FORM

Patient with Insurance:

In Network:

As a courtesy to patients with private healthcare insurance, we will complete and file claims with the appropriate insurance companies provided all necessary information is obtained. All patients are kindly requested to understand that financial responsibility for physician services still remains theirs, the patients, – and not their insurance companies. Even though an insurance claim is filed on the patient's behalf, this office cannot accept responsibility for collection of the claim nor can it get involved in negotiating settlement on a disputed claim. Payment of our fees is at all times the sole responsibility of the patient and due at the time of service to include copays, coinsurance and remaining deductibles.

Out of Network:

This means that the practice is not contracted with your insurance plan and will not bill your insurance for services. We do, however, offer discounted cash rates for services. Fees will be collected at the time of service or before scheduling surgery.

Patient with Medicare:

It is the policy of this office to "accept assignment" on all claims submitted to Medicare on behalf of our patients. This means that we will file a claim with Medicare on the patient's behalf and look for payment directly from Medicare for 80% of the allowable fees. We will then bill the patient's secondary insurance or the patient directly if there is no secondary insurance or if we are out of network with the secondary insurance.

Patient with Medi-Cal:

This practice is not enrolled and is a non -participating provider with Medi-Cal. This means that if you have Medicare or private insurance as primary, you will be responsible for any copays, coinsurance and deductibles allowed by your primary insurance. You agree to accept financial responsibility and pay for all services provided to you.

Financial Responsibility:

I, the undersigned, do hereby assume full responsibility for the payment of the services rendered to this patient. Furthermore, I assign my insurance benefits, in connection with all services, rendered, to Roee E. Rubinstein M.D. Inc. I understand that I shall be responsible for any service, which is not covered in part, or as whole by insurance. Should the account be referred to a professional collection agency for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts shall bear interest at the legal rate. I understand that, in matters of dispute of/over payment, I relinquish physician-patient privilege afforded under the Health Information and Privacy Protection Act. The undersigned certifies that he/she has read the foregoing, and has received a copy thereof and furthermore attests that he/she is either the patient or an authorized representative of the patient to execute this form and accept its terms.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

_____ _____

Patient Signature Patient's Agent or Representative

_____ _____

Patient Name (please print) Relationship to patient

_____

Date

Informed Consent for Medical Photography:

Dr. Roee Rubinstein often takes pre-operative, intra-operative, and post-operative photographs of patients to help provide the best care possible. These photographs are used for planning your surgery and evaluating the outcome of your procedure. We respect your privacy and will only take photographs with your expressed consent.

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 ask the front desk if you wish to keep a copy for your records or if you would like an electronic copy emailed.

ROEE E. RUBINSTEIN M.D.
400 S Reino Road Ste 200
THOUSAND OAKS, CA 91320
PHONE: 805-379-9353 FAX: 805-379-4494

I acknowledge that I have received and understand the Notice of Privacy Practices:

_____ _____

Patient Signature Date