Ellen McDonald MD
doctorellenmcdonald.com

800 Fairmount Ave, Suite 210
Pasadena CA 91105
626-872-4195 office
626-628-1836 fax
office@doctorellenmcdonald.com

Name:					**Date:**
PATIENT INFORMATION (please print)					
Gender:	**DOB:**	**SSN:**	**Driver's License Number:**	**Expiration Date:**	**State:**
Home Phone:		**Work Phone:**	**Mobile Phone:**	**Email:**	
Address:			**City:**	**State:**	**Zip Code:**
Ethnicity: (please only indicate non-Hispanic or Hispanic)			**Preferred Language: (if not English)**	**Race(s):**	
INSURANCE INFORMATION (please give your insurance card(s) to the receptionist					
Occupation:		**Employer:**	**Employer Address:**		**Employer Phone:**
Primary Insurance:			**Secondary Insurance: (if applicable)**		
Policy Holder's Name: (as it appears on insurance card)			**SSN:**		**DOB:**
Group Number:			**Policy Number:**		**Co-Pay:**
IN CASE OF EMERGENCY					
Emergency Contact: (local friend or relative)			**Relationship to Patient:**	**First Phone Number:**	**Second Phone Number:**
Referred to Dr. McDonald via:					
SURGERIES					
1.		**Date:**	**2.**		**Date:**
3.		**Date:**	**4.**		**Date:**
DRUG ALLERGIES (please indicate exact type of reaction)					
1.			**2.**		
3.			**4.**		

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Name:	Date:

PAST/PRESENT MEDICAL PROBLEMS

☐	Acid Reflux	☐	Emphysema/Chronic Bronchitis	☐	Kidney Disease, Type:
☐	Allergies/Hay Fever	☐	Epilepsy/Seizures	☐	Kidney Stones
☐	Anemia	☐	Gallstones	☐	Liver Disease, Type:
☐	Anxiety/Panic Attacks	☐	Glaucoma	☐	Migraines
☐	Asthma	☐	Gout	☐	Obesity
☐	Autoimmune Disease	☐	Headache	☐	Osteoarthritis
☐	Back Pain	☐	Heart Attack	☐	Osteoporosis
☐	Bleeding from Bowels	☐	Heart Murmur	☐	Prostate Problems
☐	Bleeding Problems, Type:	☐	High Blood Pressure	☐	Skin Problems, Type:
☐	Blood Clot	☐	High Cholesterol	☐	Stroke
☐	Cancer, Type:	☐	Irregular Heart Beat	☐	Thyroid Problems
☐	Congestive Heart Failure	☐	Irritable Bowel Syndrome	☐	Urinary Incontinence
☐	Depression	☐	Insomnia	☐	Other:
☐	Diabetes/High Blood Sugar	☐	Joint Pain	☐	Other:

PLEASE LIST ALL PHYSICIANS WHOSE CARE YOU ARE CURRENTLY UNDER

1.	Location:	2.	Location:
3.	Location:	4.	Location:

FAMILY HISTORY

☐	Alcohol/Drug Addiction	☐	Glaucoma	☐	Osteoporosis
☐	Anxiety or Depression	☐	Heart Attack	☐	Stroke
☐	Asthma	☐	High Blood Pressure	☐	Thyroid Problems
☐	Bleeding Problems	☐	High Cholesterol	☐	Tuberculosis
☐	Cancer, Type:	☐	Kidney Disease, Type:	☐	Other:
☐	Diabetes/High Blood Sugar	☐	Liver Disease, Type:	☐	Other:
☐	Epilepsy/Seizures	☐	Migraines	☐	Other:

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Name:			Date:
PREVENTATIVE CARE			
Vaccinations With Date: (i.e. Flu, Hepatitis A/B, Pneumococcal) **1.**		**2.**	
3.		**4.**	
WOMEN		**MEN**	
Colonoscopy Last Date:	**Have you ever had an abnormal result? If so, please indicate date:**	**Colonoscopy Last Date:**	**Have you ever had an abnormal result? If so, please indicate date:**
Mammogram Last Date:	**Have you ever had an abnormal result? If so, please indicate date:**	**Prostate Exam Last Date:**	**Have you ever had an abnormal result? If so, please indicate date:**
Breast Exam Last Date:	**Have you ever had an abnormal result? If so, please indicate date:**	**PSA Level Checked Last Date:**	**Have you ever had an abnormal result? If so, please indicate date:**
PAP/Pelvic Exam Last Date:	**Have you ever had an abnormal result? If so, please indicate date:**		
Last Menstrual Period:	**Pregnancies:**	**Deliveries:**	
Current Form of Birth Control if Sexually Active:		**Current Form of Birth Control if Sexually Active:**	

LIFESTYLE			
Exercise:	**Frequency:**	**Duration: (in Minutes)**	**Type:**
Smoking Status:	**Frequency: (in Packs)**	**Duration: (in Years)**	**Past Attempts to Quit:**
Alcohol:	**Frequency:**	**Duration:**	**Type:**
Drug Use:	**Frequency:**	**Duration:**	**Type:**

CURRENT MEDICATIONS INCLUDING SUPPLEMENTS, WITH DOSAGE AND FREQUENCY	
1.	**2.**
3.	**4.**
5.	**6.**

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The following outline of financial responsibilities and consent policies have been established to assist us in providing the highest quality medical care and outline possible disclosures of health information for treatment, payment, and patient healthcare options.

Insurance: It is your responsibility to know and understand your coverage and benefits. As a courtesy, we file your insurance forms from our office. Please make sure your insurance and demographic information is kept up to date with our office. This includes any change of information such as address, phone numbers, and insurance changes. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security number, and relationship to the patient to file all claims. Patients are responsible for all fees that are not covered by insurance, including co-payments, coinsurance, deductibles and non-covered services or items received. At every visit, please make sure you have all insurance card(s) and photo identification as well as any other forms that may assist us in processing your claims correctly.

No Insurance: If you are not covered by insurance at the time of service, please be advised that you will be responsible for all charges incurred at the time of service. Cash, PayPal, or credit card is accepted.

Returned Check: There will be a thirty dollar ($30.00) charge assessed for any check returned by your bank for any reason.

Collections: Accounts that are not paid within sixty (60) days from the date of service may be sent to our collections department. If acceptable terms cannot be reached to satisfy the past due balance, the patient may be dismissed from our practice.

Medical Records: We will provide a digital or analog copy of your medical records upon request for a twenty-five dollar ($25.00) administrative fee. You will be required to sign a medical record release form and pay the medical record fee in full prior to having your medical records copied. Please allow up to one (1) week for this request to be processed.

Dismissal Process: There are several reasons that a patient may be dismissed from our practice. A few reasons are as follows:

- Failure to keep scheduled appointments
- Being verbally abusive or physically abusive to staff
- Failure to meet financial obligations

A certified letter will be sent to your last known address notifying you that you are being dismissed from Dr. McDonald's practice. If you have a medical emergency within thirty (30) days of the date of the letter, Dr. McDonald will see you. After the thirty (30) days, you will no longer be seen by Dr. McDonald or her practice. A copy of your medical record may be forwarded to your new doctor after a formal request is made and appropriate fees are paid.

Patient Acknowledgement:

I,_____(print name) have read and agree to the Patient Financial Responsibilities and Policies.

I agree to pay at the time of service. I also understand that Ellen McDonald MD Inc. reserves the right to dismiss patients that fail to keep their accounts current after reasonable attempts to collect payments have been made. I further agree to pay all reasonable costs and late fees should my account be turned over to collections. I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations, and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have electronic access to Ellen McDonald MD Inc's Notice of Privacy Practices that provides a more complete description of my health information uses and disclosures at www.doctorellenmcdonald.com. I understand that Ellen McDonald MD Inc. reserves the right to change its notice and practices and, prior to implementation, will post a copy of any revised notice online. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Ellen McDonald MD Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Ellen McDonald MD Inc. has already taken action in reliance thereon.

Patient Signature (Date)

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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 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 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 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, 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 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.

Patient Initials: _____

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.

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 THE CONTRACT.

EMcDonald, MD	
Physician Signature	Patient Signature (Date)
Ellen McDonald MD	
Name of Physician	Name of Patient

A signed copy of this document is to be given to Patient. Original is to be filed/scanned in Patient's medical records.