Uri M. Ben-Zur, M.D., F.A.C.C.
The Cardiovascular Institute
Heart Rhythm and Interventional Cardiology Center

Dear Valued Patient,

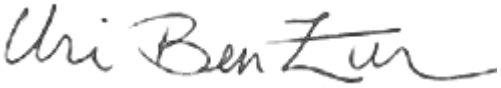
Welcome to the family!

At the Cardiovascular Institute all of our patients are like family. We strive to provide the best cardiovascular care available in a comfortable environment. I personally have many years of experience treating complicated cardiovascular cases and am confident that your experience in our office will be an unforgettable one.

We are a unique practice with our compassionate care and our seamless integration of medical technology. One important feature of our innovative approach to managing your health is the use of an electronic medical records system, which allows us to have all of your medical records in one secure database. This gives us the ability to send your records to any medical professional who needs them, rapidly. In the event of a medical emergency where seconds and minutes make the difference, this is extremely important.

Thank you for choosing our practice. My team and I look forward to caring for you and helping you to preserve your health.

Again, welcome to the family.



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Patient Information Sheet

First Name:_____Middle Initial:_____

Last Name:_____

Date of Birth:_____Marital Status:_____Gender: M F

Social Security Number:_____Driver's License Number:_____

Street Address:_____

City:_____State:_____Zip:_____

Email:_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Emergency Contact:_____Relationship:_____

Emergency Contact Phone Number(s):_____

Occupation:_____Employer:_____

How were you referred to the practice? Another Patient Another Physician Internet Other

Referring Physician:_____

Referring Physician's Phone/Address:_____

Dr. Uri M. Ben-Zur is a cardiologist and does not practice general internal medicine. If you do not already have an internist, you are strongly advised to seek the care of one so that routine examinations such as breast, prostate, colonoscopy procedures, as well as other internal medicine issues may be addressed. Please note that this agreement remains active as long as you are under Dr. Uri M. Ben-Zur's care.

Patient's Signature:_____Date:_____

Print Patient's Name:_____

Witness' Signature:_____Date:_____

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Today's Date:_____

Patient's Last Name, First Name:_____

Patient's Date of Birth:_____

Referring MD:_____Previous Cardiologist:_____

Primary Complaint(s):

Previous Cardiac Procedures:

Prior/Present Medical Conditions:

Previous Surgeries:	**Dates:**

Allergies/Reactions to Medication:

Current Medications:	Mg Dosage:	Frequency:	Start Date:

Blood Relative	Age and Medical Conditions	If Deceased, Age and Cause of Death
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Children:		
Siblings:		

Please circle any conditions that you have experienced in the last 12 months.

Cardiac:	Chest Pain	Palpitations	Unusual Sweating	Stroke	
Vascular:	Leg Pain	Swelling	Phlebitis	Calf Pain	
Constitutional:	Weight Gain	Weight Loss	Fever		
HEENT:	Vision Changes	Hearing Loss			
Respiratory:	Snoring	Coughing Up Blood	Shortness of Breath	Asthma	TB
	Inhalers	Valley Fever	Pneumonia/Pleurisy		
Gastrointestinal:	Nausea	Reflux	Bloody Stools	Diarrhea	Constipation
	Gall Bladder Trouble	Frequent Abdominal Pain	Change in Bowel Habits	Indigestion or Heartburn	Peptic Ulcers
Genitourinary:	Blood in Urine	Night-time Urination >2	Leaking Urine	Painful Urination	Kidney Stones
	Urinary Tract Infection				
Psychiatric:	Depression	Hallucinations	Anxiety	OCD	
Reproductive (Men):	Venereal Disease	Erectile Dysfunction			
Reproductive (Women):	Venereal Disease	Infertility	Oral Contraceptives	Irregular Menstruation	Painful Menstruation
	Irregular Pap Smear	Menopause	Pregnancies Total:	Miscarriages Total:	Terminations Total:
Endocrine:	Goiter	Tremor	Enlarged Glands	Thyroid Disease	
Dermatological:	Rash	Skin Sores	Hives		
Muscoskeletal:	Joint Pain	Muscle Aches	Scoliosis	Broken Bones	Arthritis

Please circle the appropriate response and provide additional information when necessary.

Caffeine:	Do you drink caffeinated beverages?	Yes No	Drinks per day:
Alcohol:	Do you drink alcohol?	Yes No	Drinks per day:
Tobacco:	Do you smoke tobacco?	Yes No Quit Year Quit	If yes, Years smoked: Packs/day: Cigarettes? Pipes? Cigars?
Drugs:	Do you use drugs recreationally?	Yes No	List drugs used:
Exercise:	How would you describe your level of activity?	Sedentary Occasionally Active Regularly Active Very Active	How many blocks can you walk?
Diet:	How would you describe your diet?	Varies Low Fat Low Salt Vegetarian Diabetic Gluten-free Fast Food	How many glasses of water do you drink daily?
Stress Level:	How would you describe your stress level?	Low Moderate High Very High	

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Billing Policies

To Our Valued Patient:

The following details our policies regarding insurance and billing procedures. Please take a few moments to review and sign below. If you have any questions, please do not hesitate to ask.

Co-Payments: All co-payments are due at the time of service. The amount of your co-payment is noted on your insurance identification card.

HMO Patients: We do not coordinate payment with HMOs. Patients with HMO coverage are responsible for complete payment of our bill.

Private or PPO Insurance Patients: We will bill your primary and secondary insurance providers; please be aware that we do not coordinate with tertiary insurance providers. The patient is responsible for any unpaid balances.

Medicare Patients: We do accept Medicare assignment. We will bill Medicare directly, as well as any secondary insurance. We do not coordinate with tertiary insurance providers. The patient is responsible for any unpaid balances.

All Patients: Please be aware that insurance companies offer myriad coverages, and it is your responsibility to understand what your plan provides for. This may change over time, so it is always useful to check with your insurance company on a regular basis. The patient is responsible for all unpaid balances. If you need assistance regarding your insurance or bill payment, please contact us immediately.

My signature below indicates my authorization that my insurance benefits are to be paid directly to Uri Ben-Zur, M.D., F.A.C.C. I am financially responsible for any charges and/or services not covered by my insurance company. I also authorize the physician and his staff to release any information required. I have received the notices of privacy and disclosure and have been provided opportunity to review them.

Please note that this agreement remains active as long as you are under Dr. Uri M. Ben-Zur's care.

Patient's Signature:_____**Date:**_____

Print Patient's Name:_____

Witness' 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 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.

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 Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician,
Medical Group or Association

By: _____ _____
Patient or Patient Representative's Signature (Date)

By: _____ _____
Print Patient's Name (Date)

_____
(If Representive, Print Name & 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.