

William F. Sima, M.D., Inc. ~ Orthopaedic Surgeon

322 Posada Lane, Suite A ~ Templeton, Ca 93465

Phone: 805.434.5555 ~ Fax: 805.434.5502

Welcome,

Thank you for scheduling an appointment with my office. I look forward to evaluating your orthopaedic condition.

As a new patient I need your assistance with the information that will be used to establish your account and medical chart. Attached is paperwork for you to complete PRIOR to your appointment. If a question does not apply to you, write N/A (not applicable) in the appropriate space.

TO AVOID RESCHEDULING PLEASE BRING THE FOLLOWING ITEMS FOR YOUR INITIAL APPOINTMENT:

- PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT
- FILMS **AND** REPORTS (MRI, X-RAY, CT SCANS, ETC.)
- ALL COMPLETED FORMS SENT TO YOU FROM OUR OFFICE
CURRENT INSURANCE CARDS

MEDICATION REFILL POLICY: I am often out of the office due to my surgical schedule. Please allow 72 hours for refill requests to be processed. If you need a refill on an existing prescription, please call your pharmacy and they will fax a request to our office.

I appreciate your effort and assistance.

Sincerely,

William F. Sima, M.D.

William F. Sima, M.D. Orthopaedic Surgeon
 322 Posada Lane, Ste A
 Templeton, CA 93465-4003
 (805)434-5555

PATIENT INFORMATION (REQUIRED)				
NAME (LAST, FIRST)				
PHYSICAL ADDRESS (ADDR WHERE YOU CURRENTLY RESIDE)			CITY, STATE, ZIP	
MAILING ADDRESS (ADDR WHERE YOU RECEIVE YOUR MAIL)			CITY, STATE - ZIP	
HOME	WORK	CELL	EMAIL(Responsible Party)	
SSN	DOB	SEX M F	(I do not wish to receive updates: _____) Marital Status S M D W	
EMPLOYMENT STATUS (CIRCLE ONE) F/T P/T Retired Disabled Other _____		EMPLOYER NAME OR SCHOOL (IF STUDENT)		OCCUPATION
PRE RETIREMENT EMPLOYER/OCCUPATION		PRIMARY MD		REFERRING MD
FINANCIALLY RESPONSIBLE PARTY INFORMATION (PERSON "LEGALLY" RESPONSIBLE TO PAY)				
NAME	RELATIONSHIP TO PATIENT	SSN	DOB	
MAILING ADDRESS		CITY, STATE - ZIP		
HOME	WORK	CELL		
PRIMARY INSURANCE (REQUIRED)				
NAME OF INSURANCE COMPANY	INSURED'S EMPLOYER		OCCUPATION	
NAME OF INSURED	RELATIONSHIP TO PATIENT	SSN	DOB	SEX M F
ADDRESS OF INSURED	CITY	STATE	ZIP	
SECONDARY INSURANCE (IF APPLICABLE)				
NAME OF INSURANCE COMPANY	INSURED'S EMPLOYER		OCCUPATION	
NAME OF INSURED	RELATIONSHIP TO PATIENT	SSN	DOB	SEX M F
EMERGENCY CONTACT				
NAME		PHONE #	RELATIONSHIP	

- I am responsible for payment due at time of service (ie: co-pay, co-ins, ded, non-covered/denied services, and/or cash pay)
- 1.5% per month (18% per yr) interest charge and/or late fee may be added to unpaid balances over 30 days.
- \$25.00 non-sufficient funds (NSF) fee will be charged for all returned checks.
- \$50.00 may be charged for appointments cancelled or missed without 24 hours notice.
- \$15.00 **minimum** charge may be charged for completion of forms.
- \$15.00 may be charged for providing inaccurate, outdated, and/or incomplete insurance information that result in additional billing.
- There may be a charge for copying medical records.
- I authorize payment of medical benefits to William F. Sima, MD for services provided.

 Patient/Responsible Party Signature

 Date

WILLIAM F. SIMA , MD, INC.
322 POSADA LANE, STE. A
TEMPLETON, CA 93465
805-434-5555

PATIENT NAME: _____ DATE: _____

Dr. Sima is required by federal regulations to request the following demographic information:

ETHNICITY: (PICK ONLY ONE)

RACE: (PICK ONLY ONE)

____ Hispanic or Latino

____ American Indian or Alaska Native

____ Not Hispanic or Latino

____ Asian

____ Indian

____ Cambodian

____ Chinese

____ Japanese

____ Korean

____ Laotian

____ Vietnamese

____ Black or African American

____ Native Hawaiian/Other Pacific Islander

____ Filipino

____ Guamanian

____ Samoan

____ White

____ Other Race

____ Unknown

____ Unknown

____ Unreported/Refused

____ Unreported/Refused

PREFERRED LANGUAGE: ____ English ____ Spanish ____ Other: _____

William F. Sima, M.D.

Medicare Coverage Information

DO YOU HAVE MEDICARE COVERAGE ? ☐ Yes ☐ No If "NO" & 65 or over, please

explain why you do not have Medicare: _____

(FAILURE TO DISCLOSE ALL INSURANCE PLANS CAN CAUSE DENIAL/DELAY OF CLAIM PAYMENT!)

**This form must be completed by patients with
Medicare coverage (primary or secondary)**

Medicare requires that providers determine whether Medicare is the primary or secondary payer for each claim for a Medicare beneficiary. The MSP form is used as a guide during the registration process to help identify other payers which may be primary to Medicare.

- ❖ Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation? ☐ Yes ☐ No

If yes, please provide the following information:

Date of accident; _____/_____/_____

Nature of accident: ☐ Auto ☐ Workers Compensation ☐ Liability

Claims address (Auto/Work Comp/Liability): _____

Claim Number: _____

- ❖ If under age 65, is your Medicare coverage due to disability? ☐ Yes ☐ No

Are you covered by a large Employer Group Health Plan based on your current employer or your spouse's current employer (20 or more employees)? ☐ Yes ☐ No

(if yes, Medicare is secondary and primary information must be obtained)

- ❖ If 65 and over, are you covered by Employer Group Health Plan based on your own or spouse's current employer? ☐ Yes ☐ No

(if yes, Medicare is secondary and primary information must be obtained)

SIGNATURE SECTION

Patient Name: _____

Signature (Patient/Responsible Party): _____ Date: _____

Name of Responsible party: _____ Relationship to Patient: _____

William F. Sima, M.D., Inc.
Orthopaedic Surgery, Sports Medicine and Joint Replacement

AUTHORIZATION TO RELEASE / OBTAIN INFORMATION

I hereby authorize William Sima, M.D. to obtain any and all medical records pertinent to my care from any physician, hospital, or other health care professional.

I also hereby authorize William Sima, M.D. to release any medical records belonging to them concerning my care to any physician, hospital, or other health care professional. These may include but not be limited to mental health records protected by Lanterman Pertis Short Act, drug and alcohol abuse records and HIV test results to any except as specifically follows: _____

This authorization is effective now and will be in effect for the time that I am a patient of William Sima, M.D., or until I revoke it in writing.

William Sima, M.D. reserves the right to modify the privacy practices outlined in the notice.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM

A copy of the HIPPA guidelines for the office of William Sima, M.D. was made available to me to read at the front desk. Upon request a copy can be made. I understand that due to these guidelines, medical information will only be discussed with me and those listed below. Medical information may include but is not limited to appointments, prescriptions, test results and chart notes.

NAME: _____ Relationship to Patient: _____ Date of Birth: _____

NAME: _____ Relationship to Patient: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Signature (Patient/Responsible Party): _____ Date: _____

Name of Responsible party: _____ Relationship to Patient: _____

Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices

An attempt was made to obtain an acknowledgement of receipt of the "Notice of Privacy Practices" on _____.
The acknowledgement was not obtained because:

- ☐ The patient was undergoing emergency treatment.
- ☐ The patient declined to sign the acknowledgement.
- ☐ Other _____

Name of Staff Member: _____ Date: _____

Consent to Photograph/Videotape/Film/Interview Individuals

I give William Sima, M.D., Inc. permission to photograph, videotape, film and/or interview myself, and to publish said photographs, videotapes, films, written testimonials and/or interviews on the internet, Dr. Sima's web site and all other forms of media. The photographs, videotapes, etc. shall constitute the exclusive property of William Sima, M.D., Inc. and may be reproduced by William Sima, M.D., Inc., without compensation or payment to the individual concerned or any other person. I also hereby release William Sima, M.D., Inc. and his employees from all claims, demands, and liabilities whatsoever in connection with the above.

Patient Name: _____ Signature: _____ Date: _____

Responsible party: _____ Signature: _____ Relationship to Patient: _____

William F. Sima, M.D., Inc.
Orthopaedic Surgery, Sports Medicine and Joint Replacement

ORIGIN of PAIN

(This information is required by all insurance companies)

Under the provisions of the contract with your private insurance for you and your dependent (s), liability may be an exclusion of your policy. So that your private insurance company can determine if they are correct in accepting liability for the services provided for this problem/injury, they will need the following information:

BODY PART FOR THIS VISIT: _____ (Right or Left)

1. **Is your pain/concern due to:** (Circle one of the below)

A. Gradual onset = skip to #'s 3 & 4

B. Accidental injury = complete #'s 2, 3, & 4

2. **Briefly describe the onset of your current symptoms** (include where injury occurred i.e. work, home, etc.):

3. **Date symptoms started:** _____

4. **Do you think your problem is related to work?** YES or NO (IF YES, ANSWER #5)

5. **Have you filed a workers' comp claim with your employer?** YES or NO

If "yes"

A. Have you notified our office? YES or NO

a. If "NO", **immediately** call our office at 434-5555.

b. If "YES", bring a copy of your claim form to your appointment.

B. Has your claim been denied or put in delay? YES or NO

a. If "YES", bring a copy of your denial/delay letter to your appointment.

I CERTIFY THE ABOVE STATEMENTS TO BE TRUE TO THE BEST OF MY KNOWLEDGE.

Patient Name: _____

Signature (Patient/Responsible Party): _____ Date: _____

Name of Responsible Party: _____ Relationship to Patient: _____

Name: _____

Date: _____

William F. Sima, M.D., Inc.
Orthopedic Surgery, Sports Medicine and Joint Replacement

MEDICAL HISTORY

Previous Tests and Treatments

☐ Circle here if none apply

- | | | | |
|--|--|---|------------------------------------|
| ☐ Physical Therapy | ☐ Made it worse | ☐ Made it better | ☐ No effect |
| ☐ Anti-inflammatories | ☐ Made it worse | ☐ Made it better | ☐ No effect |
| ☐ Narcotic medication | ☐ Made it worse | ☐ Made it better | ☐ No effect |
| ☐ Chiropractic/Manipulation | ☐ Made it worse | ☐ Made it better | ☐ No effect |
| ☐ Epidural steroid injection | ☐ Made it worse | ☐ Made it better | ☐ No effect |
| ☐ Steroid injection | ☐ Made it worse | ☐ Made it better | ☐ No effect |
| ☐ X-rays ☐ CT ☐ MRI | | ☐ Made it better | ☐ No effect |

Please describe your current problem _____

Current Medication(s): ☐ Circle here if none Preferred Pharmacy: _____

Name of Medication	Dose	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any ALLERGIES? ☐ Yes ☐ No

1. _____	Reaction: _____
2. _____	Reaction: _____
3. _____	Reaction: _____

Social History (circle all that apply to you)

Drink alcohol? ☐ Never ☐ Social ☐ Mild ☐ Moderate ☐ Heavy

Employment? ☐ Work in the home ☐ Student ☐ Retired ☐ Employed Full Time ☐ Employed Part Time
Occupation _____

Disabled? ☐ Permanent ☐ Temporary ~ Reason for Disability _____

Exercise? ☐ Never ☐ Rarely ☐ Weekly ☐ Daily What type? _____

Marital Status? ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Live alone ☐ Life Partner

Smoking? ☐ No ☐ Yes _____

Quit smoking? ☐ No ☐ Yes When? _____ Previously smoked _____ packs per day for ____ years

Name: _____

Date: _____

Family History

Do any of your grandparents, parents, siblings or children have the following diseases?

	Relationship		Relationship
Anemia	☐ Yes ☐ No _____	Hypertension	☐ Yes ☐ No _____
Asthma	☐ Yes ☐ No _____	Kidney Disease	☐ Yes ☐ No _____
Autoimmune disorder	☐ Yes ☐ No _____	Liver problems	☐ Yes ☐ No _____
Bleeding disorder	☐ Yes ☐ No _____	Lung problems	☐ Yes ☐ No _____
Cancer type: _____	☐ Yes ☐ No _____	Rheumatoid arthritis	☐ Yes ☐ No _____
Cardiovascular	☐ Yes ☐ No _____	Seizures	☐ Yes ☐ No _____
Deep Venous Thrombosis	☐ Yes ☐ No _____	Stroke	☐ Yes ☐ No _____
Diabetes	☐ Yes ☐ No _____	Thyroid disease	☐ Yes ☐ No _____

Past Medical History (circle all that apply to you)

☐ CHECK HERE IF NONE APPLY

Dermatologic: lupus / melanoma / skin cancer

Neurological: epilepsy / seizure disorders / stroke

Renal / Urinary: hematuria / kidney problems / incontinence

Endocrine: diabetes / thyroid disorder

Head and Neck: Dentures / migraines / glaucoma

Genetic Background: congenital heart defect / hemophilia / sickle cell

Childhood Illnesses: polio / asthma

Female Reproductive: cancer / tumors

Male Reproductive: BPH / prostate conditions

Gastrointestinal: Crohn's disease / gastritis / GI bleed / irritable bowel syndrome / ulcer

Respiratory: asthma / bronchitis / emphysema / pulmonary embolism / shortness of breath / tuberculosis / COPD

Musculoskeletal: ankylosing spondylarthritis / arthritis conditions / fibromyalgia / osteoporosis / polio / Rheumatoid arthritis

Cardiovascular: cardiac catheterization / cardiac disease / congestive heart failure / deep vein thrombosis / edema / heart valve conditions / myocardial infarction / stroke / hypertension / Atrial fibrillation

Hematologic/lymphatic: anemia / bleeding tendencies / hemophilia / hepatitis

Psychiatric: alcoholism / depression

All Previous Surgeries

☐ CHECK HERE IF NO HISTORY OF PRIOR SURGERY

1. Date _____ Type _____ L/R	4. Date _____ Type _____ L/R
2. Date _____ Type _____ L/R	5. Date _____ Type _____ L/R
3. Date _____ Type _____ L/R	6. Date _____ Type _____ L/R

Did you have any complications with your surgeries or anesthesia? ☐ No ☐ Yes

Explain if yes _____

Name: _____

Date: _____

Review of Systems (circle all that apply to you)

☐ **CHECK HERE IF NONE APPLY**

Allergic/ Immunologic: Seasonal Allergies

Cardiovascular: Elevated blood pressure / Heart attack / Heart palpitations / Pacemaker / Atrial fibrillation / Heart valve replacement

Constitutional Symptoms: Chills / Fever / Nausea

Ears, Nose, Mouth, Throat: Difficulty with hearing / Cough / Difficulty with swallowing / Loss of hearing

Endocrine: Dry skin / Unusual fatigue / Weight change / Thyroid disease

Eyes: Eye or vision problems / Glasses / Loss of vision

Gastrointestinal: Blood in stool / Diarrhea / Hemorrhoids / Stomach ulcers / GERD

Genitourinary: Blood in urine / Painful urination / Incontinence

Hematologic/ Lymphatic: Anemia / Bleeding problems / Bruise easily

Integumentary: Non healing wound / Rash

Musculoskeletal: Back pain / Difficulty getting out of a chair

Neurological: Balance problems / Difficulty walking / Headaches / Migraines / Seizures / Stroke

Psychiatric: Depression / Anxiety

Respiratory: Asthma / Chest pain / Shortness of breath / Sleep apnea

Hip Evaluation
William F. Sima, M.D.

Name: _____ **Date:** _____

What hip are you here for? ☐ Right
 ☐ Left

Your first symptoms began: ☐ Suddenly
 ☐ Gradually

In detail please explain how you injured yourself _____

What date did your pain begin? _____

Previous Treatment:

☐ I have not received any treatment for this condition

I was evaluated by _____ at:

☐ Twin Cities Hospital ☐ French Hospital
☐ Sierra Vista Hospital ☐ Urgent Care ☐ Other _____

Referring physician: _____

☐ X-rays – Where: _____
☐ MRI – Where: _____
☐ Physical Therapy - Where: _____
☐ Cortisone Injection
☐ Surgery - With: _____

Current Symptoms: ☐ Feeling great ☐ Somewhat better ☐ Worse
 ☐ Much better ☐ Same as it was

Quality of Pain:	☐ No pain	☐ Pressure	Pain Radiates: ☐ Into the groin ☐ To the thigh ☐ Down the leg ☐ Down the leg to the foot ☐ To or from the back
	☐ Achy	☐ Sharp	
	☐ Burning	☐ Stiffness	
	☐ Dull	☐ Throbbing	
	☐ Gnawing	☐ Tightness	
		☐ Tired feeling	

Pain Worse With:	☐ Bending	☐ Putting on socks & shoes	☐ Squatting
	☐ Driving	☐ Running	☐ Stairs
	☐ Exercise	☐ Shopping	☐ Standing
	☐ Prolonged sitting	☐ Getting in/out of chair	☐ Walking
	☐ Kneeling	☐ Sitting Indian style	☐ Weight bearing
	☐ Pivoting	☐ Sleeping	☐ Other: _____
	☐ Sitting		

Other Symptoms:	☐ Intermittent locking	Walking Ability: ☐ Very limited ☐ Limited to a few stairs ☐ 1-2 blocks ☐ 5-10 blocks ☐ More than 10 blocks ☐ Not limited
	☐ Cracking	
	☐ Popping	
	☐ Catching	
	☐ Clicking	
	☐ Tightness	

Name: _____

Date: _____

Sports Limitations:

- ☐ Has no limitations
☐ Participates with difficulty in:

☐ Unable to participate in: _____

Walking Aids:

- ☐ Cane
☐ Crutches
☐ Walker
☐ Shopping cart
☐ Brace
☐ Shoe inserts
☐ Boots

Medications for pain:

- ☐ Not required
☐ Used occasionally
☐ Required daily
☐ Brace for sports
☐ Orthotics

Location of Pain:

- ☐ Groin
☐ Thigh
☐ Buttock
☐ Side of hip

PAIN

What amount of hip pain have you experienced the **last week** during the following activities?

1. Going up or down stairs

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

2. Walking on an uneven surface?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

FUNCTION, DAILY LIVING

The following questions concern your physical function. By this we mean your ability to move around and to look after yourself. For each of the following activities please indicate the degree of difficulty you have experienced in the **last week** due to your hip.

3. Rising from sitting

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

4. Bending to floor/pick up an object

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

5. Lying in bed (turning over, maintaining hip position)

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

6. Sitting

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Extreme

WORKER'S COMPENSATION INJURY INFORMATION

HISTORY OF INJURY

Name _____ Date of the injury _____

What part of your body was injured? _____

Do you feel this injury is work related? ☐ Yes ☐ No If yes, why? _____

Describe how the injury occurred _____

How did you feel immediately after the injury and where did you have the pain? _____

Did you report the injury to your supervisor? ☐ Yes ☐ No Supervisor's name _____

What happened after your injury? (e.g., you were taken to a hospital, you continued working, etc.) _____

Who has treated you for this problem in the past?

Dates: _____

Dates: _____

Dates: _____

Have you ever injured this body part in the past? ☐ Yes ☐ No

If yes, please explain _____

Did your symptoms begin gradually? ☐ Yes ☐ No

Please describe how you feel now. Do you still have symptoms? If you still have symptoms, please indicate where it hurts, how often, how intense the pain is and if the pain travels:

Do you feel you have a disability resulting from this injury? ☐ Yes ☐ No

If yes, please explain _____

Have you ever had any of the following:

☐ Motor vehicle accident ☐ Motorcycle accident ☐ Fall from any height

☐ Yes ☐ No If yes, please explain _____

NAME _____

Have you ever had a permanent disability as a result of any injury or illness?

☐ Yes ☐ No If yes, when? _____

Please describe the disability _____

WORK HISTORY

What company did you work for at the time of your injury? _____

What date did you begin employment with this company? _____

What position did you hold at the time of the injury? _____

Please describe your normal job duties at time of injury (**including** lifting, bending, reaching, stooping with frequency and weight in pounds, if applicable. Include any protective devices)

Are you still working for this employer? ☐ Yes ☐ No

If **yes**, please answer the following:

Are you doing the same work? ☐ Yes ☐ No

If not, what are your job duties now? _____

If **no**, please answer the following:

Last date worked: _____

Why did you leave?

☐ Lay-off ☐ Termination ☐ Resignation ☐ Other _____

After your injury, did you look for other jobs? ☐ Yes ☐ No

Work History:

Company Name	City	Job Duties	Dates Worked	Reason for Leaving
--------------	------	------------	--------------	--------------------

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

PREVIOUS WORK COMP RELATED INJURIES

Have you ever had previous work comp related injuries? ☐ Yes ☐ No If yes, please list below.

Body part injured

Date of injury

_____	_____
_____	_____

Have you ever been considered disabled? ☐ Yes ☐ No If yes, please explain below.

M.D. Review

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

By: _____
Physician or Authorized Representative's
Signature

(Date)

By: _____
Print Patient's Name

William F. Sima MD, Inc.

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

(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to Patient. Original is to be filed in Patient's medical records.
G:front office