SAM RATNAYAKE, M.D., INC
PATIENT REGISTRATION
PLEASE PRINT CLEARLY

[ ] NEW PATIENT [ ] UPDATE [ ] MINOR

PATIENT _____ MALE/FEMALE DOB_____ Married/Dvd/Wid/Sing
Last, First MI

COMPLETE HOME ADDRESS: _____
Number Street City State ZIP

COMPLETE MAILING ADDRESS _____
Number Street City State ZIP

Best Phone#_____ SS# _____ DRIVER'S LIC. _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____ WORK PHONE _____
Number Street City State ZIP

NAME OF PARENT/SPOUSE_____ SS#_____ DOB_____
Last, First MI

PARENT/SPOUSE'S EMPLOYER_____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

NEAREST RELATIVE NOT LIVING WITH YOU _____ PHONE_____

NEAREST FRIEND NOT LIVING WITH YOU _____ PHONE _____

WHO SHOULD WE NOTIFY IN CASE OF EMERGENCY? _____ PHONE _____

COMPLETE AND ACCURATE INSURANCE INFORMATION IS NECESSARY IN ORDER TO PROCESS YOUR CLAIMS IN A TIMELY MANNER

PRIMARY INSURANCE:_____ PPO/HMO PHONE_____

SUBSCRIBER ID#:_____ Group#:_____

SUBSCRIBER FULL NAME:_____ DOB:_____ SS#_____

SECONDARY INSURANCE:_____ PPO/HMO PHONE _____

SUBSCRIBER FULL NAME :_____ DOB_____ SUB ID#_____

CONSENT FOR MEDICAL TREATMENT

I HEREBY AUTHORIZE *Sam Ratnayake, M.D.* and whom ever he may designate to provide medical treatment as deemed necessary to [ ] MYSELF [ ] MY MINOR/DEPENDANT

Signature of patient/guardian_____ Date:_____ office staff initials_____

HEALTH QUESTIONAIRE

Date:_____

Patient Name:_____ **DOB**_____

What brings you to the office today?:_____

_____

Past Medical Hx (Diabetes, Heart Attacks, Stroke, Ulcers High Cholesterol, High Blood pressure)

_____

_____

Past Surgical Hx (Appendix, Gall Bladder Disease, Hysterectomy, Eye surgery, Heart Surgery,)

_____

_____

Female Last Menstrual cycle _____ **Last Mammo:**_____ **Last Pap** _____

Male Last Prostate Blood test: _____

Date of colonoscopy:_____

Immunizations: Flu Vaccine __Yes __No Pneumovax __Yes __No Other:_____

Family Hx (Diabetes, Heart Disease, Cancer, etc.)

Mother_____

Father_____

Siblings_____

Social Hx:___Married ____Single ____Divorced ____Widowed # Children_____

Exercise ___Yes____ No Smoker? ___Yes/____No Packs per day_____ **#Years**_____

Alcohol Use: ____ No_____ Yes How many drinks per week? _____

Medications: _____

_____

_____

Drug Allergies: _____

Have you Executed a Power of Attorney for health care decision? Yes_____No_____

Sam Ratnayake M.D., Inc
Statement of Patient Financial Responsibility

Patient Name: _____ **DOB:** _____

Dr. Sam appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Sam Ratnayake, MD, Inc, for providing medical services to me or the above-named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Sam Ratnayake, MD, Inc., the full and entire amount of bill incurred by me or the above-named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature _____ Date _____

Guarantor Signature _____ Date _____
(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature _____ Date _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Sam Ratnayake M.D., Inc, through its appropriate personnel, to perform or have performed upon me, or the above-named patient, appropriate assessment and treatment procedures.

I further authorize Sam Ratnayake M.D., Inc, to release to appropriate agencies, any information acquired in the course of my or the above named-patient's examination and treatment.

Patient/Guarantor Signature _____ Date _____

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to canceling your appointment.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care.

Our office will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor 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 of 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 of 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 an other provision.
I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that is 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's or Authorized Representative's Signature (Date)

By:_____
Print Patient's Name

_____
Print or Stamp Name of Physician

_____
If Representative, Print Name and Relationship to Patient

SAM RATNAYAKE MD INC

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 REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Neurosurgery, P.A. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Sam Ratnayake MD Inc. Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.
We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office satff of Sam Ratnayake, MD, Inc.. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Sam Ratnayake
Sam Ratnayake MD Inc
6001-B Truxtun Ave, Ste 200
Bakersfield CA 93309

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

[Same as Above]

Effective Date
This notice is effective on or after 04/01/2014

Personal Health Care Delegate(s)
I hereby authorize the office staff of Sam Ratnayake, MD, Inc. to disclose my health Information to:

1._____Phone:_____ Relation:_____

2._____ Phone: _____ Relation: _____

3._____Phone:_____Relation: _____

_____ _____
Print Patient Last, First Name Date of Birth

_____ _____
Signature Date

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient name:_____ **DOB:**_____

I acknowledge I have received a copy of Sam Ratnayake, MD, In. Notice of Privacy Practices. I understand this document provides an explanation of when my health information may be disclosed by the office of Sam Ratnayake, MD, Inc. and any of my rights with respect to my health information.

I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information

_____ _____

Patient Signature *Date*

_____ _____

Signature of Representative if patient is Unable to sign *Date*

_____ _____

Office Use Only

Was the patient provided with a copy of the Notice of Privacy Practices? _____Yes_____No

Briefly describe efforts to obtain the patient's acknowledgement of receipt of the Notice. Please explain why the patient was unable or unwilling to sign this form:

_____

_____

_____

_____

_____

Physician's or Authorized Representative's Signature *Date*