Advanced Disc Replacement
Spinal Restoration Center

Patient Details		
Name:		
Age:	DOB:	Gender:
Social Security #:		
Contact Details		
Home Address:		
City, State, Zip:		
Home #:	Mobile #:	Other #:
Email:		
Preferred method of contact:		
Referral Details		
Referral Name:		Phone #:
Additional Info:		
Primary Care Physician		
Physician Name:		Phone #:
Address:		
Emergency Contact		
Emergency Contact Name:		
Emergency Contact #:		Relationship:
Pharmacy Details		
Pharmacy Name:		
Pharmacy Address:		Phone #
Insurance Details		
Insurance Name:		
Subscriber Name:		Subscriber DOB:
Relationship:	ID #:	Group #:
Claims Phone # :	Claims Fax #:	

NOTICE OF PRIVACY PRACTICES

Todd H. Lanman, M.D., Inc. & Jason M. Cuellar, M.D., Inc.

450 N. Roxbury Dr., 3rd Floor
Beverly Hills, California 90210

Ph: (310) 385-7766 Fx: (310) 385-9007

EFFECTIVE DATE: MAY 7, 2019

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

A. How this Medical Practice May Use or Disclose Health Information

This medical practice collects medical and related identifiable patient information (such as billing information, claims information, referral and health plan information) and stores it in a chart, in administrative or billing files, and on a computer. The medical record is the property of this medical practice, but the information in the medical record is accessible to the patient. This information is considered "protected health information" (PHI) under the HIPAA Privacy Rule. The law permits us to use or disclose health information for the following purposes without the patient's written authorization:

1. **Treatment.** We use medical information to provide medical care. We disclose medical information to our employees and others who are involved in providing the care our patients need. For example, we may share medical information with other physicians or other health care providers who will provide services that we do not provide, or we may share this information with a pharmacist who needs it to dispense a prescription, or a laboratory that performs a test. We may also disclose medical information to members of patients' families or others who can help them-when they are sick or injured or following the patient's death.

2. **Payment.** We use and disclose PHI to obtain payment for the services we provide. For example, we give health plans the information they require for payment. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to our patients.

3. **Health Care Operations**. We may use and disclose PHI to operate this medical practice e. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get health plans to authorize

services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services, and audits, including fraud and abuse detection and compliance programs, and business planning and management. We may also share PHI with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of this PHI. Although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan, health care clearinghouse, or one of their business associates, California law prohibits all recipients of health care information from further disclosing it except as specifically required or permitted by law.

a. We may also share PHI with other health care providers, health care clearinghouses, or health plans that have a relationship with our patients when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, protocol development, case management or care coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, their activities related to contracts of health insurance or health benefits, or their health care fraud and abuse detection and compliance efforts.

4. Appointment Reminders. We may use and disclose medical information to contact and remind our patients about appointments. If the patient is not home, we may leave this information on the patient's answering machine or in a message left with the person answering the phone.

5. Sign-in Sheet. We may use and disclose medical information about our patients by having them sign in when they arrive at our office. We may also call out their names when we are ready to see them.

6. Notification and Communication with Family. We may disclose our patients' health information to notify or assist in notifying a family member, personal representative or another person responsible for their care about their location or general condition in the event of their death, unless a patient had instructed us otherwise. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with our patient's care or helps pay for care. If our patient is able and available to agree or object, we will give the patient the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over the patient's objection if we believe it is necessary to respond to the emergency circumstances. If our patient is unable or unavailable to agree or object, our health professionals will use their best judgment in communication with the patient's family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact our patients to encourage them to purchase or use products or services related to their treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to them. We may similarly describe products or services provided by this practice and tell our patients which health plans we participate in. We may receive financial compensation to talk with our patients face-to-face, to provide them with small promotional gifts, or to cover our cost of reminding them to take and refill medication or otherwise communicate about a drug or biologic that is currently prescribed for the patient, but only if the patient either:
(1) has a chronic and seriously debilitating or life-threatening condition and the communication is made to educate or advise the patient about treatment options and otherwise maintain adherence to a prescribed course of treatment, or
(2) the patient is a current health plan enrollee and the communication is limited to the availability of more cost-

effective pharmaceuticals. If we make these communications while the patient has a chronic and seriously debilitating or life-threatening condition, we will provide notice of the following in at least 14-point type: (1) the fact and source of the remuneration; and (2) the patient's right to opt-out of future remunerated communications by calling the communicator's toil-free number. We will not otherwise use or disclose PHI for marketing purposes or accept any payment for other marketing g communications without the patient's prior written authorization. The authorization will disclose whether we receive any financial compensation for any marketing activity our patients authorize, and we will stop any future marketing activity to the extent the patient revokes that authorization.

8. Sale of Health Information. We will not sell our patients' health information without their prior written authorization. The authorization will disclose that we will receive compensation for PHI if the patient authorizes us to sell it, and we will stop any future sales of information to the extent that the patient revokes that authorization.

9. Required by Law. As required by law, we will use and disclose our patients' health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose our patients' health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform our patients or their personal representative promptly unless in our best professional judgment, we believe the notification would place a patient at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose our patients' health information to health oversight agencies during audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose our patients' health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about our patients in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify them of the request and they have not objected, or if their objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose out patients' health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose our patients' health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose our patients' health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose our patients' health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school where the law requires the school to have such information prior to admitting a student if the patient has agreed to the disclosure on behalf of themselves or their dependent.

18. Specialized Government Functions. We may disclose our patients' health information for military or national security purposes or to correctional institutions or law enforcement officers that have the patient in their lawful custody.

19. Workers' Compensation. We may disclose our patients' health information as necessary to comply with workers' compensation laws.
For example, to the extent our patients' care is covered by workers' compensation, we will make periodic reports to their employer about their conditions. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. If this medical practice is sold or merged with another organization, our patients' health information/record will become the property of the new owner, although our patients will maintain the right to request that copies of their health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify our patients as required by law.
If they have provided us with a current email address, we may use email to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

[Note: Only use email notification if you are certain it will not contain PHI and it will not disclose inappropriate information. For example, if your email address is "digestivediseaseassociates.com" an email sent with this address could, if intercepted, identify the patient and their condition.]

22. Other disclosures specified in our Notice of Privacy Practices. We may disclose our patients' health information as otherwise described in our Notice of Privacy Practices.

23. Research. We may disclose our patients' health information to researchers conducting research with respect to which their written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When this Medical Practice May Not Use or Disclose Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies individual patients without their written authorization. If a patient authorizes this medical practice to use or disclose health information for another purpose, the patient may revoke the authorization in writing at any time.

C. Our Patients' Health Information Rights

1. Right to Request Special Privacy Protections. Our patients have the right to request restrictions on certain uses and disclosures of their health information by a written request specifying what information they want to limit, and what limitations on our use or disclosure of that information they wish to have imposed. If our patients tell us not to disclose information to their commercial health plan concerning health care items or services for which they paid for in full out-of -pocket, we will abide by their request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request and will notify our patients of our decision.

2. Right to Request Confidential Communications. Our patients have the right to request that they receive their health information in a specific way or at a specific location. For example, they may ask that we send information to an email account or to their work address. We will comply with all reasonable requests submitted in writing which specify how or where our patients wish to receive these communications.

3. Right to Inspect and Copy. Our patients have the right to inspect and copy their health information, with limited exceptions. To access their medical information, our patients must submit a written request detailing what information they want access to, whether they want to inspect it or get a copy of it, and if they want a copy, their preferred form and format. We will provide copies in the requested form and format if it is readily producible, or we will provide our patients with an alternative format they find acceptable, or if we can't agree and we maintain the record in an electronic format, their choice of a readable electronic or hardcopy format. We will also send a copy to any other person our patients designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary, as allowed by federal and California law. We may deny our patients' request under limited circumstances. If we deny a request to access a child's records or the records of an incapacitated adult because we believe allowing access would be reasonably likely to cause substantial harm to the patient, the guardian or legal representative will have a right to appeal our decision. If we deny a patient's request to access their psychotherapy notes, our patients will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement Our patients have a right to request that we amend their health information if they believe it is incorrect or incomplete. Our patients must make a request to amend in writing and include the reasons they believe the information is inaccurate or incomplete. We are not required to change our patients' health information and will provide them with information about this medical practice's denial and how they can disagree with the denial. We may deny their request if we do not have the information, if we did not create the information (unless the person or entity that created the information Is no longer available to make the amendment}, if they would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny a request, our patients may submit a written statement of their disagreement with that decision, and we may, in turn, prepare a written rebuttal. Our patients also have the right to request that we add to their record a statement of up to 250 words concerning anything in the record they believe to be incomplete or incorrect. All information related to any request to amend or supplement will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5.Right to an Accounting of Disclosures. Our patients have a right to receive an accounting of disclosures of their health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to them or pursuant to their written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to Impede their activities.

6.Right to Paper Copy of Notice of Privacy Practices. Our patients have a right to notice of our legal duties and privacy practices with respect to their health information, including a right to a paper copy of this Notice of Privacy Practices, even if they have previously requested its receipt by email. If we have a website, we must post our current Notice of Privacy Practices on our website.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend our privacy practices and the terms of this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles our patients' health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If our patients are not satisfied with the way this office handles a complaint, they may submit a formal complaint to:
Region IX
Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
(800) 368-1019; (800) 537-7697 (TDD)
(202) 619-3818 (fax)
OCRMail@hhs.gov

Advanced Disc Replacement
Spinal Restoration Center

INSTRUCTIONS FOR COMMUNICATING PERSONAL HEALTH INFORMATION (PHI)

Dear Patient:

By signing this form, you are acknowledging that you have received, read and understand a copy of the "**NOTICE OF PRIVACY PRACTICES"** form.

To respect your privacy, please tell us which of the following numbers we should call to communicate with you regarding appointment reminders, lab results, etc. Only list the phone number, or numbers you want us to call. Please specify if a message can be left on an answering machine or voice mail with a spouse or significant other or with another designated person.

METHOD OF CONTACT	OKAY TO LEAVE MESSAGE?	
Work#:	☐ Yes	☐ No
Home#:	☐ Yes	☐ No
Mobile#:	☐ Yes	☐ No
Other#:	☐ Yes	☐ No
Email Address:		

My PHI ***may be*** communicated to: _____

Do not communicate my PHI to: _____

NAME:_____ **DOB:** _____

SIGNATURE:_____**DATE:** _____

ADR Advanced Disc Replacement
Spinal Restoration Center

NEUROLOGICAL SURGERY – PATIENT QUESTIONNAIRE

Name: _____ Date: _____ / _____ / _____

1) List any allergies you have and the reaction you have when exposed to them.	
ALLERGY	**REACTION**

2) What is bothering you?			
☐ Neck	☐ Shoulder	☐ Right Arm	☐ Left Arm
☐ Lower Back	☐ Buttock	☐ Right Leg	☐ Left Leg
☐ Mid/Upper Back	☐ Other:		

3) When did you first have pain? (please provide a date – even if only an approximation)	
AREA	**DATE**
Neck/Shoulder/Arms or Hands	
Low Back/Buttocks/Legs/Feet	
Mid Back	
Other:	

4) How often do you have pain?			
☐ Less than 1 x month	☐ About 1x per month	☐ About 1x every 2 wks	☐ About 1x per week
☐ About 2-3x per week	☐ Every day	☐ Other:	

5) Have you ever had spinal pain in the past?	☐ Yes	☐ No
If **yes**, was it similar?	☐ Yes	☐ No
If **not similar**, briefly explain old pain:		

6) Rate your pain on a scale of 1-10 (1=no pain and 10=most severe pain)										
AREA	**MINIMAL**				**MODERATE**			**SEVERE**		
Neck	1	2	3	4	5	6	7	8	9	10
Shoulder(s)	1	2	3	4	5	6	7	8	9	10
Arm(s)	1	2	3	4	5	6	7	8	9	10
Back	1	2	3	4	5	6	7	8	9	10
Buttock(s)	1	2	3	4	5	6	7	8	9	10
Leg(s)	1	2	3	4	5	6	7	8	9	10
Other:	1	2	3	4	5	6	7	8	9	10

7) Are you able to walk normally?	☐ Yes	☐ No
8) How long are you able to walk?		
☐ less than 1 block ☐ 1 block	☐ 2 blocks	☐ 3 or more blocks
9) Does walking increase your pain?	☐ Yes	☐ No
If **yes**, is it relieved with resting?	☐ Yes	☐ No
If **yes**, do you? ☐ Sit down	☐ Bend forward	☐ Lie down

10) Which of the following activities ***worsen*** the pain? (check all that apply):			
☐ Sitting	☐ Standing	☐ Walking	☐ Lying Down
☐ Bending forward	☐ Bending backward	☐ Sneezing	☐ Coughing
☐ Driving a car	☐ Riding in a car	☐ Other:	

11) Which of the following activities ***relieve*** the pain? (check all that apply):			
☐ Sitting	☐ Lying Down	☐ Manipulations	☐ Tens Unit
☐ Standing	☐ Heat/Ice	☐ Hot Baths	☐ Exercise
☐ Walking	☐ Massage	☐ Stretching	☐ Brace
☐ Running	☐ Acupuncture	☐ Running	☐ Rest
☐ Other:			

12) Have you ever had spine surgery?	☐ Yes	☐ No
If **yes**, please indicate date(s) and procedure below:		
DATE	**TYPE**	
Did the surgery/surgeries provide relief of your symptoms?		
☐ Complete relief ☐ Partial relief	☐ No relief	☐ Short-term relief
Were you able to return to work?		
☐ No ☐ Yes, full duty	☐ Yes, light duty	☐ Yes, w/ restrictions
Are your current symptoms in the same area as they were prior to surgery?		
☐ Yes ☐ No		

13) Which of the following tests have you had? List the dates you had them, if known.			
TEST	**DATE**	**TEST**	**DATE**
☐ MRI		☐ CAT scan	
☐ X- Rays		☐ Myelogram	
☐ Discogram		☐ Epidural injection	
☐ Nerve block		☐ EMG/NCS	
☐ Other:			

14) What other methods have you tried to alleviate your symptoms? (check all that apply):			
☐ Over the Counter Meds (Aspirin, Tylenol)	☐ NSAIDS (Ibuprofen, Motrin, Aleve, etc.)	☐ Narcotics (Vicodin, Percocet, Codeine, etc.)	☐ Medrol Dose Pak (oral steroids)
☐ Epidural Injections	☐ Physical Therapy	☐ Chiropractor	☐ Aqua Therapy
☐ Meditation	☐ Acupuncture	☐ Exercise	☐ Stretching
☐ Bracing	☐ Rest	☐ Other:	

15) Do you have any of these medical conditions? (check all that apply):			
☐ Anemia	☐ Arthritis	☐ Diabetes	☐ Heart Disease
☐ Cancer	☐ High Blood Pressure	☐ High Cholesterol	☐ HIV
☐ Hepatitis-C	☐ None known	☐ Other:	

16) Do you smoke?	☐ Yes	☐ No
If **yes**, how many? _____ per day. I have smoked for _____years.		
If **no**, but you have been a smoker in the past, please provide quit date: _____		
17) Do you drink alcohol?	☐ Yes	☐ No
If **yes**, how much? _____ glasses of _____ per week		

18) Marital Status (choose answer that fits best):			
☐ Married	☐ Divorced	☐ Divorced/Remarried	☐ Separated
☐ Domestic Partner	☐ Widowed	☐ Single	☐ Other:
If married/partnered, how many years? _____			
19) Do you have children?		☐ Yes	☐ No
If yes, how many?		Ages?	
20) Are you currently employed?		☐ Yes	☐ No
If employed, what is your occupation?			
Physical Labor?	☐ Light	☐ Moderate	☐ Heavy

Advanced Disc Replacement
Spinal Restoration Center

Patient Name: _____DOB: _____

MEDICATIONS

MEDICATION	DOSE/SIG	DATE STARTED

SUPPLEMENTS

SUPPLEMENT	DOSE/SIG	DATE STARTED

Advanced Disc Replacement
Spinal Restoration Center

Reviewed by: Choose an item.

REVIEW OF SYSTEMS

SYSTEM	YES/NO		EXPLANATION
CARDIOVASCULAR:			
Chest Pain	YES ☐	NO ☐	
Shortness of breath on exertion	YES ☐	NO ☐	
Lower extremity swelling	YES ☐	NO ☐	
Difficulty breathing while laying flat in bed without multiple pillows	YES ☐	NO ☐	
PULMONARY:			
Cough	YES ☐	NO ☐	
Difficulty breathing	YES ☐	NO ☐	
Pain with deep breaths	YES ☐	NO ☐	
GASTROINTESTINAL:			
Abdominal pain	YES ☐	NO ☐	
Nausea or vomiting	YES ☐	NO ☐	
Diarrhea	YES ☐	NO ☐	
SKIN:			
Rashes	YES ☐	NO ☐	
Easy bruising	YES ☐	NO ☐	
Open sores	YES ☐	NO ☐	
HEAD:			
Headaches	YES ☐	NO ☐	
Dizziness or fainting	YES ☐	NO ☐	
VISUAL:			
Blurry vision or change in vision	YES ☐	NO ☐	
EXTREMITIES/JOINTS:			
Joint pain	YES ☐	NO ☐	
Joint swelling	YES ☐	NO ☐	
NEUROLOGICAL:			
Numbness or tingling in the hands	YES ☐	NO ☐	
Numbness or tingling in the feet	YES ☐	NO ☐	
Imbalance or frequent falls	YES ☐	NO ☐	
Difficulty with fine motor skills (like buttoning a shirt or writing)	YES ☐	NO ☐	

ASSIGNMENT OF BENEFITS AND APPOINTMENT AS REPRESENTATIVE

ASSIGNMENT OF ALL RIGHTS AND BENEFITS:

In exchange for and in connection with any and all of the medical and related ("services") provided to me by Todd H. Lanman, M.D., Inc., or Jason M. Cuellar, M.D., Inc.. ("Physician"), I hereby assign to Physician all of my rights, benefits, privileges, protections, claims and any other interests of any kind whatsoever, without limitation, that I had, have or may have in the future pursuant to or in connection with any insurance policy or plan, health benefit plan, health management agreement, risk-bearing agreement, trust, fund or any other source of payment, insurance, indemnity or health or medical coverage of any kind (collectively, "Health Coverage"). This assignment includes, without limitation, direct payment by my insurance carrier or health plan directly to Physician and/or its designated associates for the Services, appeal rights (both internal and external), fiduciary rights, rights to sue, rights to payment, rights to full and fair claims review, rights to penalties or interest, rights to plan documents and plan information, and rights to notices and disclosures from any source (collectively, "Rights"). I am here by transferring to Physician all of these Rights under any Health Coverage to which I am now, previously, or may be entitled to in the future with respect to the Services. Unless otherwise agreed between me and Physician, this assignment is irrevocable.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE:

I hereby designate Physician and/or Physicians' designated agents and representatives as my duly authorized representative(s) in connection with all matters arising from or relating to Rights and Health Coverage, such that Physician completely and without reservation "stands in my shoes" and takes my place for all applicable purposes, and is granted absolute power and legal authority to seek, claim and directly receive payment or reimbursement for Services; challenge or appeal any adverse benefit determination of any kind whatsoever; or take any other action or obtain anything that I would have been entitled to do, seek, claim, appeal or obtain in my own capacity pursuant to or in connection with the Rights or Health Coverage in any legal, private, administrative, formal or informal process or forum whatsoever and without limitation, including any internal or external appeal, review, grievance or any other process, procedures or entitlement under any Health Coverage.

AGREEMENT TO COOPERATE:

I hereby agree to personally cooperate with, and take all steps necessary, required or reasonably requested by any Health Coverage or by Physician (or its designated associates) to effectuate, perfect, confirm, validate or enforce my Assignment of Rights and Benefits to Physician or authorization of Physician as my authorized representative, as provided above. I promise to make my best efforts to assist and cooperate with Physician as needed or reasonably requested by Physician in connection with any action in any forum, whether legal, formal or informal, without limitation, commenced or maintained by Physician in order to exercise, secure or enforce any Rights provided under the Health Coverage.

PRINTED NAME: _____ **DOB:**_____

PLEASE READ CAREFULLY:

I hereby authorize my insurance carrier to release information regarding medical benefits payable under my policy, and to pay medical benefits directly to Todd H. Lanman, M.D. or Jason M. Cuellar, M.D., a medical corporation.

I hereby authorize any medical care provider to release any medical records and reports concerning my illness and/or treatment directly to Todd H. Lanman, M.D. or Jason M. Cuellar, M.D. a photocopy of this authorization is as valid as the original.

Dr. Lanman or Dr. Cuellar is pleased to be affiliated with the 90210 surgery center, located in Beverly Hills, California. While Dr. Lanman or Dr. Cuellar at times may believe it is in his patient's best interest to refer them to this surgery center, patients should be aware that they are free to choose any organization or surgical center to provide the services which Dr. Lanman or Dr. Cuellar recommends.

_____

SIGNATURE OF PATIENT OR GUARDIAN **DATE**

ACKNOWLEDGEMENTS AND AUTHORIZATIONS REGARDING PAYMENT

CERTIFICATION OF ACCURATE PERSONAL AND COVERAGE INFORMATION:
I certify that the personal and Health Coverage information that I have provided to Physician (on the "Patient Information Sheet" or otherwise) is, to the best of my knowledge, accurate, complete and correct and that the Health Coverage information is current and in effect as of the date of this form. I certify that I have furnished all required information requested by Physician regarding any and all insurance policies or plans, health benefit plans, health management agreements, risk-bearing agreements, trusts, funds or any other source of payment, insurance, indemnity or health or medical coverage of any kind that may be responsible for my medical costs and expenses. Should my Health Coverage change or experience any additions, deletions or cancellations of coverage or benefits for any reason, I agree that I will notify Physician's office of such changes immediately. I agree that I will be responsible for any charges resulting from changes to my Health Coverage should they adversely affect the payment of health insurance or plan benefits to Physician.

ACKNOWLEDGEMENT OF PATIENT RESPONSIBILITY FOR ALL CHARGES:
I understand and agree by signing below that I am financially responsible for all charges regarding the medically necessary and related medical services rendered to me by Todd H. Lanman, M.D., Inc. or Jason M. Cullar, M.D., Inc ("Physician"). As a courtesy to me, Physician may submit a claim of Physician's charges for payment to my health insurance carrier and/or health plan ("Health Coverage") pursuant to the attached "Assignment of Benefits" agreement that I am executing herewith. **I hereby acknowledge that Physician may release my medical records to my health insurance carrier or health plan, or to Physician's designated Business Associates, as becomes necessary to process, complete or enforce any claim for payment submitted by Physician to my Health Coverage.** In the event that my Health Coverage refuses to cover any portion of the charges submitted by Physician for payment, I understand and agree that I (or parties responsible for me) shall be liable for any remaining unpaid charges and, unless Physician and I agree otherwise, I agree to pay such charges no later than sixty (60) days upon receiving an invoice for payment from Physician. Physician reserves the right to require that I pay any deductible required by my Health Coverage or other deposit prior to services.

LATE CHARGES AND ATTORNEY'S FEES:
I agree to pay all charges for which I am liable in a timely manner. I understand and agree that a late charge of 1.5% or $10.00 per month (whichever is greater) will be charged on accounts past due 60 days or more. If my account is referred to Physician's legal counsel or a collection agency to obtain payment, or if legal action is brought against me, I agree to pay the total amount due with applicable late charges or interest as well as all reasonable attorney's fees or collection fees or related expenses incurred in collecting or recovering payment on my debt.

CANCELLATION CHARGE:
I understand that a twenty-four (24) hour notice of cancellation of my appointment is required or a $50.00 charge will be owed and added to my account.

COPY VALID AS ORIGINAL: I agree that a photocopy of this signed form is as valid as the original and may be used in place of the original signed form.

PRINTED NAME: _____ **DOB:** _____

SIGNATURE_____**DATE**_____

OUT OF NETWORK BENEFITS

I understand that I have an insurance policy which allows me to use both 'in network' and 'out of network' providers.

✔ At this time, I am choosing the ***OUT OF NETWORK*** benefits of my insurance policy, where I can select any doctor of my choice without authorization. I fully understand that I may be responsible to pay a yearly deductible, co-payments and any portion that is not covered by my insurance company.

✔ At this time, I am choosing the ***PPO*** portion of my policy and I understand I may be responsible for a deductible, co-payment, and any portion that is not covered by my insurance company. I can select any doctor of my choice without authorization. I also understand that I am electing not to use my 'in network' benefits.

✔ At this time, I am choosing Dr. Lanman as my neurosurgeon. I am fully aware that Dr. Lanman is a ***NON-PROVIDER*** for my insurance company. Therefore, I will be responsible for a higher co-payment, deductible or any portion not covered by my insurance company.

PRINTED NAME: _____ **DOB:** _____

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.

_____
Patient's or Patient Representative's 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 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, 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 files in Patient's medical records.

fThis agreement is between Dr. Todd H. Lanman ("Physician"), whose principal place of business is 450 N. Roxbury Drive, 3rd Floor, Beverly Hills, California 90210, and _____ ("Patient"), who resides in _____and is a Medicare Part B Beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on July 1, 2015 for a period of at least two years, and is excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the following medical services to Patient (the "Services"):

Consultation office visits, follow-up office visits, surgery, post-operative care.

In exchange for the Services, the Patient agrees to make payments to Physician pursuant to the Attached Fee Schedule. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.]

Executed on _____

Between _____and Todd H. Lanman, M.D.

Patient signature_____Dr.Signature_____

[NOTE to physicians: keep a copy of all of these contracts in case CMS demands them! CMS requires that this contract be re-executed each period.]