Dr. Michael Sabat, DO Melissa Brown, PA-C, MPAP Lindy Elbert, MSN, FNP-BC, DCNP Robin Reyes, PA-C, MPAP



15840 Ventura Blvd. Suite 101 Encino, CA 91436 (818) 789-3811

Patient Information						
Name	ameDriver's Lic. #					
Last	First	Initial	Dirvor o Bic. n			
Address		City	StateZip			
Home Phone	Cell Phone	Wo	rk Phone			
Best Phone Number to c	Best Phone Number to call for appointment reminders and results: Home / Cell TEXT REMINDER YESNO					
			EMAIL REMINDERYESNO			
Sex: MF	Birth date	Maiden Name	Marital Status: S M W			
In case of emergency,	who should be notified?_		Phone			
,			ewsletters via email?YESNO			
Email Address:						
Subscriber Name		Primary Insurance				
	LastSSN #	First	Initial Relation to Patient			
Subscriber Birth date	Last	First Secondary Insurance	Initial			
Subscriber Birth date Is Patient covered by add Subscriber Name	LastSSN #	First Secondary Insurance No	Initial Relation to Patient			
Subscriber Birth date Is Patient covered by add Subscriber Name	LastSSN # ditional insurance? Yes Last	First Secondary Insurance No First	Initial Relation to Patient			
Is Patient covered by add Subscriber Name Subscriber Birth date	LastSSN # ditional insurance? Yes LastSSN #	Secondary Insurance No First	Initial Relation to Patient Initial			
Is Patient covered by add Subscriber Name Subscriber Birth date	LastSSN # ditional insurance? Yes LastSSN #	Secondary Insurance No First f Receipt of Notice	Initial Relation to Patient Initial Relation to Patient			
Is Patient covered by add Subscriber Name Subscriber Birth date I have reviewed or rece	LastSSN # ditional insurance? Yes LastSSN # Acknowledgement of the Notice of t	First Secondary Insurance No First First of Receipt of Notice of Privacy.	Initial Relation to Patient Initial Relation to Patient			
Is Patient covered by add Subscriber Name Subscriber Birth date I have reviewed or rece Signature of Patient/If I	LastSSN # ditional insurance? Yes LastSSN # Acknowledgement of the Notice of t	First Secondary Insurance No First First Frivacy. of Patient Representative	Initial Relation to Patient Initial Relation to Patient Of Privacy Practices			

Patient Name:			
D			
Reason for Today's Visit:			
Who referred you or how did you find us? _			
Who is your Primary Care Provider/Physic	an?		
History and In	take Form		
Pact Madical History, (places single all that apply)			
Past Medical History: (please circle all that apply) Anxiety	Hepatitis		
Arthritis	Hypertension		
Artificial joints	HIV/AIDS		
Asthma	Hypercholesterolemia		
Atrial fibrillation	Hyperthyroidism		
BPH (Benign Prostatic Hyperplasia)	Hypothyroidism		
Bone Marrow Transplantation	Leukemia		
Breast Cancer	Lung Cancer		
Colon Cancer	Lymphoma		
COPD (Emphysema)	Pacemaker		
Coronary Artery Disease	Prostate Cancer		
Depression	Radiation Treatment		
Diabetes	Seizures		
End Stage Renal Disease	Stroke		
GERD (Acid reflux)	Valve Replacement None		
Hearing Loss Other	None		
Past Surgical History: (please circle all that apply)			
Appendix Removed	Kidney Biopsy		
Bladder Removed	Kidney Removed (Right, Left)		
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal		
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant Ovaries Removed: Endometriosis		
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis Ovaries Removed: Cyst		
Breast Reduction Breast Implants	Ovaries Removed: Ovarian Cancer		
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer		
Colectomy: Diverticulitis	Prostate Biopsy		
Colectomy: IBD	TURP		
Gallbladder Removed	Skin Biopsy		
Coronary Artery Bypass	Basal Cell Cancer Surgery		
PTCA	Squamous Cell Carcinoma Surgery		
Mechanical Valve Replacement	Melanoma Surgery		
Biological Valve Replacement	Spleen Removed		
Heart Transplant	Testicles Removed (Right, Left, Bilateral)		
Joint Replacement, Knee (Right, Left,	Hysterectomy: Fibroids		
Bilateral)	Hysterectomy: Uterine Cancer		
Joint Replacement, Hip (Right, Left, Bilateral)	None		
Joint Replacement within last 2 years			
Other			

Acne Actinic Keratoses Asthma Basal Cell Skin Cancer Blistering Sunburns Dry Skin Eczema Flaking or Itchy Scalp Other		Aapply) Hay Fever/Allergies Melanoma Poison Ivy Precancerous Moles Psoriasis Squamous Cell Skin Cancer None		
Do you wear Sunscreen? Yes If yes, what SPF?	No			
Do you tan in a tanning salon?	Yes No)		
Do you have a family history of Me If yes, which relative(s)?Any other family history:			No	
Medications: (Please enter all cur	rent medic	ations)		
Allergies: (Please enter all allergie	es)			
Social History: (Please circle one)				
Cigarette Smoking Never smoked Quit: former smoker Smokes less than daily Smokes daily	Alcohol Us YES NO How Muc		Language: English Spanish Other	
Race: White Black/African American Asian American Indian or Native Alaskan		Hi	hnicity: spanic/Latino on-Hispanic/Latino	

Native Hawaiian/Pacific Islander

Pharmacy: Name:	
Street:	Zipcode:
How often do you exercise? Once a day A few times a week A few times a month Never	What is your caffeine use? Once a day A few times a week A few times a month Never
Occupation and Workplace	
Patient Signature	Date



PRACTICE/PATIENT FINANCIAL AGREEMENT

Patient Name:	Date:		
(Please print)			
insurance or other financial arra	your healthcare needs. Our goal is to keep your angements as simple as possible. In order to ive manner, we ask you adhere to the following		
1. Proof of Insurance and Photo ID	are required for <u>all</u> patients.		
2. It is your responsibility to provious number and insurance information	de us with your current address, telephone ion at each visit.		
3. It is your responsibility to know your insurance benefit levels (Deductibles, co pays). If We are <u>Unable</u> to advise of your final patient responsibility until claim has been processed by your insurance.			
4. We do accept checks for copa patient is responsible for retu	yments or self-pay/cosmetic procedures. However, rned check fees.		
	r do not cancel within 24 business hours you at will be due prior to rescheduling a new		
All medical record requests mus hours prior to the date needed.	st be in writing and received in our office 72		
7. The adult accompanying a mino responsible for full payment.	or and the parents (or guardians) are		
	n-emergency treatment will be denied unless and payment arrangements have been made and		
"Outside Laboratory". You will a bill from us for services rende	specimens it may be necessary to utilize an I receive a separate bill from them in addition to cred. Patient to advise our office of their Lab s; we will do our best to accommodate lab		
I have read and understand the Skin and Laser Center.	he Financial Policy set forth by Honest Dermatology		
If Minor, Responsible Party's N	ameRelationship		
Patient Signature	Date		

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrata: 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 covited to, emergency treatment) patient should initial below:	er services rendered before the date it is signed (including, but not lim-	
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 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.

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By:	Physician's or Authorized Representative's Signature	Date		Patient's or Patient Representative's Signature Print Patient's Name	Date
	Print or Stamp Name of Physician,			(If Representative, Print Name and Relationship to Pa	ntient)