Ruben M. Ruiz, III M.D.

Patient Record

Date: _____

First Name: _____ **Last Name:** _____

DOB: _____ **Social Security:** _____ **Sex:** ☐Male ☐Female

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ ☐Cell ☐Home **E-mail:** _____

Check any of the following to best contact you: ☐Cell ☐Home ☐E-mail

Marital Status: ☐Single ☐Married ☐Widow ☐Divorce ☐Child

Preferred Language: _____ **Race:** _____

Ethnicity: _____ **Religion:** _____

Smoking: ☐Every day ☐Some days ☐Former Smoker ☐Never Smoked

Frequency: ☐ 1 Pack Daily ☐ 2 Packs Daily ☐ Other

How did you hear about us? ☐Penny saver ☐Radio ☐Friends/Family

☐Internet ☐Yelp ☐Website ☐Google ☐Other _____

Method of Payment (Check all that applies)

☐Insurance ☐Private/Cash ☐Medical ☐Medicare ☐Medical & Medicare

Insurance

Name: _____

Group#: _____ **Name of Insured:** _____

Dependent Name: _____

In Case of Emergency

Emergency Contact

Name: _____ **Relationship:** _____

Phone Number: _____ ☐Cell ☐Home

☐3012 San Gabriel Blvd.
Rosemead, Ca 91770

☐3342 Whittier Blvd
Los Angeles, Ca 90023

Reason for Visit

What brings you to the office today?

_____

_____

_____

_____

_____

Current Medications

What medications are you currently taking?

Name_____
Dosage_____ Frequency_____

Name_____
Dosage_____ Frequency_____

Name_____
Dosage_____ Frequency_____

Past Medical History

□Alcoholism	□Back Problems	□Ear Problems
□Allergies	□Bleeding Disorder	□Eating Disorder
□Anemia	□Blood Disease	□Epilepsy
□Anxiety Disorder	□Blood Transfusion	□Glaucoma
□Arthritis	□Cancer	□Gout
□Asthma	□Diabetes	□Heart Disease
□AIDS/HIV	□Depression	□Heart Problems

Family History

Has anyone in your family ever had any of the following conditions?

□Alcoholism	□Cancer	□Joint Disorder
□Allergies	□Depression	□Kidney Disease
□Alzheimer's	□Diabetes	□Liver Disease
□Anemia	□Epilepsy	□Lung Disease
□Anxiety	□Generic Disorder	□Migraines
□Arthritis	□Glaucoma	□Psychiatric Dis.
□Asthma	□Heart Disease	□Osteoporosis
□AIDS/HIV	□Hepatitis	□Stroke
□Bleeding Disorder	□High Cholesterol	□Substance Abuse
□Blood Disorder	□High Blood Press.	□Thyroid Disorder

Details:_____
_____
_____
_____
_____

How is your general health?
□Excellent □Good □Fair □Poor

Do you have any other concerns you would like to address?

_____
_____

Allergies

Are you allergic to any of the following?

□Adhesive Tape □Antibiotics □ Latex

□Barbiturates(Sleeping Pills) □Aspirin □Iodine

□Codeine □Sulfa □Local Anesthetics

Do you have any other allergies?

Name:_____ Reaction:_____
Name:_____ Reaction:_____

□Hepatitis - A, B, C	□Measles	□Skin Disorder
□High Blood Pressure	□Migraines	□Stomach Ulcer
□High Cholesterol	□Osteoporosis	□Substance Abuse
□Joint Disorder	□Pneumonia	□Thyriod Disorder
□Kidney Disease	□Polio	□Tuberculosis
□Liver Disorder	□Rheumatic Fever	□Venereal Disease
□Lung Disease	□ Stroke	

Women Only:

of pregnancies____ # of Miscarriages____ # of Abortions____ #of Living___ Last Pap Smear_____
Last Mammogram_____ Birth Control Method_____

Lifestyle Factors

Are you sexually active? □Yes □No # of partners in past year__
Do you wish to check for STDs? □Yes □No
Has anyone in your home physically or verbally hurt you? □Yes □No
Have you ever smoked? □Yes □No # of years___ #packs/day__
Do you smoke now? □Yes □No #packs/day__
Do you use recreational drugs? □Yes □No
types?_____ # times/week_____
How much alcohol do you drink per week?#drinks/week____
How much caffeine do you drink per day?#drinks/day____
How often do you exercise? #times/week_____

Ruben M. Ruiz III MD Inc.

General Consent Form

I hereby request and consent to diagnostic procedures, including x-rays, blood test, urine test, physical exams, and medical treatments that may include injection, inhalation, or ingestion of medications that are deemed advisable by the professional staff Ruben M. Ruiz III MD Inc. I accept any sequel that may result from my refusal of any procedure or laboratory exam that was recommended by the staff of Ruben M. Ruiz III MD Inc.

I acknowledge that I agree to this consent form and understand its consents. I have had an opportunity to discuss this consent and any questions i have had been answered to my complete satisfaction

Patient Signature_____ Date_____

Parent/Guardian_____ Date_____

Assignment of Benefits Form

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Ruben M. Ruiz III medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Dr. Ruben M. Ruiz III: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generates in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing. I have requested medical services from Dr. Ruben M. Ruiz III on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I understand and agree that I am responsible for the following expenses: any service my insurance plan deems "non-covered", all coinsurance and/or co-payment amounts, all deductibles, any amount that exceeds benefit limits under my insurance plan and any amount my insurance plan deems not covered because I was not insured on the date of service.

_____ _____

Patient/Responsible Party 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: Ruben M Ruiz III MD _____
Physician's or Authorized Representative's Signature (Date)

Ruben M. Ruiz, III MD
3012 N. San Gabriel Blvd.
Rosemead, CA 91770
(626)572-8692 Fax (626)572-9736

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.

Welcome To Our Practice

ABOUT OUR DOCTOR

Ruben M. Ruiz III MD trained in general practice: he specializes in the diagnosis and treatment of illnesses for adults and children. The types of illnesses treated include stomach and colon disorders, heart disease, arthritis, diabetes, glandular conditions, disorders of the nervous system, disease of the lungs and bronchial tubes and respiratory conditions. Dr. Ruiz is also certified in HCG medical weight loss, dermal filler and Botox.

Dr. Ruiz will be your family doctor and handle the majority of your health care and beauty needs.

Dr. Ruiz and staff strive to offer the highest quality of health care possible. Dr Ruiz is highly skilled, and continually updates his medical knowledge.

APPOINTMENTS

Patients are seen on an appointment basis. Please make an appointment for all office visits. Appointments can be made by calling 626 572-8692 from 9am to 5pm Monday thru Friday, first and third Saturday of the month from 9am to 1pm. Please describe your problem to the receptionist or nurse so that a convenient appointment can be scheduled for you and your doctor. If you have a medical problem that needs immediate attention and cannot wait for an appointment, we will work you in for an office visit.

If you are unable to keep an appointment please notify the receptionist as soon as possible. As an aid to us in providing you complete services and for your safety, at each appointment please bring all your medication that you are currently taking including prescriptions and over the counter medications. Please bring a list of your concerns to discuss with the doctor.

We try to see you at the appointed hour. We believe strongly in the value of your time and will do our best to keep you from having to wait for a long period of time.

TELEPHONE CALLS AND PRESCRIPTIONS REFILLS

The telephone is answered during regular office hours. Our employees are instructed to handle all incoming calls. Dr. Ruiz is usually very busy seeing patients and our nurse has been trained to answer most questions. This is to ensure each patient's time with his/her physician. When you call our office and ask us to return the call to you, we try to do so on a timely basis. It is helpful to advise us of a telephone number where you can be reached both during the day and after hours.

When you need to renew a prescription call the office during regular office hours. Sometimes prescription refill request appear simple but may require an examination or new instructions.

FEES AND PAYMENT

Office Visits: We make every effort to control the cost of our services. An important way we accomplish this is by eliminating the need for mailing statements. Therefore, we request payment at the time of your visit. You may pay by cash, check or credit card.

Medicare: If you are a Medicare patient, your charges will be billed to Medicare by this office, and we will accept assignment of benefits. You are required to have a valid Medicare identification card in your possession at the time of your visit. You are responsible for your deductible expected to pay for any charges that Medicare does not cover.

HMOs /PPOs: Dr. Ruiz is a participating member of a few Health Plans and Medical Groups. Please call our office for a list (626) 572-8692.

HOSPITAL CHARGES

Private Insurance: We accept assignment for benefits for all in-patient charges and we will bill your insurance company. You will be notified of any balance due after your insurance pays.

Medicare: Dr. Ruiz accepts assignment for all in-patient charges. This means that Medicare will pay us directly for 80% of their allowable charge. If you have supplemental insurance we will bill them for the remaining 20% balance. Otherwise, you are responsible for the balance, as well as for your deductible. If you have secondary insurance, it is necessary that you submit directly to the carrier.

Payment Arrangements: If payment in full is not possible, please contact Nancy Torres, she will work out a payment plan with you.

AFTER HOURS

For medical problems after regular office hours, a physician may be reached by calling our answering service at (626)572-8692. They will instruct you on how the doctor may be reached. If it is a true emergency, proceed to the nearest hospital emergency room where the physician on duty will begin treatment and notify your doctor.

OFFICE HOURS

Rosemead

Monday- Friday 9am to 5pm
Saturday 9am to 1pm (1st and 3rd Saturday of the month)

East Los Angeles

Monday - Friday 9am to 5pm

HOSPITALIZATION

Dr. Ruiz is on staff at L.A. Community Hospital, Pacific Alliance Medical Center and Monterey Park Hospital. He can admit you and make daily visits. If another hospital is preferred, we will be glad to refer your care to another doctor who does make visits at the hospital of your choice.

YOUR RECOMMENDATIONS

We know that the recommendations of your friends and neighbors to our practice is the highest compliment we can receive and we sincerely appreciate your recommendation. Be assured Dr. Ruiz will always make time for a new patient.