

# BETH ANNE ARY, M.D.

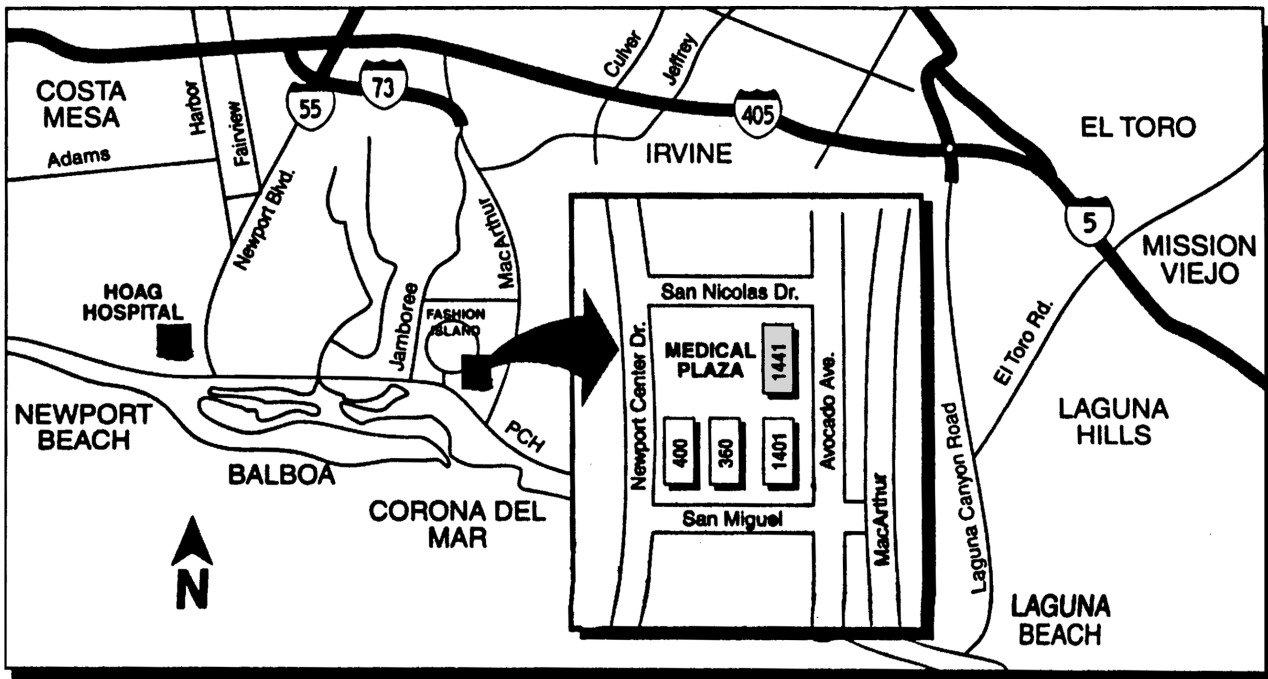
1441 Avocado • Suite 203 • Newport Beach, CA 92660

Tel: (949) 640-7200 • Fax: (949) 720-0203

Please complete these forms and bring them with you to your appointment on \_\_\_\_\_ am/pm. If possible, please fax a copy of your insurance card ahead of your appointment so that we may assist in verifying your benefits.

## DIRECTIONS:

1. 55- Newport Freeway of 405:  
Exit 73 Corona del Mar Freeway  
to MacArthur Blvd. (3-4 miles).  
Rt. on San Miguel, Rt. On Avocado,  
second building on your left.
2. Laguna Beach, San Juan  
Capistrano: North on P.C.H.  
pass MacArthur, Rt. on Avocado,  
past light and stop sign.
3. Huntington Beach: South on P.C.H.  
Lt. on Avocado, past light and stop sign.
4. Irvine: University, South bound on  
MacArthur, Rt. on San Miguel,  
Rt. on Avocado.



# PATIENT REGISTRATION

Date / /

PATIENT SHOULD COMPLETE  
WHITE AREAS ONLY

PATIENT # \_\_\_\_\_

## PATIENT INFORMATION

LAST NAME				FIRST NAME & INITIAL			
ADDRESS							
CITY					STATE		ZIP
PATIENT'S SS#				HOME PHONE			
DATE OF BIRTH		AGE		SEX		MARITAL STATUS M / S	
HAVE YOU EVER BEEN OUR PATIENT BEFORE		YES/NO	WHEN				
NEAREST RELATIVE NOT LIVING WITH YOU				RELATIONSHIP			
RELATIVE / FRIEND PHONE:					REFERRED BY		

**PATIENTS PLEASE NOTE: DOES YOUR INSURANCE COMPANY REQUIRE ANY PRE-AUTHORIZATION? ( Y / N )**  
**IF YOU ARE A MEMBER OF ANY PPO OR HMO PLEASE INFORM US. FAILURE TO DO SO MAY GREATLY REDUCE BENEFITS YOU MAY BE ENTITLED TO.**

PATIENT'S EMPLOYER							
EMPLOYER ADDRESS							
CITY					STATE		ZIP
EMPLOYER PHONE		EXT		PATIENT'S OCCUPATION			

## SPOUSE / PARTNER / RESPONSIBLE PARTY

LAST NAME				FIRST NAME			
ADDRESS							
CITY					STATE		ZIP
RELATIONSHIP			SPOUSE DOB			SPOUSE'S SS#	
RESP. PARTY LAST NAME				FIRST NAME			PHONE #
RESP. PARTY EMPLOYER							
EMPLOYER ADDRESS						EMPLOYER PHONE #	

## INSURANCE INFORMATION (1)

INS. NAME							
INS. ADDRESS						INS. PHONE	
POLICY HOLDERS LAST NAME				FIRST NAME			RELATIONSHIP
CERTIFICATE NO.			GROUP NO.			MEMBER NO.	

## INSURANCE INFORMATION (2)

INS. NAME							
INS. ADDRESS						INS. PHONE	
POLICY HOLDERS LAST NAME				FIRST NAME			RELATIONSHIP
CERTIFICATE NO.			GROUP NO.			MEMBER NO.	

## SIGNATURE

<p><b>ASSIGNMENT OF BENEFITS:</b> I hereby irrevocably assign the insurance benefit payment, both basic and major medical, to which I am entitled directly to the doctor rendering service. I understand that I am financially responsible for the charges not covered by the assignment. A photo copy of this authorization is acceptable with the same authority as the original. I hereby authorize doctor rendering service to release any information acquired in the course of my examination or treatment.</p>	<p style="text-align: center;">SIGNATURE _____ DATE _____</p>
<p><b>CONSENT TO TREAT A MINOR:</b> I give my consent for any needed medical care/treatment for my son/daughter deemed necessary. This authorization will remain in effect until written retraction is received.</p>	<p style="text-align: center;">SIGNATURE OF FATHER/MOTHER OR LEGAL GUARDIAN/WITNESS _____ DATE _____</p>

# HEALTH HISTORY

(Confidential)

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of last physical examination \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

<p><b>GENERAL</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p><b>EYE, EAR, NOSE, THROAT</b></p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision - Flashes <input type="checkbox"/> Vision - Halos	<p><b>MEN only</b></p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other	
<p><b>MUSCLE/JOINT/BONE</b> Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p><b>SKIN</b></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p><b>WOMEN only</b></p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other	
<p><b>GENITO-URINARY</b></p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination				<p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>

**CONDITIONS** Check (✓) conditions you have or have had in the past.

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
---	---	---	--

<b>MEDICATIONS</b> List medications you are currently taking	<b>ALLERGIES</b> To medications or substances
Pharmacy Name _____ Phone _____	



# BETH ANNE ARY, M.D.

1441 Avocado • Suite 203 • Newport Beach, CA 92660

Tel (949) 640-7200 Fax (949) 720-0203

---

## ***AUTHORIZATION OF PAYMENT TO PHYSICIAN***

During your visits our office staff will collect your insurance information. This usually includes a copy of your insurance card, and any other benefit information available. Using this information, we will make every effort to contact your insurance carrier to determine what benefits, if any, are payable on your particular insurance coverage.

Based on the insurance company's response, we will calculate what portion of our fees will be covered as a benefit of your policy. Your insurance will not pay for your deductible and co-payments. Certain insurance companies disallow portions of Dr. Ary's fee, which you the patient will be responsible for.

If you are here for infertility, we will bill your insurance with a diagnosis and try to get them to pay. If they disallow any portion of the fees, **you the patient will be responsible.**

We will file your insurance claim immediately after your visit. The contract is between you and the insurance company. As their customer, you are our best advocate in dealing with them. We often ask for your help in contacting your insurance company to accelerate slow payments.

We allow eight weeks for your insurance carrier to pay your claim. If no payment has been received within this eight weeks, the balance remaining on your account is payable in full by you. We do not accept partial payments. If you receive insurance reimbursement subsequent to your account being paid, we will immediately refund any overpayment directly to you.

**I AGREE TO COMPLY WITH THE ABOVE PAYMENT PROCEDURES. I ALSO AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR ARE NOT COVERED BY INSURANCE.**

\_\_\_\_\_  
**Patient's Signature**

\_\_\_\_\_  
**Social Security #**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
**Date**

**AUTHORIZATION FOR DISCLOSURE OF INFORMATION**

I authorize Beth Ary, M.D. to disclose complete information concerning her medical findings and treatment of the undersigned, from the initial office visit until date of the conclusion of such treatment, to those individuals who, in Beth Ary, M.D.'s sole determination, are required to receive such information for the purpose of *medical treatment, medical quality assurance and peer review*.

PATIENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

\*\*\*\*\*

## 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 right 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 services 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. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

**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 thereafter. 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.

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 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.

**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 arbitration 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 and if not revoked will govern all medical services received by the patient.

**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 or Patient's Representative's Initials

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.**

### THIS AGREEMENT MUST BE SIGNED IN ORDER TO SEE THE PHYSICIAN.

By: \_\_\_\_\_  
Physician's or Duly (Date)  
Authorized Representative's Signature

\_\_\_\_\_  
Print Name of Physician

By: \_\_\_\_\_  
Patient's Signature (Date)

\_\_\_\_\_  
Print Patient's Name

By: \_\_\_\_\_  
Signature of Translator (if applicable) (Date)

\_\_\_\_\_  
Print Name of Translator

By: \_\_\_\_\_  
Patient's Representative's Signature (Date)

\_\_\_\_\_  
Print Name & Relationship to Patient

A signed copy of this document is to be given to the patient. Original is to be filed in patient's medical records.

## Notice of Privacy Practices

*To our patients:* This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

### **Our commitment to your privacy**

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of health information.

We realize that these laws are complicated, but we must provide you with the following important information:

### **Use and disclosure of your health information in certain special circumstances:**

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety of another individual or the public. We will only make disclosures to a person or organization able to prevent the threat.
5. If you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Worker's Compensation and similar programs.

### **Your rights regarding your health information**

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than at work. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment of your care, such as family members or friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to *Dr. Beth Ary, (949) 640-7200, 1441 Avocado Street, Suite 203, Newport Beach, CA 92660.*
4. You may ask to amend your health information if you believe it is incorrect or incomplete, as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to *Dr. Beth Ary, (949) 640-7200, 1441 Avocado Street, Suite 203, Newport Beach, CA 92660.* You must provide us with a reason that supports your request for amendment.
5. Right to copy this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of Department of Health and Human Services. To file a complaint with our practice contact: *Dr. Beth Ary, (949) 640-7200, 1441 Avocado Street, Suite 203, Newport Beach, CA 92660.* All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact *Dr. Beth Ary, (949) 640-7200, 1441 Avocado Street, Suite 203, Newport Beach, CA 92660.*

**I hereby acknowledge that I have been presented with a copy of Dr. Beth Ary's Notice of Privacy Practices.**

---

Signature

---

Date

---

Name of Patient

**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR  
TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

**NAME:** \_\_\_\_\_

**BIRTHDATE:** \_\_\_\_\_ **SOCIAL SECURITY #:** \_\_\_\_\_

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

**I understand that this information serves as:**

- A basis for planning my care and treatment.
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

**I understand that I have the right:**

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

**I request the following restrictions to the use or disclosure of my health information:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PATIENT:**

\_\_\_\_\_  
Signature of Patient or Legal Representative Date

\_\_\_\_\_  
Witness Signature

**OFFICE USE ONLY:**

Accepted \_\_\_\_\_  
 Denied Signature Title Date

BETH ARY, M.D.  
1441 AVOCADO AVE., #203  
NEWPORT BEACH, CA 92660  
(949) 640-7200

### FINANCIAL POLICY

All fees for procedures and treatment are due and payable at the time services are rendered. If you are enrolled in a health plan that is contracted with Dr. Ary, all services that are a covered benefit will be billed directly to your health plan. Your GYN/Infertility co-pay and deductible is due at the time of service. Any treatment that is a *non-covered benefit* will be due at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We bill your insurance as a courtesy for you; however, **you are the responsible party if your insurance fails to pay.** We will allow eight weeks for your insurance carrier to pay on your claim. If at that time payment is not received within eight weeks, the balance remaining on your account is payable in full by you.

Prospect Medical Group is the only IPA we belong to for infertility which require you to obtain a referral to see Dr. Ary for the initial consultation. Subsequently, all future services need to be pre-authorized by your IPA. Any services that have not received prior authorization, or are a non-covered benefit, *will be the financial responsibility of the member.* Please communicate with the office staff prior to beginning new treatment to ensure that proper authorization has been obtained.

It is your responsibility to be aware of your own *GYN/Infertility* benefits. We will make every effort to contact your insurance carrier to determine what benefits, if any, are covered. If your insurance company disallows any portion of the fees, **you the patient will be responsible.**

Our office accepts payments in the form of cash, personal checks, Visa, and MasterCard. A \$25.00 fee will be charged for all returned checks.

**I AGREE TO COMPLY WITH THE ABOVE FINANCIAL POLICY. I ALSO AGREE TO PAY ANY AND ALL CHARGES THAT EXCEED OR ARE NOT COVERED BY INSURANCE.**

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date