Dr. Kevin W. Louie
2100 Webster Street, Suite 117
San Francisco CA, 94115
415.600.3835

Patient Information:

Name: ______________________ SSN: ______________
Street Address ______________________ Date of Birth______________
City______________ State________ Zip______________ Marital Status: S M W Sep D
Telephone: Home ______________ Office ______________ Mobile ______________
Referred by: ______________________
Emergency Contact: ______________ Phone ______________ Mobile ______________
Relationship to patient: ______________________

Patient Employer Information:

Employer Name: ______________________ Phone: ______________
Street Address ______________________
City______________ State________ Zip______________
Patient's Occupation: ______________________

Insured Person (if not patient):

Name: ______________ SSN: ______________ DOB: ______________
Street Address ______________________
City______________ State________ Zip______________
Relationship to Patient: ______________________

Insurance:

Primary Insurance Company Name: ______________________
ID#______________ Group# ______________ Phone# ______________
Secondary Insurance Company Name: ______________________
ID#______________ Group# ______________ Phone# ______________
Medicare # (if applicable)______________

Acknowledgement of Receipt of
Notice of Privacy Practices

Kevin W. Louie, M.D. A Professional Corporation
2100 Webster Street, Suite 117, San Francisco CA, 94115

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed: X ______________________________ Date: ______________________
Print Name: ______________________________

If not signed by patient, please indicate:

Relationship:
- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator or an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: ______________________________

Office Policies

Dear Patient,

Thank you for your continued support of this practice. We would like to take this opportunity to inform you about our policies.

We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments, and by notifying us at least 24 hours In advance if you are unable to do so. Patients who fail to arrive for their scheduled appointment or who cancel with less than 24 hours advanced notices will be charged a missed appointment fee of $50. This fee cannot be charged to your insurance carrier.

All office visit co-payments are expected at the time of service.

Please allocate at least 1½ hours towards your appointment. This is at times a difficult area to find parking, therefore remember to include enough time for this while planning your visit.

For all medication refills, please call your pharmacy directly. Please allow 24 hours turnaround time for prescription requests. Please note that we do not process these requests on Fridays.

If you have any billing questions, please contact our billing department between 8:00am and 4:30pm, Monday through Friday at (415)972-4500.

We will bill your insurance companies as a courtesy; however, it is the patient's responsibility to pay for all charges not covered by their insurance, including but not limited to, co-payments, deductibles, co-insurance, and non-covered services. The patient also agrees to complete all necessary paperwork in order for his/her claim to be paid by an insurance company and accepts full liability for all charges if payment is not made by the insurance company.

Finally, as a courtesy to staff and other patients, please refrain from using your cell phone while in the office.

Signature: X ______________________________ Date: ______________________

Patient Consent

Kevin W. Louie, M.D. A Professional Corporation
2100 Webster Street, Suite 117, San Francisco CA, 94115

By signing this Consent Form, you give us permission to use and disclose protected health information about you for treatment, payment, and healthcare operations.
Protected health care information is individually identifiable information we create or receive, including information related to your physical and/or mental health that we use to provide healthcare services to you as well as obtain payments for services provided.

With this consent, Dr. Louie may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out healthcare operations, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including tests and laboratory results among others.

With this consent, Dr. Louie may mail to my home or other alternative location any items that assist the practice in carrying out healthcare operations, such as patient statements as long as they are marked Personal and Confidential. In addition, I give Dr. Louie permission to speak with the following family members, spouse, roommate, etc. regarding billing issues, lab results, or any other information pertaining to my treatment and care.

Name: ______________________ Relationship: ______________

Name: ______________________ Relationship: ______________

Name: ______________________ Relationship: ______________

If you do not sign this Consent Form, we have the right to refuse treatment unless we are required by law to treat you. You have the right to revoke this consent in writing except where we have already made disclosures in reliance to your prior consent. You may use our Authorization for Release of Information Form for purposes of requesting your revocation, or you may simply send us a letter with written request.

I have read and understand this policy as outlined above.

Signature of
Patient/Legal Guardian: X______________________ Relationship: X______________

Patient Name (print): X______________________ Date: X______________

Arbitration Agreement

ARTICLE 1

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

a. Parties To The Agreement. The term "Patient" as used in this Agreement includes the undersigned individual, his or her spouse, children (whether born or unborn), and heirs, assigns, or personal representatives. The individual signing this Agreement signs it on behalf of the foregoing persons, and intends to bind each of them to arbitration to the full extent permitted by law.

The term "Provider" as used in this Agreement includes the undersigned doctor, nurse practitioner, nurse midwife, or other health care provider and his or her professional corporation or partnership, and any employees, agents, successors-in-interest, heirs and assigns of the foregoing individuals or entities. The provider signing this Agreement signs it on behalf of all the foregoing individuals and entities, and intends to bind each of them to arbitration to the full extent permitted by law.

b. Treatment Covered. Patient understands and agrees that any dispute of the sort described in Article 1 between Provider and Patient will be subject to compulsory, binding arbitration.

c. Other Providers (If Applicable). Patient understands that he or she may at times receive treatment from one or more health care providers who take call for or otherwise practice jointly with the undersigned Provider. It is understood and agreed that any dispute of the sort described in Article 1 between Patient and such health care providers will be subject to compulsory, binding arbitration.

d. Coverage of Prenatal Claims (If Applicable). Patient understands and agrees that, if Provider treats her during pregnancy, any dispute of the sort described in Article 1 as to medical treatment rendered to or affecting the unborn child will be subject to compulsory, binding arbitration.

ARTICLE 3

a. Informal Resolution of Disputes. In the event Patient feels that a problem has arisen in connection with the medical care rendered by Provider to Patient, Patient will promptly notify Provider so that Provider may have the opportunity to resolve the matter. Notice may be given orally or in writing, and shall stop the running of the statute of limitations for 90 days.

b. Method of Initiating Arbitration. If the dispute is not resolved by mutual agreement, Patient may initiate arbitration by notifying Provider to that effect and by designating an arbitrator to act on Patient's behalf. Within 20 days of receipt of such notice, Provider will designate an arbitrator to act on Provider's behalf. In the event that more than two parties participate, parties aligned with Patient shall select one arbitrator, and parties aligned with Provider shall select a second arbitrator. The two "party" arbitrators shall select a neutral arbitrator. The controversy shall then be submitted to the three arbitrators for a final and binding decision.

c. Applicable Law. The arbitration shall be conducted pursuant to the California Arbitration Act (C.C.P. 1280-1296). The arbitrators shall, in addition, have authority to order such other discovery as they deem appropriate for a full and fair hearing of the case. A determination on the merits shall be rendered in accordance with the law of the State of California which shall apply to the same extent as if the dispute were pending before a superior court of this State.

d. Interpretation of Agreement. If any part of this Agreement is held unenforceable, it shall be severed and shall not affect the enforceability of the remainder. This Agreement supersedes and replaces any previous arbitration agreement between Provider and Patient and applies to all care previously rendered by Provider to Patient.

ARTICLE 4

a. Rescission. Once signed, this Agreement governs all subsequent medical services rendered by Provider to Patient until or unless rescinded by written notice within 30 days of signature. Written notice may be given by a guardian or conservator of Patient if Patient is incapacitated or a minor.

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.

Patient's Name *(Please Print)*: X ______________________

Dated: X ______________ Signed: X ______________

Provider's Name *(Please Print)*: Kevin W. Lowe, M.D.

Dated: ______________ Signed: ______________