

# *Pacific Coast Spine Institute and Pain Center*

17822 Beach Blvd Suite 101 Huntington Beach, CA 92647

Phone (714) 847-3666

Fax (714) 847-7171

*Surgery Center is located on the first floor of the Medical Towers building in suite #101.*

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Injection Appointment Day and Time: \_\_\_\_\_

Procedure: \_\_\_\_\_

Blood Thinner/Anti-inflammatory Medication Taken: \_\_\_\_\_

Date to **STOP** Blood Thinner/Anti-inflammatory Meds: \_\_\_\_\_

## **OUT-PATIENT INJECTION INSTRUCTIONS:**

You must NOT take any blood thinning medication for 1 week prior to your injection. This includes Aggrenox (dipyridamole + ASA), Coumadin (warfarin), Persantine (dipyridamole), Ticlid (ticlopidine), Agrylin (anagrelide HCl), Lovenox, Plavix (clopidogrel) and aspirin. If another physician has prescribed any of these medications, let him/her know of the need to discontinue it for the week prior to your injection.

You must NOT take any anti-inflammatory medication for 3 days prior to your injection. This includes ibuprofen, Motrin, Aleve, Advil, Celebrex, Naprosyn, etc. You **MAY** take Tylenol, Vicodin or other pain relief medication which is not anti-inflammatory.

If you regularly take other prescribed medications for blood pressure or diabetes, you may take them prior to your injection with water.

The first day of your injection you may use an ice pack to the area 3-4 times at 20 minute intervals as needed for comfort.

The second day of your injection you may use either a low-heat warming pad or an ice pack to the area 3-4 times as needed for comfort.

If you are going to receive IV sedation for your procedure, you should be fasting for 8 hours prior to the procedure and must also have a driver to take you home. Also, if you take an oral sedative prior to your procedure, you must have a driver.

**Visit our website at [www.pacificcoastspineandpain.com](http://www.pacificcoastspineandpain.com) for more information about your procedure.**

**Please be advised that 48 hours notice is required for all procedure cancellations. If the procedure is cancelled less than 48 hours prior, you will be subject to a \$100.00 charge to help cover our costs.**

**Please contact the office if you have any questions or concerns before or after your procedure.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date signed

# *Pacific Coast Spine Institute and Pain Center*

17822 Beach Blvd Suite 101  
Huntington Beach, CA 92647  
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Fax (714) 847-7171

## **FACILITY DISCLOSURE STATEMENT**

Your physician, **Dr. Maryam Rahbar**, has scheduled you for a procedure at Pacific Coast Spine Institute and Pain Center in which she has a financial interest. Pacific Coast Spine Institute and Pain Center also wishes to make you aware of the fact that there are other facilities in our medical community where the procedure(s) can be performed.

### **Advanced Directive**

Should and outpatient surgical procedure become necessary, I am aware that Pacific Coast Spine Institute and Pain center, and all of its personnel, **do not honor Advanced Directives**, and full resuscitation is attempted.

**Do you execute an advanced directive**

- YES
- NO

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Printed Name

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Signature

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Date

*Maryam Rahbar M.D.*  
*Pacific Coast Spine Institute and Pain Center*

17742 Beach Blvd, Suite 355 Huntington Beach, CA 92647  
Phone: 714-847-3666 Fax: 714-847-7171

**Insurance Disclosure Statement**

I understand in some cases the insurance payments will be sent to the patient instead of to the doctor. If I receive the insurance payment I will either endorse the original check or write a personal check to the appropriate provider for the same amount within 3 business days. I will also attach a copy of the EOB(explanation of benefits). If the payment is not forwarded to the provider within the 3 days, I understand that I will be turned into a collection company with a 30% extra collection fee as well as be charged with interest.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

# PACIFIC COAST SPINE INSTITUTE AND PAIN CENTER

## PATIENT RIGHTS

1. Exercise these rights without regard to sex, cultural, economic, educational, religious background, or the source of payment for care.
2. Patients of PCSIPC are treated with respect, consideration, and dignity.
3. Patients are provided the appropriate privacy. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly, including the right of the patient to have auditory privacy for any discussion of his/her medical treatment at PCSIPC.
4. The patient has the right to be advised as to the reason for the presence of any individual involved with his/her patient care.
5. Knowledge of the name of the physician who has primary responsibility for coordination of the care at PCSIPC, as well as the names and professional relationships of other physicians and non-physicians who will be involved with the patient care.
6. Except when required by law, patient disclosures and records are treated confidentially, and written permission shall be obtained from the patient before the medical records can be made available to anyone not directly concerned with the care.
7. Patients are provided, to the degree known, complete information concerning their diagnosis, evaluation, treatment, prognosis and prospect for recovery in terms that the patient can understand. When it is medically inadvisable to give such information to a patient, the information is provided to a person designated by the patient or to a legally authorized person.
8. Patients are given the opportunity to participate in decisions involving their healthcare at PCSIPC, except when such participation is contraindicated for medical reasons.
9. Receive as much information about any proposed treatment or procedure as the patient may need in order to give informed consent or to refuse this course of treatment. This information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the person(s) who will carry out the procedure or treatment.
10. Information is available to patients and staff concerning:
  - a. Patient rights, including those specified above
  - b. Patient conduct and responsibilities
  - c. Services available at the organization
  - d. Provisions for after-hours and emergency care
  - e. Fees for services
  - f. Payment policies
  - g. Patient's right to refuse to participate in experimental research
  - h. Methods for expressing grievances and suggestions to PCSIPC
  - i. Advance directives, if so requested by the patient
  - j. Credentialing of healthcare professionals.
11. Patients are informed of their right to change primary or specialty physicians if other qualified physicians are available.
12. Marketing or advertising regarding the competence and capabilities of the organization is not misleading to patients.
13. Patients are provided with appropriate information regarding the absence of malpractice insurance coverage.
14. Patients will receive information in a format that they can readily understand. When necessary, an interpreter will be used.
15. Reasonable responses to any reasonable requests made for services.
16. Patients may leave PCSIPC, even against the advise of Physicians, with a release.
17. Reasonable continuity of care and to know in advance the time and location of appointment, as well as the identity of persons providing the care.
18. Be informed of continuing healthcare requirements following discharge from PCSIPC.
19. Patients have the right to have their pain assessed and treated promptly, effectively, and for as long as the pain persists. PCSIPC shall insure that pain assessment is performed in a consistent manner that is appropriate to the patient.
20. Have all "Patients' Rights" apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
21. File a grievance. If you want to file a grievance with PCSIPC, you may do so by calling DecDee Corley at (714) 847-3666 or writing to P.O. Box 11869 Newport Beach, CA 92658.
22. Any patient having a grievance or complaint may address the issue with the following accrediting agency:  
AAAHC, 5250 Old Orchard Rd, Ste 200, Skokie, IL 60077  
Dept of Public Health General Information Line 916-558-1784  
Medicare Beneficiary 1-800-MEDICARE (633-42273)

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 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. 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 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 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 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.

By: \_\_\_\_\_

Patient's or Patient Representative Signature (Date)

By: \_\_\_\_\_  
Physician's or Authorized Representative's (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 the Patient. Original is to be filed in Patient's medical records.