Patient Name: ________________________ **Date**: ____________

Dear Patient,

We want to inform you of the steps we are taking to ensure your safety as well as the safety of our staff:

- All staff will be taking their temperature both the night before a workday and the morning of, to ensure the safety of everyone in the office.
- All patients will be required to have their temperature taken before getting any treatment. Again, this is just an added safety measure for everyone in the office.
- We will minimize the use of the waiting room.
- We will be limiting the number of patients we see at any one time and per day.
- To help limit cross contamination, no magazines will be available in the waiting room or the exam rooms.
- We ask that patients wear a mask when entering the office and remain wearing it for the duration of your visit.
- Please sanitize your hands before being brought back to the exam rooms.
- Doctors and nurses will adhere to strict and frequent hand washing and will be wearing masks throughout your appointment.
- We kindly ask that if you are experiencing any flu-like symptoms or have any potential exposure or recently traveled that you please not come to the office.
- Unless you have a caretaker, we request that you do not bring any other family or friends with you to our office. If you must, we ask that they please remain outside or in the car.

As always, we will continue to strictly adhere to OSHA guidelines on infection control with instrumentation and treatment rooms. Additional measures are being taken to completely disinfect treatment rooms in between patients and to decrease the number of patient and staff encounters per physical distancing protocols. You are understanding regarding this safety matter is appreciated. We thank you for your patience during this challenging time.

By signing this form, you acknowledge that we are doing everything possible to keep you and our staff safe and healthy.

1) Have you received BOTH vaccine OR One J&J Vaccine? ☐YES ☐NO (if you answered NO move on to question 2&3)

☐ **Johnson & Johnson** **Month ONLY** _________

☐ **Pfizer** or ☐ **Moderna** **First Vaccine Month ONLY** ___________ **Second Vaccine Month ONLY** ___________

2) Do you have any of the following: fever, respiratory symptoms including cough, shortness of breath, or new loss of taste or smell?

☐**YES** ☐**NO**

3) Have you been in close contact with someone with COVID-19? **Temp** _________

☐**YES** ☐**NO**

_____________________________ _____________________________

Patient Signature Witness Signature

The Kopelson Clinic, Inc.
414 N. Camden Drive, Suite 640
Beverly Hills, CA 90210

Peter L. Kopelson, M.D.
Sheri G. Feldman, M.D.

PLEASE PRINT CLEARLY **Patient Information**

_______________________________________ _____________________ ____________________
(First) *(Middle)* *(Last Name)* *(Prefer to be called)* *(Date of Birth)*

_______________________________________ _____________________________________
(Home Address) *(City, State, Zip Code)*

______________________ ______________________ ______________________ ______________
(Home Telephone Number) *(Work Telephone Number)* *(Cell Telephone Number)* *(*Cell Provider)*
**Provider needed for appt. reminders.*

_______________________________________ ___________________________
(EMAIL) appt. confirm., medical results, promotional *(Social Security Number)*

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** **Sex:** ☐ **Male** ☐ **Female**

Employment Status: ☐ **Employed** ☐ **Part-time Student** ☐ **Full-time Student** ☐ **Child**

Insurance Info needed from Medicare patients only:
Copy of Medicare card & supplement insurance

Parent/Guardian if Patient is a child (under 18 yrs old)

_______________________________________ _____________ ____________________
Print:* *Mother/Father name ***Date of Birth*** ***Social Security Number***

Employment Information

_______________________________________ _______________________________________
(Occupation) ***(Employer)***

Emergency Contact

_______________________________________ ___________________ ___________________
(Name) ***Phone #*** ***(Relationship to Patient)***

****Authorization to leave a message / lab results at: Home: ☐ yes ☐ no Work: ☐ yes ☐ no**
Email: ☐ yes ☐no Cell: ☐ yes ☐ no Spouse / Assistant: ☐yes ☐ no Name: ______________

HOW WERE YOU REFERRED to our office? Please print

☐ **By a Doctor** ☐ **Other:**
☐ **By a Patient** ____

**** What PHARMACY do you prefer your prescriptions to be called in?**

Name: -------------------------- **Location/cross street:** --------------------------- **Phone:** ---------------------

Consent to Treatment

I voluntarily consent to receive medical and health care services that may include diagnostic procedures examinations and treatment. I authorize the release of medical information to my primary care or referring physician and to consultants if needed as necessary to process medical insurance, applications and prescriptions. I also authorize payment of medical benefits (medicare patients) to the physician.

Financial Responsibility: ***Payment is required for all services at the time they are rendered. Please ask for pricing prior to procedure.*** A bank fee of $25 for returned checks. We are not contracted with any insurance companies except Medicare. Cancelling with less than 24 hours notice or missed appointments will incur a charge. *Your signature below signifies your understanding and willingness to comply with this policy.*

____ ______________________
(Patient or Other Legally Authorized Person) ***(Date)***

I **(Patient Name)** ________________________________ **date of birth**_________________________ wish to be called regarding **my care** including but not limited to **biopsy results, lab results** and or **follow-up.** The best telephone number(s) to reach me are: **(Please provide only ONE number)**

Home: _________________________

Cell: __________________________

Other: _________________________

I understand that the office will contact me with the results within 7-10 business days. **Initials**: ______

I do ☐, **I do not** ☐ give permission to leave relevant medical information on my answering machine or voice mail.

I do ☐. **I do not** ☐ **(if checked I do; please print relative/ friend name)** want relevant medical information shared with the person who may answer telephone. The name(s) of the individuals(s) with whom you may leave pertinent information are:

Relative / Friend: 1) ____________________________ Phone: ____________________________

Relative / Friend: 2) ____________________________ Phone: ____________________________

Other: ____ Phone: ____________________________

Pharmacy Name: _____________________________ **Zip Code** _______________

Address ____**OR Cross streets** _________________________

Patient Signature: ____________________________ **Date**: ___________________________

The Kopelson Clinic, Inc.

Peter L. Kopelson, M.D. Sheri G. Feldman, M.D.

Dermatology Medical History

Patient: ______________________________ **Date:** _____/_____/____
Last First Middle Initial

Reason for today's visit: ______________________________

Are you ***allergic*** to any medications? ☐ YES ☐ NO If yes, please list below:
1. ______________________ 2. ______________________

Have you ever had dental anesthesia (Novocaine)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

Do you have a history of *cold sores* around the mouth and/or ***herpes virus?*** ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1. ____________ 3. ____________ 5. ____________
2. ____________ 4. ____________ 6. ____________

Do you have now, or have you ever had diseases or conditions of: (Please check each with a **YES or NO**)

Cardiovascular:	YES	NO
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Artificial Heart Valve	☐	☐
Pacemaker	☐	☐
Pulmonary (Lungs):	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Gastrointestinal	**YES**	**NO**
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea	☐	☐

Rheumatologic:	YES	NO
Rheumatoid Arthritis	☐	☐
Joint Deformity	☐	☐
Osteoarthritis	☐	☐
Artificial Joint	☐	☐
Collagen Vascular Diseases (e.g. Lupus, Scleroderma, Dermatomyositis, etc.)	☐	☐
Genitourinary	**YES**	**NO**
Bladder	☐	☐
Frequency/burning	☐	☐
Eyes:	**YES**	**NO**
Glaucoma	☐	☐
Cataracts	☐	☐
Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Yeast Infections	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

List any other diseases or SKIN conditions: ______________________________

List surgical procedures you have had in the last 6 months: ______________________________

Skin:

Have you ever had skin cancer? ☐ YES ☐ NO Location:______________________
If so, what type? ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ **Melanoma**

Has anyone in your family had skin cancer? ☐ YES ☐ NO Family Member: ______________
If so, what type? ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ **Melanoma**

Social History:

Do you drink alcohol? ☐ YES ☐ NO
Do you use IV drugs? ☐ YES ☐ NO
Do you smoke? ☐ YES ☐ NO
HIV Status __ POS __NEG ___ Don't Know

Please answer the following questions:
(Women) Are you pregnant? ☐ **YES** ☐ **NO** Weeks:__________ Months__________

Completed by: ☐ Patient ☐ Patient's Guardian

______________________________ Date: _____/_____/____
Signed by Patient or Patient's Guardian

The Kopelson Clinic, Inc.
Financial Policy:

Thank you for choosing The Kopelson Clinic, we look forward to providing you with the highest quality of prompt and thorough medical treatment. In order to do so, we require that **payment is due in full at the time of service.**

The only insurance our office directly submits charges to is Medicare, however upon receipt of payment in full we will gladly provide you with a form that you may submit to your health insurance provider on your own behalf. We accept payment by cash, check, Visa, MasterCard, American Express, and Discover.

I have read, understand and agree to the above Financial Policy. I understand that it is my sole responsibility to provide payment in full at the time of service for any office visits and/or procedures performed by Dr. Peter Kopelson and/or Dr. Sheri Feldman. If I should seek financial reimbursement from my health insurance provider, I am responsible for doing so on my own behalf.

X___________________________ ______________

Signature of Patient or Guardian Date

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** lt 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 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 before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must Be Arbitrated:** lt is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association , their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, 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.

Filing by Physician 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 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 by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§1-4) The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: **Retroactive Effects:** The patient intends this agreement to cover all services rendered by Physician not only after the date it is signed (including but not limited to, emergency treatment), but also before it was signed as well.

Article 5: **Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed there from and the remainder of the Agreement enforced in accordance with California law.

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: Lauren W. Diamond ______________________
Physician's or Duly Authorized Representative Signature (Date)

By: ______________________
Patient's Signature (Date)

By: The Kopelson Clinic, Inc.
Peter L. Kopelson, M.D.
Sheri G. Feldman, M.D. ______________________
Print or Stamp Name of Physician, Medical Group or Association Name

By: ______________________
Print Patient's Name

By: ______________________
Signature of Translator (if applicable) (Date)

By: ______________________
Patient's Representative's Signature (Date)
(if applicable)

____
Print Name of Translator

____
Print Name of Translator

Peter L. Kopelson, M.D.
Sheri G. Feldman, M.D.

The Kopelson Clinic, Inc.

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I, ___________________, have received a copy of The Kopelson Clinic Inc.'s Notice of Privacy Practices.

X______________________ ______________

Signature of Patient Date