

Healthy. Together.

Eugene W. Tsai, MD

12522 E. Lambert Road, Unit B, Whittier, CA 90606

1294 W. Sixth Street, Suite 206A San Pedro, CA 90731

12225 South Street, Suite 102, Artesia, CA 90701

Ph: (310) 241 - 0822 or (562) 865 - 2402

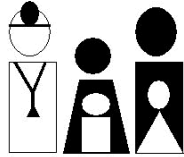
Website: www.sanpedroallergy.com or www.eugenetsaimd.com

LIST OF FORMS

- 1) Introduction Letter (read only)
- 2) New Patient Form (print and fill out)
- 3) Message about Arbitration (read only)
- 4) Arbitration Agreement (read only)
- 5) HIPAA Consent Form (print and fill out)
- 6) Environmental, Social, Family History Form (print and fill out)

Please bring the New Patient Form, HIPAA Consent Form, Environmental, Social, Family History Form, and your insurance card to your appointment with Dr. Tsai.

Thank you.



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INTRODUCTION LETTER

Dear Patient or Parent,

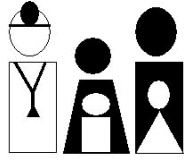
We look forward to meeting you at your first visit. For new patients, we like to spend the appropriate amount of time needed to understand your problems with allergy, asthma, or immunology and to explain options for diagnosis and treatment. Your first visit with us will usually last 45 to 90 minutes depending on the complexity of your case. So, please be sure to allow enough time in your schedule for this consultation. If you need to reschedule your appointment with us, as a courtesy, please notify our office 24 hours in advance of your scheduled appointment.

In our office, we perform allergy testing. In general, we schedule allergy testing during a follow up visit AFTER a patient's first visit with us if it is determined that allergy testing is needed. We prefer to spend the time during the first visit to carefully assess your condition and discuss options for further diagnosis and treatment. However, if you prefer to have allergy testing done at your first visit, please contact our front office, we will try to accommodate your request if possible.

For more information about our office, you can visit us at www.eugenetsaimd.com or www.sanpedroallergy.com.

Sincerely,

Eugene W. Tsai, MD



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NEW PATIENT INFORMATION RECORD

Patient _____
First Name Middle Name Last Name
Marital Status: Single Married Widowed Other _____
Gender: Male Female Age: _____
Address _____
City _____ Zip Code _____ Birth Date _____
Phone Number () _____ Cell () _____
Social Security Number _____ Email _____

INSURANCE INFORMATION

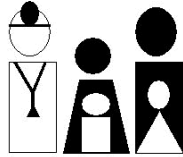
Name on Insurance Card: _____
First Name Middle Name Last Name
Relationship to Patient: Self Parent Spouse Other _____
Social Security Number: _____ Birth Date: _____
Referred By: _____
(name of the physician or referring person)
Friend or Relative to Contact in Case of Emergency: _____
Relationship to Patient: _____
Phone Number: () _____ Cell () _____

RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS

I hereby authorize Eugene W. Tsai, M.D. to disclose when requested by the above named insurance carrier of its representatives any and all information with respect to any illness(es) of injury(ies), medical history, or treatment and copies of all medical records. A photographic copy of this authorization shall be considered as effective and valid as the original.

I hereby authorize payment directly to Eugene W. Tsai, M.D. of the surgical and /or medical benefit if any, otherwise payable to me for professional services rendered to me. I understand that I am financially responsible for the charges not covered by this authorization. I further agree in the event of non-payment to bear the cost of reasonable legal fees should this be required.

Date _____ Signature _____



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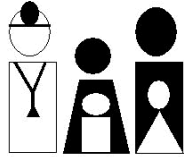
A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The following document is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where you claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitration (party arbitration), who then selects a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal cost for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceeding.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that the most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

For specific details about this arbitration agreement, you may read the following Physician-Patient Arbitration Agreement. You do NOT need to sign anything now. You will be asked to sign the Physician-Patient Arbitration Agreement at your first visit.



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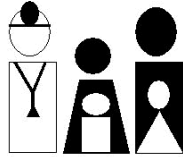
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PHYSICIAN-PATIENT ABRITRATION AGREEMENT

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 the 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 I, 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 claim may arise out of the related 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 case of ant 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 estate of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damage. 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 claims against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolve 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 the 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 the contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.



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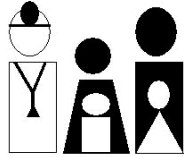
Article 3 (continued): Either party shall have the absolute right to arbitrate separately the issue of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and joinder in the arbitration of any persons or entity with would otherwise be a proper additional party in the 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 provision of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but no limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Codes Sections 3333.1 and 3333.2. Any party may bring before the arbitrator a motion for summary judgment of summary adjudication in accordance with the Code of Civil Procedures. Discovery shall be conducted pursuant to the Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and for ever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, will be barred by 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 governed by the California Code of Civil Procedure provision 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 as indicated.

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, I acknowledge that I have received a copy.



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HIPPA PATIENT CONSENT FORM

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. The notice contains a patient rights section describing your rights under the law. You have the right to receive our notice before signing the consent. The terms of our notice may change. If we change notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclose for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for your treatment, payment, and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

- 1) Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- 2) The practice has a Notice of Privacy Practice and that the patient has the opportunity to review this notice.
- 3) The Practice reserves the right to change the notice of privacy practices.
- 4) The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
- 5) The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- 6) The practice may condition receipt of treatment upon the execution of this consent.

This Consent was signed by:

Signing of Consent was witnessed by:

Printed Named-Patient or Representatives

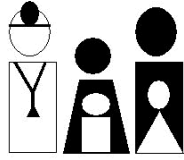
Physician

Patient or Representatives Signature

Signature of Physician

____/____/____
Date

____/____/____
Date



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Environmental, Social, and Family History

Environmental Survey

What city or cities does the patient live in? _____

Patient lives in a (house, condo, apartment, or other _____). Please circle one.
How old is your home? (less than 10 years old, between 10 to 25 years old, older than 25 years old). Please circle one. How many years has the patient been living there? _____

What type of flooring do you have (hardwood, laminate, carpet, rugs, tile). Please circle all that apply. For patients with carpeting, how old are your carpets? _____

What type of pets do you have? (Dog, Cat, Other _____) Please circle all that apply.
Does patient smoke? Yes No If yes, how many packs per day _____
Does anyone in the family smoke? Yes No Has patient ever smoked? Yes No
Does patient have their own bedroom? Yes No If no, how many people share? _____

Social History (fill out for patients older than 6 years of age)

What does patient do for a living or what grade in school? _____
What does patient do in their spare time or hobbies? _____
What does patient do for exercise? _____
Any recent foreign travel in the past 12 months? _____

Social History (fill out for patients less than 5 years of age)

Does your child attend daycare? Yes No (please circle) Do any of your other children attend daycare? Yes No (please circle) What type of formula did your child use in their first year of life? _____ At what age did you introduce solid foods to your child? _____ At what age did you introduce cow's milk to your child? _____
List any foods that your child avoids because of allergies? _____

Family History

Does anyone in your family have nasal allergies, asthma, or eczema? Yes No
What type of medical problems run in the family? _____