321 N. LARCHMONT BLVD. SUITE 825 • LOS ANGELES, CA 90004 • (323) 464-4458 • FAX (323) 464-5329

Patient Information

First and last name: ______________________________________ Preferred name: _________________________

Address: _________________________________ City: _______________ State: ______ Zip Code: ___________

Primary Ph: ___________________ Cell Home Work ◆ Secondary Ph: __________________ Cell Home Work

Date of Birth: _________________ Age: ______ Social Security #: _______________________

Marital Status: Single Married Domestic Partner Divorced Widow

Email Address: ____ Biological sex: F M

Employer: ___________________________________ Occupation: ________________________________

Emergency Contact: ________________________ Phone #:___________________Relationship: _____________

Name of referring doctor: ___________________________ Doctor's phone number: _______________________

Would you like an appointment reminder? YES or NO ◆ If yes, please choose **ONE** below:

☐Text ⇨Cell Phone *Provider*: ____________ ☐ Email ☐ Phone Call (to primary number)

Is this an accident related injury? Y / N - If yes, date of injury: ______ Work - Auto – Other (please describe): _______________

ARBITRATION AGREEMENT

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 the 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 in a court of law before a jury, and instead are accepting the use of arbitration.

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. It is your right to decline our arbitration agreement. However, if you choose to decline our arbitration, then it is our right to refuse services to you.

X____ ________________________________

Patient Signature / Parent or Guardian Signature Date Witness Initial (Office Staff) Date

CONSENT TO TREAT

Your signature below provides us with your permission/consent to perform reasonable and necessary evaluations, testing, and treatment within the scope of your therapist's license and/or recommended by your physician. You have the right to discontinue services at any time.

X____

Patient Signature / Parent or Guardian Signature Date