Julio Garcia, MD, F.A.C.S.
6020 S. Rainbow Blvd.
Las Vegas, NV 89118
(702) 870-0058

NEW PATIENT INFORMATION SHEET

*Please complete before your appointment and bring it with you. Thank you.

Patient Name: ____

Parent or Legal Guardian: ____

Address: ____ Apt. #:_________________

City: ____________________________________ State: _________ Zip:_______________

Home Phone: __________________________ Work Phone: _________________________

Cell Phone: ____

E-mail Address: ____

Social Security Number: ____

Sex: ______________ Date of Birth: ______________________Age: _________________

Employer: _________________________________ Occupation: ______________________

Employer Address: ____

Name of spouse or significant other: ____

Their employer & occupation: ____

Their phone number: ____

Nearest relative not residing with you: ____

Address & Phone Number: ____

**REFERRED BY: ____

Reason for Consultation Appointment: ____

NOTICE OF ASSIGNMENT, RELEASE OF MEDICAL INFORMATION AND AGREEMENT TO TREAT:

I hereby authorize the release of any medical information necessary to process this file. To assure the highest quality of patient care, I give my consent for a peer review physician to review my chart to obtain information about the delivery of my medical care. **I fully understand that I am personally financially responsible for my consultation appointment today and for all services rendered by Julio L. Garcia, M.D.** I understand that Dr. Garcia will not obtain preauthorization nor submit claims to my insurance company.

Signature:____ Date: _______________

PATIENT MEDICAL HISTORY

NAME: ____ DATE: ________________

* Have you been hospitalized during the past 2 years? ____

* If yes, what for? ____

* Have you been under a physician's care in the past 2 years? _______________________________________

* What is that physician's name? ____

* Have you ever had bleeding or clotting problems? ____

* Do you engage in regular or strenuous exercise? ____

* How many alcoholic beverages do you have per week? _________ * Do you smoke cigarettes? __________

* Do you smoke marijuana or hashish? ____

* Do you take sedatives or related substances? ____

* Do you have any known allergies to medications? ____

* Do you have any allergies to any other substances? ____

* Have you ever had a problem with anesthetics? ____

* Have you required injections for pain more than the average patient for dental work? ___________________

* Do you have a history of Cold Sores/Herpes? ____

* Have you recently traveled out of the U.S. or lived in concentrated housing? __________________________

* Have you ever had a T.B. Test, chronic cough greater than three weeks, bloody sputum, unexplained weight loss or night sweats? _______________

* List ALL present medications: (This Includes vitamins, herbs, prescription medications and over-the-counter drugs like aspirin etc ....)

____
____
____
____

* Have you had any serious illness? ____

* Have you experienced any of the following?

__ HEART TROUBLE/HEART SURGERY
__ ARTHRITIS
__ ASTHMA/EMPHYSEMA
__ HEART MURMUR
__ ALLERGY
__ CHRONIC COUGH FOR MORE THAN 3 WEEKS
__ STOMACH ULCER
__ THYROID CONDITION
__ ANXIETY
__ DEPRESSION
__ ANEMIA
__ HEPATITIS/JAUNDICE
__ CONGENITAL HEART LESIONS
__ STROKE
__ DIABETES
__ HIGH BLOOD PRESSURE
__ EPILEPSY
__ TUBERCULOSIS
__ RHEUMATIC FEVER
__ KIDNEY DISEASE
__ CANCER

WOMEN ONLY

* Are you pregnant at the present time? _______ Are you taking birth control pills at the present time? ______

* Have you had surgery for the removal of Ovaries? ____

* Have any of your female blood relatives had breast cancer? _______________________________________

* Date of your last menstrual cycle? ____

CONSENT TO BE PHOTOGRAPHED AND USE OF PHOTOGRAPHS

The use of photographs is essential to the planning and evaluation of cosmetic or reconstructive surgery. These photographs are a permanent part of my medical records and will never be shown to anyone else without my consent. I understand that I will be photographed before and after my procedures. I hereby certify that I have read the foregoing and fully understand its meaning and effect. I hereby consent to be photographed by Julio L. Garcia, M.D. and his staff.

Signature: ____ Date: _____________

For various reasons, Julio L. Garcia M.D. is often asked to show before and after photos of patients. Many patients, happy with their results, have given permission to use their photos anonymously. We now ask that you do so as well. Every attempt will be made to represent all patients and Julio L. Garcia M.D. accurately and with integrity and dignity in all media. Please consider the following and initial the paragraphs you consent to:

*I recognize that prospective patients, such as myself, will ask to look at before and after photographs in the process of choosing a surgeon and evaluating specific procedures. I authorize the anonymous use of my photographs for this purpose by Julio L. Garcia M.D.

Initial: ______

*I authorize the anonymous use of my photographs by Julio L. Garcia, M.D. in seminars, health fairs and conferences for interested and/or prospective patients.

Initial: ______

*I authorize the anonymous use of my photographs by Julio L. Garcia, M.D. for publication in medical journals, magazines, newspapers or programs produced for cable TV so long as I am notified in writing of such use prior to publication or production.

Initial: ______

*I authorize the anonymous use of my photographs by Julio L. Garcia, M.D. on the internet so long as I am notified in writing of such use prior to production.

Initial: ______

MUTUAL BINDING ARBITRATION AGREEMENT

Patient's Name: ____

This mutual binding arbitration agreement constitutes an integral part of a contract for medical services by and between Julio L. Garcia MD, or any of his employees, and ___________________ _________________________________ who agrees to be bound as described hereunder:

I. 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 by the American Arbitration Association office in Las Vegas, Nevada, as provided in Nevada law, and not by lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Any arbitration proceedings must take place in the State of Nevada. 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.

2. Such arbitration shall be in accordance with the current arbitration rules of the American Arbitration Association, even though the American Arbitration Association will not be overseeing the proceedings, yet always within accordance of Nevada Regulatory Statutes. This Mutual Binding Arbitration Agreement shall apply to any legal claim or civil action in connection with any and all medical services rendered, whether inpatient or outpatient, against Julio L Garcia MD or any of Dr. Garcia's employees or contracted staff.

3. Procedures to enhance one's appearance are considered desirable and elective. There is no medical necessity for such procedures. Patient understands that they have chosen to undergo this procedure even though no medical necessity exists.

4. As all services that Dr. Garcia and his employees perform are elective and not life saving, the execution of this Mutual Binding Arbitration Agreement shall be a precondition of the furnishing of medical services by Dr. Julio L Garcia MD. This Mutual Binding Arbitration Agreement may be rescinded by written notice from the Patient or Patient's legal representative prior to undergoing any treatment or diagnostic evaluation. This contract will renew yearly beginning the date of signature in perpetuity unless rescinded in writing. Dr. Garcia may assume that if the patient proceeds with the treatment/evaluation that he/she is willing to abide by this binding arbitration agreement

5. The Mutual Binding Arbitration Agreement shall bind the parties hereto, including newborns, and the heirs, representatives, executors, administrators, successors, and assigns of such parties and newborns.

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. NEVADA REGULATORY STATUTE PROVIDED UPON REQUEST. THE PREVAILING PARTY IS ENTITLED TO RECOVER FEES. YOU ALSO AGREE THAT ALL OF YOUR QUESTIONS REGARDING THIS ISSUE HAVE BEEN ANSWERED.

Date: ____ Time: __________ A.M./P.M.

Signature: ____

(Patient/parent/legal guardian/legal representative)

If signed by other than patient, indicate relationship:____________________________________

Julio L. Garcia MD, LTD
6020 S. Rainbow Blvd
Las Vegas, Nevada 89118

Julio Garcia, M.D.

PREAMBLE

We take great pride in our reputation for providing the highest levels of quality medical care to our patients. However, we realize there are times when some patients will not be satisfied with the outcomes of their treatments. We also recognize that in these instances, a patient has every right to pursue legal action if he/she feels we have been negligent in some way. We respect every patient's rights to do so.

While some healthcare legal claims are justified, there are also frivolous legal claims filed in our country - claims that are driving up insurance rates and impacting court decisions for the patient who truly deserve compensation. We believe that an agreement early in the treatment process regarding the use of board-certified experts will help expedite resolution of concerns.

OUR COMMITMENT TO YOU

We commit to using only American Board of Medical Specialties (ABMS) board-certified expert medical witness(es) in any legal situation, who follows the code of ethics of our national specialty society. These steps ensure that expert medical witnesses we use have passed examinations, demonstrated expertise in their field and adhere to a solid code of ethics.

We demonstrate this commitment to you with our signature on the attached form.

WHAT WE ARE ASKING YOU TO DO

We are asking you or any representative to commit to this process also, by using only board-certified physicians expert medical witness{es) if you are dissatisfied with your medical care and decide on legal action.

We hope, and believe, you will never have to consider this again. But if you do, we will honor this commitment to you.

AGREEMENT AS TO RESOLUTION OF CONCERNS

I, ____ understand that I am entering into a contractual relationship with Julio Garcia, M.D. for professional care. I further understand that merit less and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care to patients and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Julio Garcia, M.D., I agree· not to initiate or advance, directly or indirectly, any merit less or frivolous claims of medical malpractice against Julio Garcia, M.D.

Should I initiate or pursue a meritorious medical malpractice claim against Julio Garcia, M.D., I agree to use as expert witnesses (with respect to issues concerning the standard of care), only physicians who are board certified by the American Board of Medical Specialties in the same or similar specialty as Julio Garcia, M.D. Further, I agree that these physicians retained by me or on my behalf to be expert witnesses will be members in good standing of the medical specialty society to which Julio Garcia, M.D. belongs. I agree the expert will be obligated to adhere to the guidelines or code of conduct defined by that physician's specialty society.

I agree to require any attorney I hire and any physician hired by me or on my behalf as an expert witness to agree to these provisions.

In further consideration, Julio Garcia, M.D., agrees to exactly the same above-referenced stipulations.

Each party agrees that a conclusion by a specialty society affording due process to any expert will be treated as supporting or refuting evidence of a frivolous or merit less claim.

Patient and physician agree that this Agreement is binding upon them individually and their respective successors, assigns, representatives, personal representatives, spouses and other dependents.

Physician and patient agree that these provisions apply to any claim for medical malpractice whether based on a theory or contract, negligence, battery or any other theory of recovery.

Patient acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

Patient Signature: ____

Date of Signature: ____

Physician Signature: ____

Effective from Date of Treatment: ____