Canyon Medical Center

Welcome to Canyon Medical Center! We are honored that you have chosen us as your health care provider! Our goal is to provide the highest quality care to all of our patients in a timely and respectful manner.

We are different than other medical offices you may have visited. This is a private practice, not owned by a large healthcare entity or a large group of physicians. Because of this, we practice medicine the way it should be practiced: we spend time with our patients and really listen to their needs. Small practices like ours are an endangered species in this ever-changing healthcare environment. We try to represent what is right with medicine. We hope you agree!

In addition to primary care for your whole family, we offer other in-house specialty services such as massage, acupuncture, prenatal care, minor surgery, therapeutic & diagnostic ultrasound, allergy testing and more. Many of these services are billable to insurance, depending on your plan.

To maximize your visit, please ensure you have thoroughly read our Patient Policies & Procedures. Additionally, please arrive with completed intake forms, a valid ID, Insurance Card and Verification of Benefits form, if applicable.

Thank you for choosing Canyon Medical Center!

Patient Policies & Procedures for Canyon Medical Center

LEGAL VERBIAGE: you (THE PATIENT) we (Canyon Medical Center or CMC)

1. **Insurance.** Many of our providers are credentialed with most insurance plans, including Medicaid's Care Oregon and Open Card. Understanding your plan's specific benefits, coverage and associated cost is ultimately your responsibility. Your plan has the final say in how much of your visit is covered. Please contact your insurance company with any questions you may have regarding your coverage and consult the Billing & Insurance page on our website if you need a template to guide you in asking the right questions.

   If you have any questions or are interested in reviewing your benefits, we offer complimentary consults with our Billing and Financial Specialist; please schedule ahead of time if you wish to utilize this benefit.

   a. **Billing**. As a courtesy, we bill most insurance carriers directly but do not bill Out of Network Benefits. Therefore, if you have out-of-network benefits, payment in full is expected at each visit. You are ultimately responsible for any services and labs not covered by your insurance plan.
   b. **Verification of Benefits (VOBs)**. The Canyon Medical Center Billing Department requires you present your ID and Insurance Card in order to bill your insurance.
      i. In order to ensure an efficient billing process, it is highly recommended that all patients complete the insurance Verification of Benefits form before seeing the doctor. The Verification of Benefits form is not a guarantee of coverage.
      ii. To avoid our 48-hour cancelation fee for having to cancel last minute due to insurance coverage issues, we strongly encourage you to inquire about your benefits.
      iii. Providing correct insurance information is the responsibility of the patient and therefore, patients are ultimately responsible for all charges resulting from treatment provided by their physician.
   c. **Proof of insurance**. The Canyon Medical Center Billing Department requires you present your ID and Insurance Card in order to bill your insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim at the time of service.
   d. **Coverage changes**. If you have not supplied us with up-to-date insurance information, your visit may result in full patient responsibility. **You are ultimately responsible for any services and labs not covered by your insurance plan**.
   e. **Co-payments and deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.
   f. **Claims submission**. Your insurance company may need you to supply certain information directly in order to process your claim. It is your responsibility to comply with their request.
   g. **Submitting for Reimbursement** At your request, we can provide itemized receipts to include diagnosis and CPT codes, as well as the patient's provider and their affiliated NPI and Tax ID numbers at no charge.

2. **Payments** Payment is due at the time of service. We accept cash, check, Visa, Master Card or American Express.
   a. **Discounts**. A 20% discount is offered to out-of-pocket paying, uninsured patients who pay for their visit at time of service. If the account is not settled on the same day, then the discount is forfeited.
   b. **Nonpayment/Collections**. If your account is over 90 days past due, you will receive a statement requesting that you pay your account in full. Failure to pay for medical services delivered in good faith will cause a patient's account to be turned over to an outside agency for collection.
      i. If collection proceedings occur, you will be notified by both regular and certified mail that you have 30 days to find alternative medical care.
      ii. During that 30-day period, our physicians will only be able to treat you on an acute basis.
      iii. If you should ever decide to file for bankruptcy proceedings against an outstanding debt owed to Canyon Medical Center, it is the policy of our practice to withdraw as a health care provider, giving the legally required notice.
   c. **Payment Plans or partial payments** will not be accepted unless otherwise approved by our Office Manager and/or Billing & Financial Specialist.

3. **Patient Conduct & Responsibilities**. We promote safe and healthy environments for our patients, providers and staff. Please refer to our handout for more detail regarding Patient Conduct & Responsibilities.
    a. We expect everyone to be considerate and respectful to healthcare providers and staff as well as other patients; abusive or and aggressive behavior will not be tolerated.
    b. Due to patients and staff with allergies and sensitivities, we kindly ask that you abide by CMC's Scent-sitive Free Zone and not wear perfumes, essential oils or heavily scented products

4. **Arrival and Checking In.** Please complete all forms emailed to you in our email packet, or arrive 20-40 minutes prior to your appointment to ensure all new admittance paperwork has been properly completed.
    a. Returning patients should arrive approximately 5-10 minutes prior to their appointment to check in.
    b. If you have not arrived in time for your appointment, we may call you to inquire about your arrival.
        i. Depending on if and when you are able to arrive for the appointment or procedure, you will be told if the clinic is still able to accommodate you.
        ii. Late arrivals may be subject to the cancellation policy and fees outlined below.

5. **Missed appointments & Last Minute Cancellations/Modifications.** If you must cancel or modify your appointment, we ask that you provide at least 48-hours notice. This will allow our clinic to schedule wait-listed patients.
    a. Blood draws, vaccines and other lab appointments (excluding IVs) cancelled or modified with less than 48 hours notification will be subject to a $20.00 cancellation fee.
    b. IVs cancelled or modified with less than 48 hours notification will be subject to a $35.00 cancellation fee.
    c. Office appointments cancelled or modified with less than 48 hours notification will be subject to a $50.00 cancellation fee.
    d. Procedures cancelled or modified with less than 48 hours notification, will be subject to a $150.00 cancellation fee.
    e. Patients who miss two (2) or more appointments/procedures in a six (6) month period, may be dismissed from the practice and thus denied any future appointments.
    f. If our office is unable to collect payment the day of a missed appointment or last minute cancellation/modification, the applicable fees will be applied to your account.
    g. These charges are the sole responsibility of the patient, must be paid in full before the patient's next appointment and/or may be subject to the non-payment policy outlined above.
    Questions about cancellation/modification and missed appointment fees should be directed to our clinic manager at 503-252-8125 or by emailing officemanager@canyonmedcenter.com.

6. **Phone consults.** Phone calls will be subject to charges based on the duration of the call and will be billed accordingly.

7. **Email.** Emails sent to Canyon Medical Center are not encrypted and hence are not HIPPA compliant. Discussions about medical issues are best addressed in an office visit.
    a. Emails addressing a new complaint or medication will be billed accordingly.
    b. Correspondence involving a new complaint will, in most instances, require an office visit.
8. **Prescriptions.** For the safety and well being of our patients, requests for **new medications (including antibiotics)** will not be taken over the phone or over the Internet**. An appointment and evaluation by the physician is required, and associated charges will apply**.
    a. Refills must be requested through your pharmacy and will not be filled by phone, text message or email.
    b. Please **allow 72 hours for all requests to be refilled**.

9. **Lab tests.** Drop in appointments will not be accommodated; please schedule all injections, IVs and blood draws.
    a. Before leaving, schedule your follow up appointment to review results
    b. Results are typically discussed during a scheduled office visit or by phone. Your doctor will decide which is appropriate.
    c. Medical Assistants and other clinic staff cannot give you results without approval from a doctor.

10. **Forms/Authorizations/Letters:** allow 10 working days for the completion of any forms, prior authorizations, or letters. Charges may apply for forms requiring an office visit to be completed.
    a. There is a **$10 flat fee for any form, authorization or letter completion, including FMLA and other leave of absence** forms. This amount is per individual form requested and is due at the time the forms are submitted to our office.
    b. We do not charge for prior authorizations or medical excuse notes.

11. **Records release.** Your medical records are strictly confidential. The Health Information Portability and Accountability Act (HIPAA) restricts us from releasing any information without your written permission.
    a. By law, Canyon Medical Center has 30 days to process a medical record request.
    b. A $35.00 expedite fee will be charged for requests to process within 7 business days
    c. **Other media is priced at the cost it takes to replicate, as applicable.**

12. **After hours care.** As a courtesy, we have an on-call pager for **established patients**. To reach the on call doctor, call the clinic at 503-252-8125 and press option 9. This service is for **after-hour emergency services only**.
    a. Calls to this number for non-urgent concerns such as general inquiries, medication refill requests, and to cancel, modify or make an appointment will likely result in a fee.

Canyon Medical Center

Statement of Financial Responsibility
Canyon Medical Center requests all patients sign a Statement of Financial Responsibility:

i. **Financial options are extended to our patients based on the information provided.**
ii. **It is the patient's responsibility to be aware of their in-network providers, coverage and co-pay, as well as any deductible and maximum allowed benefit.**
iii. **If a patient has not run a Verification of Benefits and chooses to see a doctor or receive treatment that ends up processing as out of network, the patient assumes full responsibility for the balance due.**
iv. **If after 90 days Canyon Medical Center has not received payment from the insurance company, the patient is responsible for the account balance.**
v. **Canyon Medical Center does not bill Out of Network Benefits.** Should your benefits happen to process as Out of Network, we will discontinue billing your insurance; you will still be responsible for any patient portion remaining.
vi. **Non-Covered Services.** Medical insurance is a contract between the insurance company and the patient. Patients acknowledge that they are financially responsible for all charges and agree to any additional charges or remaining patient portion, should their benefits and claims vary, are not covered or are not deemed reasonable or necessary by Medicaid or other insurers.
    1. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

ASSIGNMENT OF INSURANCE BENEFITS & VERIFICATION ACKNOWLEDGEMENT I, the patient, acknowledge that the insurance coverage information is valid and correct. I understand that benefit verification is not a guarantee of coverage by my insurance company, and that I am financially responsible for all services rendered to me by Canyon Medical Center (CMC). I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to CMC. A photocopy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

I have read and understand Canyon Medical Center's Patient Policies & Procedures and agree to abide by its guidelines. Additionally, I hereby authorize Canyon Medical Center to release information necessary to secure payment. I have fully read and understand the above agreements and authorizations.

_____

Print Name Patient (18 years or older) **Date**

_____

Sign Name Patient (18 years or older) **Date**

_____

Print Name Parent/Guardian/Responsible Party **Date**

_____

Sign Name Parent/Guardian/Responsible Party **Date**

EMAIL/TEXT CONSENT FORM

Before sending e-mail/text communications to Canyon Medical Center ("CMC") Providers and clinic, please read and agree to the following information regarding the risks and conditions of e-mail/text use:

RISKS ASSOCIATED WITH USING E-MAIL/TEXT
CMC offers patients the opportunity to communicate by e-mail/text. However, transmitting patient information by e-mail/text has a number of risks that should be considered. These include, and are not limited to, the following risks:

- E-mail/text can be circulated, forwarded, and stored in numerous paper and electronic files.
- E-mail/text can be immediately broadcast worldwide and be received by many intended and unintended recipients.
- E-mail/text senders can easily misaddress an e-mail/text.
- E-mail/text is easier to falsify than handwritten or signed documents.
- Backup copies of e-mail/text may exist even after sender or recipients have deleted their copy.
- Employers and on-line services have a right to archive and inspect e-mails/texts transmitted through their systems.
- E-mail/text can be intercepted, altered, forwarded, or used without authorization or detection.
- E-mail/text can be used as evidence in court.

CONDITIONS FOR THE USE OF E-MAIL/TEXT CMC will use reasonable means to protect the security and confidentiality of e-mail/text information sent and received. However, because of the risks outlined above, CMC cannot guarantee the security and confidentiality of e-mail/text communication, and will not be liable for improper disclosure of confidential information that is not caused by CMC's intentional misconduct. Thus, individuals must consent to the use of e-mail/text communication. Consent to the use of e-mail/text includes agreement with the following conditions:

- Although CMC will endeavor to read and respond properly to an e-mail/text, CMC cannot guarantee that any particular e-mail/text will be read and responded to within any particular period of time. Thus, no one shall use e-mail for medical emergencies or other time- sensitive matters. Please call 911 for emergencies and go to the nearest urgent care or immediate care center for urgent matters.
- All e-mails/texts sent to providers must be sent to their respective e-mail/text addresses.
- Providers will likewise respond to all patient e-mails/texts from their respective e-mail/text address.
- All Emails/Text to or from CMC patients concerning diagnosis or treatment will be printed out and, at the Provider's discretion, may be made a part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical records, such as a staff or billing personnel, will have access to those e-mails/texts.
- CMC may forward e-mails/texts internally to the practice's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. CMC will not, however, forward e- mails/texts to independent third parties without the patient's prior written consent, except as authorized or required by law.
- If the individual's e-mail/text required or invites a response from CMC, and the individual has not received a response in a timely manner or within a business week, it is the individual's responsibility to follow up by telephone to determine whether the intended recipient received the e-mail/text and when the recipient will respond.
- Individuals should not use e-mail/text communication regarding sensitive medical information such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse.
- Individuals are responsible for informing CMC of any types of information that they desire not to be sent by e-mail/text, in addition to those called out in the above paragraph.
- The individual is responsible for protecting his/her password or other means of access to email/text. CMC is not liable for breaches of confidentiality caused by the individual or any third party.
- CMC shall not engage in e-mail/text communication that is unlawfully practicing medicine across state lines.
- It is the individual's responsibility to follow up and/or schedule an appointment if warranted.

COMMUNICATION BY E-MAIL/TEXT To communicate by e-mail/text, patients shall:

- Limit or avoid the use of his/her employer's computer.
- Inform CMC of changes in his/her e-mail/text address.
- Put the patient's name in the body of the e-mail/text.
- Review the e-mail/text to make sure it is clear and that all relevant information is provided before sending to CMC.
- Take precautions to preserve the confidentiality of e-mail/text, such as using screen savers and safeguarding his/her computer password.
- Withdraw consent only by written communication to CMC.

EMAIL/TEXT CONSENT FORM

ACKNOWLEDGEMENT & AGREEMENT ***I understand and acknowledge that I have read and fully understood this consent form. I request and consent to Canyon Medical Center ("CMC") using e-mail/text to communicate with me at the e-mail address(es)/telephone number(s) that I provide and I understand that such communications may contain my protected health information, including health history, diagnosis and treatment information and demographic information. I understand the risks associated with e-mail/text communication between CMC and me, and consent to the conditions outlined above. In addition, I agree to the instructions for communication by e-mail/text outlined here, as well as any other instructions that CMC may impose to e-mail/text communications. I understand and acknowledge that I have the right to withdraw my consent in writing at any time and that this authorization shall remain in effect until I withdraw my consent. Furthermore, I understand that CMC may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization.***

Name of Patient	**Signature**	**Date**

Name of Guardian/Guarantor	**Signature**	**Date**

This section to be completed by Canyon Medical Center if unable to obtain written acknowledgement from patient

I made a good faith effort to obtain a written acknowledgement of receipt of the Email & Text Consent Form from the above-named patient, but was unable to because:

- ☐ Patient declined to sign the Written Acknowledgement
- ☐ Other (please specify):

Name & Title of Employee	**Signature**	**Date**

Canyon Medical Center

CONSENT TO DISCLOSE MEDICAL INFORMATION

Patient Name (Please Print): _____ DOB: _____

Authorized Individuals:

Full Name _____ Relationship to Patient _____

Full Name _____ Relationship to Patient _____

Full Name _____ Relationship to Patient _____

Full Name _____ Relationship to Patient _____

Full Name _____ Relationship to Patient _____

I HAVE AGREED TO LET CERTAIN INDIVIDUALS PARTICIPATE IN DISCUSSIONS AND DECISIONS RELATED TO MY MEDICAL CARE. THEREFORE, I HEREBY GIVE MY PERMISSION FOR CANYON MEDICAL CENTER TO DISCLOSE MY PERSONAL MEDICAL INFORMATION TO THE INDIVIDUAL(S) LISTED ABOVE.

PLEASE INITIAL DISCLOSURE BELOW:

- ☐ CANYON MEDICAL CENTER MAY DISCLOSE MY MEDICAL INFORMATION TO THE INDIVIDUAL(S) LISTED WHEN I AM NOT PHYSICALLY PRESENT, INCLUDING DISCLOSURES BY TELEPHONE, FACSIMILE, E-MAIL OR REGULAR MAIL
- ☐ REFILL/PICK-UP MEDICATIONS
- ☐ CALL FOR MEDICAL ADVICE
- ☐ SCHEDULE/CANCEL APPOINTMENTS
- ☐ PICK-UP COMPLETED FORMS

(CANYON MEDICAL CENTER WILL NOT DISCLOSE CONFIDENTIAL INFORMATION UNLESS MEDICALLY NECESSARY)

PLEASE INITIAL BELOW TO AUTHORIZE THE RELEASE OF THE FOLLOWING INFORMATION:

- ☐ ALCOHOL/DRUG ABUSE EVALUATION/TREATMENT
- ☐ HIV/AIDS/STD EVALUATION/TREATMENT
- ☐ PSYCHIATRIC/MENTAL HEALTH EVALUATION/TREATMENT

- ☐ **I REFUSE DISCLOSURE TO ANY AND ALL PARTIES**

I UNDERSTAND THAT THIS CONSENT MAY BE REVOKED BY ME AT ANY TIME BY WRITTEN NOTICE TO CANYON MEDICAL CENTER.

Patient Signature: _____ **Date:** _____

Canyon Medical Center

HIPAA NOTICE of PRIVACY PRACTICES

The Heath Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

The notice provides information about how we may use and disclose protected health information about you in order to carry out treatment, payment and healthcare operations, and for other purposes permitted or required by law. The notice also contains information about your rights under the law.

Additional information is available from the U.S Department of Health and Human Services. A copy of the Notice of Privacy Practices is available upon request.

- I have the right to
  - request restrictions to the usage and disclosure of my protected health information under certain circumstances and must do so in writing.
  - revoke this consent at any time, which must be done in writing. Canyon Medical Center may honor these requests, but are not required by law to do so. Revocations will be honored as of the date they are received by Canyon Medical Center.
  - opt out of fundraising communications.
  - be notified of a breach of unsecured Protected Health Information.
- I understand that
  - authorization is required for certain disclosures of my Protected Health Information.
  - Canyon Medical Center reserves the right to change the terms of their Notice of Privacy Practices provisions effective for all protected health information that they maintain. In the event of amendments, Canyon Medical Center will make a revised Notice of Privacy Practice available for my review upon request.
  - Canyon Medical Center may condition treatment upon the execution of this consent.

I have read and understand the HIPAA Notice of Privacy Practices and hereby consent to the use and disclosure of my protected health information by Canyon Medical Center for the purposes of treatment, payment and healthcare operations, or as otherwise required by law.

Name of Patient	**Signature**	**Date**

Name of Guardian/Guarantor	**Signature**	**Date**

This section to be completed by Canyon Medical Center if unable to obtain written acknowledgement from patient

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

- ☐ Patient declined to sign the Written Acknowledgement
- ☐ Other (please specify):

Name & Title of Employee **Signature** **Date**

INFORMED CONSENT for TREATMENT

Please read and sign the following in order to completely understand the risks and benefits of Naturopathic Care:

I _____, hereby authorize Canyon Medical Center to perform the following specific procedures as necessary to facilitate my healthcare:

- Common diagnostic procedures: e.g. laboratory, physical exam
- Medicinal use of nutrition: therapeutic nutrition, nutritional supplementation.
- Botanical medicine: botanical substances may be prescribed as teas, alcoholic tinctures, capsules, tablets, crèmes, plasters, or suppositories.
- Homeopathic medicine: the use of highly dilute quantities of naturally occurring plants, animals and minerals to gently stimulate the body's healing responses.
- Lifestyle counseling and hygiene: diet therapy, promotion of wellness including recommendations for exercise, sleep, stress reduction and balancing of work and social activities.
- Acupuncture, moxibustion and Chinese herbal therapy
- Emotional Freedom Technique
- Craniosacral Therapy
- Therapeutic Massage
- Hydrotherapy
- Psychological Counseling

I recognize the potential risks and benefits of the procedures as described below:

- **Potential risks:** allergic reactions to prescribed herbs, supplements and medications, side effects of natural medication, inconvenience of lifestyle changes, emotional release, emotional distress, healing crisis.
- **Potential benefits:** restoration of health and body's maximal functional capacity and optimal wellness, relief of pain and symptoms of disease, assistance in injury and disease recovery, and prevention of disease or its progression.
- **Notice to Pregnant women:** All female patients must alert the doctor if they know or suspect that they are pregnant. Some of the therapies used could present a risk to the pregnancy.

I understand that my provider, to the best of their ability, will answer any questions I have. I realize that I play an integral role in my healing process and in order to produce results I must take responsibility for my health. By making this appointment for a visit with a provider at this medical office I am making an investment in my health.

I understand that I am expected to have a local primary care physician if I am conducting my appointments with my Canyon Medical Center practitioner(s) by phone, Skype, or any other electronic means.

By signing below I give my consent for treatment at the discretion of my healthcare provider and agree to pay for services rendered at time of treatment.

_____ _____

Patient Signature Date

PATIENT NAME:

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 state and federal law, and not by a lawsuit or resort to court process except as state and federal 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 of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

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 thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. 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, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that 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 state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

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 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 legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as the date of first professional services.

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.

(Date)

PATIENT SIGNATURE **X**

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE **X**

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