242 Rt 79, Suite11, Morganville, NJ 07751

AcuMeridian Wellness, LLC
Carrie M. Koo L.Ac.
(732)858-1322

http://www.acumeridianwellness.com
CarrieKooLAc@gmail.com

Facial Rejuvenation Acupuncture - Initial Visit

Name Last _____First _____ Middle _____ SS# ___ /__ /____

Date of Birth_____ /_____ /_____ **Gender** F ____M _____ **Email**_____

Address _____City _____

State_____ Zip Code_____

Telephone: Home (_____) _____ - _____ Work (_____) _____ - _____ Ext _____

Marital Status: S ☐ M ☐ D ☐ Other:_____ **Occupation** _____

Height _____ **Weight** _____ **Blood Pressure**_____**Pulse**_____

Have you ever had an acupuncture facial? Y ☐ N ☐

Have you been treated by Acupuncture or Oriental medicine before? Y ☐ N ☐

Name of your physician _____Phone _____

In an Emergency Notify: Name _____ Relationship to patient _____

Home Phone (_____)_____ - _____ Cell Phone (_____) _____ - _____Work Phone (_____) _____ - _____

FINANCIAL AGREEMENT

Payment for Clinic Services Rendered: Payment is **due at the time of service** and may be paid by cash, check or all major credit cards. Any checks returned due to insufficient funds will be charged an additional $30.

Cancellation Policy:
Please be respectful of the time set aside for your treatment. All scheduled appointments require a 24 hour cancellation notice or the patient will be charged for a FULL office visit fee.

Herbal Prescriptions:
I understand that **all herb sales are final** as herbal prescriptions are intended only for the patient for whom they have been prescribed.

By signing this agreement, I am acknowledging that I have read the above financial policies and will be responsible for all charges stated above.

Patient's Signature _____ **Date**_____

MEDICAL HISTORY
Past and Present Illnesses(with dates):

_____

Surgeries(with dates):

_____

Significant Trauma (Auto accidents, falls, etc., with dates) :

_____

Do you have, or have you ever had, any **Infectious Diseases**? Yes ☐ No ☐ If so, please describe:

_____

CURRENT MEDICATIONS: (prescription and over-the-counter drugs, vitamins, herbs, etc.)

_____

_____

ALLERGIES:

_____

Do you bruise or bleed easily? Yes ☐ No☐

PERSONAL HISTORY

Hobbies & Recreational Habits _____

Do you have a regular exercise program? Yes ☐ No ☐ If so, please describe:

_____

Smoking? Yes ☐ No ☐ Alcohol? Yes ☐ No ☐

PLEAE CHECK IF YOU HAVE EXPERIENCED (IN THE LAST SIX MONTHS)

☐ Fevers ☐ Chills ☐ Poor Appetite ☐ Night Sweats ☐ Day Sweating ☐ Bleeding or Bruising

☐ Fatigue ☐ Sudden energy drops? What time of Day? _____

☐ Poor Sleep/Insomnia ☐ Dream Disturbed Sleep ☐ Emotional Changes ☐ Mania

☐ Weight Loss ☐ Weight Gain ☐ Strong thirst for Hot or Cold drinks?

☐ Joint Pain ☐ Localized Weakness ☐ Poor Balance

NEUROPSYCHOLOGICAL

☐ Seizures ☐ Areas of Numbness ☐ Anxiety ☐ Concussion ☐ Lack of Coordination ☐ Poor Memory

☐ Dizziness ☐ Loss of Balance ☐ Easily Angered ☐ Headaches ☐ Fainting ☐ Depression/Bipolar

☐ Migraines ☐ Disorientation ☐ Mania ☐ Easily Susceptible to Stress

PREGNANCY & GYNECOLOGY

☐ Period between Menses ☐Birth Control ☐ Duration of Menses _____ ☐ Painful Periods ☐ Irregular Periods

☐ Heavy or ☐ Light Periods ☐Clots ☐ Vaginal Discharge ☐Breast Lumps ☐ PMS ☐ Currently Pregnant

First Date of Last Menstrual Cycle _____/_____/_____

CARDIOVASCULAR

☐ High blood pressure ☐ Dizziness ☐ Swelling of Hands ☐ Blood Clots ☐ Irregular heartbeat ☐ Fainting

☐ Difficulty in Breathing ☐ Palpitations ☐ Low blood pressure ☐ Cold Sweats ☐ Cold Hands/Feet

☐ Chest pain ☐ Swelling of Feet

RESPIRATORY

☐ Cough ☐ Pain w/ Deep Breaths ☐ Difficulty in Breathing ☐ Asthma ☐ Bronchitis ☐ Shortness of Breath

GASTROINTESTINAL

☐ Nausea ☐ Abdominal Pain/ Cramps ☐ Digestive Disorders ☐ Vomiting ☐ Constipation ☐ Indigestion

GENITO-URINARY

☐ Pain on Urination ☐ Frequent Urination ☐ Waking up to Urinate ☐ Unable to Hold Urine

INFORMED CONSENT FOR FACIAL REJUVENATION ACUPUNCTURE
(Facial Acupuncture Treatment)

INSTRUCTIONS

This is an informed consent document that has been prepared to help your acupuncturist inform you concerning facial acupuncture treatments, the risks involved, and possible alternatives. Please be advised that this is not a surgical procedure.
It is important that you read this information carefully and completely. Please initial each page, indicating that you have read the page and sign the consent for facial acupuncture treatments, as proposed by your acupuncturist.

INTRODUCTION

A facial acupuncture treatment involves the insertion of acupuncture needles into fine lines and wrinkles on the face and neck in order to reduce the visible signs of aging. In Oriental medicine, the meridians or pathways of Qi (energy) flow throughout the entire body from the soles of the feet up to the face and head; consequently, a facial acupuncture treatment addresses the entire body constitutionally, and is not merely "cosmetic."
A facial acupuncture treatment involves the patient in an organic, gradual process, that is customized for each individual. It is no way analogous to, or a substitute for, a surgical "face lift". A treatment session may confine itself solely to facial acupuncture, or it may be used in conjunction with other procedures.

BENEFITS

Facial acupuncture can increase facial tone, decrease puffiness around the eyes, as well as bring more firmness to sagging skin, enhance the radiance of the complexion, and flesh out sunken areas. Customarily, fine wrinkles will disappear, and deeper ones be reduced. As this treatment is not merely confined to the face, but incorporates the entire body and constitutional issues of health.

ALTERNATIVE TREATMENT

Improvement of sagging skin, wrinkles and fatty deposits may be attempted by other treatments or surgery such as a surgical facelift, chemical face peels, or liposuction. Risk and potential complications are associated with these alternative forms of treatment.

RISKS OF A FACIAL ACUPUNCTURE TREATMENT

Every procedure involves a certain amount of risk and it is important that you understand the risks involved with a facial acupuncture treatment. An individual's choice to undergo a facial acupuncture is based upon the comparison of the risk to potential benefit. Although the majority of patients do not experience the following complications, you should discuss each of them with your acupuncturist to make sure you understand the risks, potential complications, and consequences of a facial acupuncture treatment.

BLEEDING

It is possible, though very unusual, that you may have problems with bleeding during a facial acupuncture treatment. Should post-acupuncture bleeding occur, it will usually only consist of a few drops. Accumulations of blood under the skin may cause a bruise, or hematoma, which will resolve itself.

INFECTION

Infection is very unusual after a facial acupuncture treatment. Should an infection occur, additional treatment, including antibiotics, may be necessary.

DAMAGE TO DEEPER STRUCTURES

Deeper structures such as blood vessels and muscles are rarely damaged during the course of a facial acupuncture treatment. If this does occur, the injury may be temporary or permanent.

ASYMMETRY

The human face is normally asymmetrical. Thus, there can be a variation from one side to the other in the results attained from a facial acupuncture treatment.

BRUISING AND PUFFINESS

There is a possibility of bruising (hematomas), puffiness, blood, tingling, itching, warmth, pain or other symptoms at the site of the needle.

NERVE INJURY

Injuries to the motor or sensory nerves rarely result from facial acupuncture treatments. Nerve injuries may cause temporary or permanent loss of facial movements and feeling. Such injuries may improve over time. Injury to sensory nerves of the face, neck and ear regions may cause temporary or more rarely permanent numbness. Painful nerve scarring is very rare.

NEEDLE SHOCK

Needle shock is a rare complication after a facial acupuncture treatment.

UNSATISFACTORY RESULT

There is the possibility of a poor result from a facial acupuncture treatment. You may be disappointed with the results

ALLERGIC REACTIONS

In rare cases, local allergies to topical preparations have been reported. Systemic reactions, which are more serious may occur to herbs used during an acupuncture facial. Allergic reactions may require additional treatment.

DELAYED HEALING

Delayed wound heating or wound disruption is a rare complication experienced by patients in the aftermath of an acupuncture facial. There is a greater risk for smokers, who frequently have dry, sagging skin, which does not heal as readily as that of non-smokers.

LONG TERM EFFECTS

Subsequent alterations in facial appearance may occur as the result of the normal process of aging, weight loss or gain, sun exposure, or other circumstances not related to a acupuncture facial. An acupuncture facial does not arrest the aging process or produce permanent tightening of the face and neck. Future facial acupuncture maintenance treatments, or other treatments, may be necessary to maintain the results of an acupuncture facial.

HEALTH INSURANCE

Most health insurance companies exclude coverage for an acupuncture facial and/or any complications that might occur from an acupuncture facial. Please carefully review your health insurance subscriber information pamphlet.

ADDITIONAL CARE NECESSARY

There are many variable conditions in addition to risk and potential complications that may influence the long term result from acupuncture facial treatments. Even though risks and complications occur infrequently, the risks cited are the ones that are particularly associated with an acupuncture facial treatment. Other complications and risks can occur but are even more uncommon. Should complications occur, other treatments may be necessary. The practice of acupuncture is not an exact science. Although good results are expected, there is no guarantee or warranty, either expressed or implied, on the results that may be obtained.

FINANCIAL RESPONSIBILMES

The cost of an acupuncture facial involves several charges for the services provided. The total includes fees charged by your acupuncturist, the cost of acupuncture supplies, and topical preparations. Depending on whether the cost of your acupuncture facial is covered by an insurance plan, you will be responsible for necessary co-payments, deductibles, and charges not covered.

DISCLAIMER

Informed-consent documents are used to communicate information about the proposed procedure along with disclosure of risks and alternative forms of treatment(s). The informed consent process attempts to define principles of risk disclosure that should generally meet the needs of most patients in most circumstances.

However, informed consent documents should not be considered all-inclusive in defining other methods of care and risks encountered. Your acupuncturist may provide you with additional or different information which is based upon all the facts in your particular case and the present state of knowledge within the field of acupuncture. Informed consent documents are not intended to define or serve as the standard of acupuncture. Standards of acupuncture are determined on the basis of all of the facts involved in an individual case and are subject to change as scientific knowledge and technology advance and as practice patterns evolve.

It is important that you read the above information carefully and have all of your questions answered before signing the consent on the next page.

CONSENT FOR FACIAL ACUPUNCTURE TREATMENT OR PROCEDURE

1. I hereby authorize _____ and such assistants as may be selected to perform facial acupuncture treatment(s). I have received the following information sheet:

INFORMED CONSENT FOR FACIAL REJUVENATION ACUPUNCTURE

2. I recognize that during the course of the acupuncture facial, unforeseen conditions may necessitate different procedures than those above. I therefore authorize the above acupuncturist and assistants or designees to perform such other procedures that are in the exercise of his or her professional judgment necessary and desirable. The authority granted under this paragraph shall include all conditions that require treatment and are not known to my acupuncturist at the time the procedure is begun.
3. I acknowledge that no guarantee has been given by anyone as to the results that may be obtained.
4. I authorize the release of my Social Security number to appropriate agencies for legal reporting and medical device registration, if applicable.
5. IT HAS BEEN EXPLAINED TO ME IN A WAY THAT I UNDERSTAND:
    a. THE ABOVE TREATMENT OR EXPOSURE TO BE UNDERTAKEN
    b. THERE MAY BE ALTERNATIVE PROCEDURES OR METHODS OF TREATMENT
    c. THERE ARE RISKS TO THE PROCEDURE OR TREATMENT PROPOSED

I CONSENT TO THE TREATMENT OR PROCEDURE AND THE ABOVE LISTED ITEMS (1-5). I AM SATISFIED WITH THE EXPLANATION.

_____

Patient's Name (Please print)

_____ _____

Patient's Signature Date

_____ _____

Practitioner's Signature Date

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Facial Rejuvenation Acupuncture Registration

This questionnaire provides valuable information to help us understand the underlying causes of your health concerns. All information contained in this form is strictly confidential and will become part of your medical record on file.

PATIENT NAME: _____ **Date:** _____

SKIN CARE HISTORY

1. Please check any of the following which are of most concern to you:

- ☐ Bags/swelling under eyes
- ☐ Wrinkles
  - ☐ Nasolabial (nose to mouth)
  - ☐ Eyes (crow's-feet)
  - ☐ Lips
  - ☐ Other: _____
- ☐ Lusterless skin
- ☐ Sagging face
- ☐ Droopy eyelids
- ☐ Double chin
- ☐ Acne
- ☐ Rosacea
- ☐ Oily skin
- ☐ Broken capillaries
- ☐ Vertical creases / furrows
- ☐ Premature graying of hair
- ☐ Sun damage
- ☐ Acne scarring
- ☐ Large pores
- ☐ Dry skin
- ☐ Protruding temporal veins

☐ Other skin conditions/issues:
_____

2. Do you wear makeup daily? ☐Yes ☐No Do you wear sunscreen daily? ☐Yes ☐No

3. Please describe your current skin care regimen and products that you use. (Toner, astringent, exfoliation, masks, etc.): _____
_____

4. Please describe any skin sensitivities or allergies:_____
_____

5. What improvements would you like to see? _____
_____

6. Do you go to tanning booths? ☐Yes ☐No

7. Do you participate in vigorous aerobic activity or sport? ☐Yes ☐No

8. Do you get facial waxing/electrolysis or use depilatories? ☐Yes ☐ No If yes, wait 5 days between treatments

9. Please check all procedures you have had or are currently undergoing.

☐ Botox injections	Date(s): _____	☐ Laser procedures	Date(s): _____
☐ Collagen injections	Date(s): _____	☐ Threading (Lift)	Date(s): _____
☐ Restalyne	Date(s): _____	☐ Rhytidectomy	Date(s): _____
☐ Silicon injections	Date(s): _____	☐ Blepharoplasty	Date(s): _____
☐ Mesotherapy	Date(s): _____	☐ Brow or Coronal lift	Date(s): _____
☐ Microdermabrasion	Date(s): _____	☐Other: _____	Date(s): _____
☐ Chemical peels	Date(s): _____		

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Privacy Notice

This Notice together with our Practices Regarding Disclosure of Health Information, describe how health information about you may be used and disclosed. They also describe how you can gain access to your health information. **Please review this information carefully.**

Understanding Your Health Record:

A record is made each time you visit our office for treatment. This record includes symptoms, clinician observations, diagnosis and treatment. The record may also contain other pertinent information provided by you or another of your health care practitioners with whom we may have spoken.

Your Health Information Rights:

Your health record is owned by the clinic, however, the content is always available to you for your review. You have the right to request a review of you file and to obtain copies of documents contained in your file. You also have the right to request that amendments be made to your record. In addition, you may request that the use of your information be restricted from certain uses and disclosures and to request a list of individuals or entities to whom your information has been disclosed. You may revoke any authorizations you have given regarding disclosure of your health information at any time. This revocation must be provided to us, in writing.

Our Responsibilities:

We are required to maintain the privacy of your health information and to provide you with a copy of this notice of our privacy practices. We will follow the terms of this notice and advise you if we are unable to comply with a request you may make regarding the use of your health information. We reserve the right to amend our privacy policies and we use our best efforts to notify you of any such amendments. Other than for reasons stated in this notice, we will not use or disclose your health information without your consent.

I, _____, have received a copy of this notice of

privacy practices and a copy of the Practices Regarding Disclosure of Patient Health Information. I understand my health information will be used and disclosed consistent with these notices.

Patient name: _____ (Please print)

Patient/Guardian Signature: _____

Date: _____

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Standard and Practices

Privacy of Patient Information

Date:

Standard

AcuMeridian Wellness is committed to treating all of its patients with appropriate care and respect. Information which our patients provide to use in connection with their treatment, Protected Health Information (PHI), is subject to standards of security and confidentiality as defined under Federal Law, the Health Information Portability and Accountability Act (HIPAA). These standards and Practices set forth our procedures to insure compliance with the requirements of HIPAA.

Practices

1. Written or electronic files containing PHI must be stored in secure facilities. Written files will be maintained in locked file cabinets and electronic files will be stored in secure databases only accessible through password protected codes. Computer screens will be positioned so that they are not viewable by persons other than our personnel authorized to access that information. All personnel shall use discretion when discussing PHI in conversations.

2. A Notice of Privacy Practices together with the statement of Practices Regarding Disclosure of PHI will be provided to all patients at the time of their initial visit. All patients will be requested to sign a statement acknowledging receipt of this information. The acknowledgement will be kept on file for 6 years.

3. Patients will be requested to advise us whether we may contact them by phone or in writing regarding their care. It is our practice to call to remind patients of their appointments and to send billing and relating information to patients homes.

4. PHI may be routinely be used for treatment, billing, payment and quality control purposes. PHI may also be used without the patients consent for the following purposes:

    a. Uses and disclosures required by law
    b. Uses and disclosures for public health activities
    c. Disclosures about victims of abuse, neglect or domestic violence
    d. Disclosures for judicial an administrative proceedings
    e. Disclosures for law enforcement purposes
    f. Uses and disclosures about decedents
    g. Uses and disclosures for cadaver or organ donation purposes
    h. Uses and disclosures to avert a serious threat to health or safety
    i. Disclosures for workers compensation
    j. Disclosures to a State Licensing Board or other professional oversight entity.

5. Patients have the right to request restrictions on the use of their PHI, although we are not always able to abide by such requests. All such requests must be submitted in writing on our Restriction Request Form. We will take all such requests under advisement and notify

the patient in writing of our determination. A copy of the determination will be maintained in our files. If the request is granted then it will be observed, except in the event of an emergency or in the event we terminate the agreement.

6. State law pertaining to parent/guardian authorization will apply in the case of a minor. When state law is silent, we reserve the right to use our professional judgment.

7. Non-routine requests for PHI will be reviewed in the normal course and may require specific patient authorization.

8. Patients may request an account of all PHI disclosures made by use in the prior six years. Such an accounting will not include disclosures:

   a. For treatment, payment and healthcare operations
   b. To the patient
   c. To persons involved in the patients care
   d. For national security or intelligence purposes
   e. To correctional institutions of law enforcement agencies
   f. Disclosures made prior to the enactment of HIPAA

In some instances PHI may be used once it has been stripped of all elements of personally identify information. Identifiers that may be stripped include:

a. Name
b. All address information
c. E-mail address
d. Dates (other than the year)
e. Social Security number
f. Medical Record numbers
g. Health Plan beneficiary numbers
h. Account numbers
i. Certificate numbers
j. License numbers
k. Vehicle identification numbers
l. Facial Photo's
m. Telephone numbers
n. Device Identifiers
o. URL's
p. IP addresses
q. Biometric Identifiers
r. Zip code, if the geographic unit includes less than 20,000 persons
s. Any other unique data which when used alone or in combination with other information might identify the individual who is the subject of the information

9. We are required to act on written requests for onsite review of PHI within thirty days of our receipt of the request. If copies are requested, we may charge a reasonable copying fee. Patients do not have the right to access:

   a. psychotherapy notes
   b. information relating to criminal, civil or administrative procedures
   c. PHI lawfully prohibited from release because it is subject to or exempted from Clinical Laboratory Improvements Amendments (CLIC)

d. Information created by someone other than us or given to use under a promise not to release.

10. Patients have a right to request amendments to their PHI. Requests to amend must be made in writing, clearly stating the requested amendment and the reason for the request. We will provide a written response within 60 days. If unamended information had previously been provided to third parties, we will undertake to advise any such person of the amendment. If the request is denied we will provide a written statement setting forth the basis for the denial.

11. Amendments Rights do not apply in the following circumstances:

    a. The information is not part of the patient file
    b. The information is accurate and complete
    c. The information was not created by us

12. We shall designate a person who shall be responsible for developing and implementing our HIPAA policies and procedures. This person shall also be responsible for training all staff in these policies and procedures. All employees will be required to sign an Employee Agreement Form acknowledging that they have been trained and that they understand their obligations. Employee infractions of HIPAA will result in discipline and may result in termination of employment. Similarly, any third party vendor who has access to PHI will be requirement to acknowledge that they are HIPAA compliant in all services provided to our business.

13. Any patient who exercises his/her rights under HIPAA shall not be adversely treated by us. The staff is expressly prohibited from intimidating, threatening, coercing, discriminating, or retaliating against any patient who exercises their HIPAA rights.

14. Any patient wishing to appeal as determination or to file a complaint regarding HIPAA should contact the Secretary of DHHS within 180 days of the alleged violation. All personnel shall fully cooperate with any resulting investigation. Complaints are to be filed:

Office for Civil Rights

U.S. Dept of Health and Human Services

200 Independence Ave, S.W.

Washington, D.C. 20201

HOTLINE 1-800-368-1019

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A Message to Our Patients About Arbitration

The attached contract 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 New Jersey courts.

By signing this agreement you are changing the place where your claim will be presented. You still can call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. This agreement generally helps to limit the legal costs for both patients and physicians. This is because the time to conduct an arbitration hearing is far less than for a jury trial. Further, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings.

Our goal, of course, is to provide you with quality medical care which fully meets your health care needs. We know that most problems begin with communication. Therefore, if you have any questions about your care, please contact us.

Answering Questions about Arbitration

Q. What is an arbitration agreement?

A. By signing an arbitration agreement, a patient and a healthcare practitioner agree to use a private, confidential, and expedited arbitration, rather than a public, lengthy and costly courtroom trial, to settle any future malpractice claims. In arbitration, a neutral arbitrator (quite often a retired judge) decides the case. By agreeing to arbitrate, the parties preserve their right to present their claims fully; however, they choose a specific forum for dispute resolution: an arbitration hearing rather than a judge or jury trial.

Q. Why does arbitration provide a speedier resolution than civil litigation?

A. With the huge backlog in our civil courts, there is often a three- to five-year wait for an available courtroom and judge. In arbitration, the wait is usually less than one year. In addition, simplified procedural rules used in arbitration hearings reduce the number of motions made by attorneys, so a decision can be expedited. That means less worry time for both the patient and health practitioner.

Q. Are arbitration agreements legal?

A. Yes. In an effort to improve the court system, the federal, and most state laws have been modified to incorporate arbitration as a standard system of dispute resolution. Our paperwork has been specifically designed and updated to meet these requirements.

Q. Is arbitration cheaper than a trial?

A. Yes. Attorney's fees in arbitration hearings are, on average, 60% less than in judge and jury trials. Thus, savings can be substantial, as attorneys' fees in a typical judge or jury trial range between $50,000 and $150,000.

Q. What if a patient won't sign an arbitration agreement?

A. While most patients sign willingly, some (statistically less than 1%) will refuse to sign and will go elsewhere for treatment. That may be to the health practitioner's advantage. That small minority of patients who won't sign is comprised of "professional plaintiffs" (people who make a living out of forcing settlements in nuisance suits) or patients who approach the doctor-patient relationship with the mind-set that they will file suit the minute they think anything has gone wrong.

Most patients see the mutual benefit of arbitration in time and cost savings. In addition, patients understand that a malpractice insurance company may require its insured health practitioners to use arbitration forms. Patients appreciate that such a practitioner really cares and has taken the proper business attitude of getting malpractice insurance in case that practitioner should inadvertently injure a patient. And, with arbitration rather than civil litigation, that injured patient won't have to wait five years to get a settlement or judgment.

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ARBITRATION ARGEEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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, as to whether this agreement is unconscionable, and any procedural disputes, 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, preceptors, or 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. This agreement is intended to create an open book account unless and until revoked.

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 of 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.

_____ _____

Patient's Name Signature of Patient or Guardian Date

_____

Practitioner's Signature Date