NEW PATIENT INTAKE FORM

Name: _____ Age: _____

Date of Birth :_____ Location of Birth: _____ Time of Birth: _____

Address: _____

City:_____ State:_____ Zip:_____

Phone: DAYTIME:_____ EVENING:_____ Message OK? Y ☐ N ☐

Email: _____ Preferred Method of Communication: _____

What gender do you identify as? FEMALE ☐ MALE ☐ OTHER ☐ (please specify) _____

Marital Status: MARRIED ☐ PARTNERED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED ☐

Housing: SPOUSE / PARTNER ☐ PARENTS ☐ CHILDREN ☐ FRIEND / ROOMATE(S) ☐ ALONE ☐

Occupation: _____ Hours per week: _____ Retired: Y ☐ N ☐

Emergency Contact:_____ Relationship:_____

Phone:_____ Email: _____

Who referred you to Flourish of Life Medicine? _____

PLEASE NOTE

* Payment is expected at the time of service.

* You are responsible for billing your primary insurance company.

* We will provide an itemized superbill for your services and treatments.

HEALTH HISTORY

Please complete this questionnaire as thoroughly as possible.

What is the main purpose of your visit to Flourish of Life Medicine? _____

_____

Are you currently being treated by any other healthcare provider(s) for this condition? Y ☐ N ☐

› If yes, please list. _____

_____

› If no, when and where did you last receive healthcare? _____

_____

› Did your condition resolve or is it ongoing? _____

_____

What are your other major health concerns?

1. _____
2. _____
3. _____
4. _____
5. _____

What are treatments you have received for these conditions? (check all that apply)

ACUPUNCTURE ☐ CHIROPRACTIC ☐ HOMEOPATHIC ☐ CONVENTIONAL / MD ☐ MASSAGE ☐
NATUROPATHIC ☐ OSTEOPATHY ☐ SHIATSU ☐ OTHER ☐ / PLEASE SPECIFY _____

What are your short and long-term goals while you are receiving care at Flourish of Life Medicine?

1. _____
2. _____
3. _____

Do you consider your health: Excellent ☐ Good ☐ Average ☐ Poor ☐

Do you currently have any contagious diseases? Y ☐ N ☐ If so, what? _____

Please list all medications, herbs, supplements, natural remedies, etc. that you are currently taking.

Medications	Dosage	Frequency

Supplements and Natural Remedies	Dosage	Frequency

ALLERGIES

Please list any hypersensitivities or allergies to:

Medications: _____

Foods: _____

Environmental Agents or Chemicals: _____

Herbs of Other Natural Remedies: _____

FAMILY HISTORY

Are any of the following diseases in your family lineage? If so, whom?

Please note other diseases not listed that you feel your practitioner should know about.

Cancer _____ Stroke _____

Heart Disease _____ Diabetes _____

Autoimmune Diseases _____ Asthma / Allergies _____

Mental Illnesses _____ Depression/Anxiety _____

Epilepsy _____ Obesity _____

Other _____

_____

LIFESTYLE. HABITS, AND ENVIRONMENT

Do you enjoy your work? Yes ☐ No ☐

›If no, why not? _____

Do you exercise? Yes ☐ No ☐ ›How Often? _____

› What kind of exercise or activity _____

Do you sleep well? Yes ☐ No ☐

› How many hours per night? _____ › Awaken feeling rested? Yes ☐ No ☐

What are your primary interests, creative activities, and hobbies? _____

_____

What activities do you use for stress relief or self care? _____

_____

Exposed to toxins? Yes ☐ No ☐ › If so, what and when? _____

_____

Tobacco use? Yes ☐ No ☐ › How much?_____ › How many years? _____

Alcohol use? Yes ☐ No ☐ › How much? _____ › How often? _____

Recreational substance use? Yes ☐ No ☐ › How much? _____ › How often? _____

› What kind(s)? _____

Are you happy with your substance habits, or wish to change them? _____

DIET AND NUTRITION

Do you follow a special diet? Yes ☐ No ☐ › If so, what is it? _____

› How long have you been on this diet? _____

What foods do you crave? _____

What is your daily water intake? _____

What other beverages do you drink regularly? (coffee, tea, alcohol, energy drinks, soda pop, etc.)

_____

› How much and how often? _____

Please complete this section with a typical day of food and beverage intake.

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

ABNORMAL LAB VALUES

High Blood Pressure Yes ☐ No ☐ Levels: _____ High Blood Sugar Yes ☐ No ☐ Levels: _____

Elevated Cholesterol Yes ☐ No ☐ Levels- LDL: _____ HDL: _____

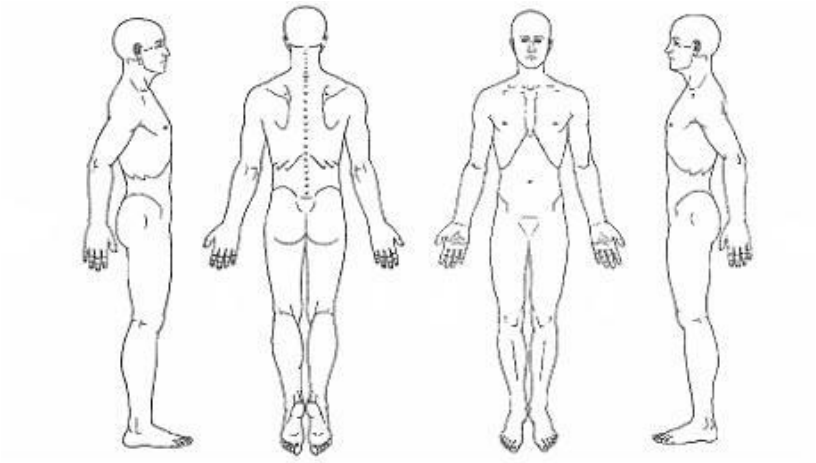
Liver Enzymes Yes ☐ No ☐ Levels: _____ Red Blood Cells Yes ☐ No ☐ Levels: _____

White Blood Cells Yes ☐ No ☐ Levels: _____ Thyroid Yes ☐ No ☐ Levels:_____

Urine Yes ☐ No ☐ Levels: _____ Other: _____

DISCOMFORT AND PAIN

If you experience discomfort or pain, please indicate location and severity on the chart below.



HISTORY OF TRAUMA, INJURIES AND HOSPITALIZATIONS

Please briefly describe any significant traumas, injuries, and/or hospitalizations with the age of occurrence to create a timeline of events.

Infancy: _____

_____

Childhood: _____

_____

_____

Adolescence: _____

_____

_____

Middle Age: _____

_____

_____

Elder Years: _____

_____

GENERAL REVIEW OF SYMPTOMS

Please check all that apply and complete any requested information. C = current, P = past

GENERAL	Weight gain C ☐ P ☐	Weight loss C ☐ P ☐	Night Sweats C ☐ P ☐
HEAD	Headaches C ☐ P ☐	H/A affecting vision C ☐ P ☐	H/A with nausea C ☐ P ☐
	Head injury C ☐ P ☐	Dizziness C ☐ P ☐	TMJ C ☐ P ☐
	Jaw Pain/Problems C ☐ P ☐		
EYES	Impaired vision C ☐ P ☐	Cataracts C ☐ P ☐	Glaucoma C ☐ P ☐
	Eye Pain C ☐ P ☐	Dryness C ☐ P ☐	Tearing C ☐ P ☐
EARS	Hearing loss C ☐ P ☐	Ear pain C ☐ P ☐	Ringing C ☐ P ☐
NOSE AND SINUSES		Frequent colds C ☐ P ☐	Sinus pain C ☐ P ☐
	Stuffiness C ☐ P ☐	Runny nose C ☐ P ☐	Nosebleeds C ☐ P ☐
	Loss of smell C ☐ P ☐		
MOUTH AND THROAT		Hoarseness C ☐ P ☐	Frequent sore throat C ☐ P ☐
	Jaw clenching C ☐ P ☐	Oral Herpes C ☐ P ☐	Sores on tongue C ☐ P ☐
	Teeth grinding C ☐ P ☐	Loss of Taste C ☐ P ☐	Trouble swallowing C ☐ P ☐
NECK	Swollen glands C ☐ P ☐	Lumps C ☐ P ☐	Stiffness C ☐ P ☐
	Pain C ☐ P ☐		
RESPIRATORY	Cough C ☐ P ☐	Coughing up blood C ☐ P ☐	Asthma C ☐ P ☐
	Wheezing C ☐ P ☐	Pneumonia C ☐ P ☐	Emphysema C ☐ P ☐
	Pain w/breathing C ☐ P ☐	Tuberculosis C ☐ P ☐	Phlegm C ☐ P ☐
	Bronchitis C ☐ P ☐	☐ Air hunger C ☐ P ☐	
	Difficulty breathing C ☐ P ☐	› w/ exercise C ☐ P ☐	› w/ lying down C ☐ P
CARDIOVASCULAR		Chest pain C ☐ P ☐	High blood pressure C ☐ P ☐
	Low blood pressure C ☐ P ☐	Irregular heartbeat C ☐ P ☐	Murmurs C ☐ P ☐
	Swelling in ankles C ☐ P ☐	Heart disease C ☐ P ☐	Rheumatic fever C ☐ P ☐
	Calf pain C ☐ P ☐		
GASTROINTESTINAL		Heartburn C ☐ P ☐	Acid reflux C ☐ P ☐
	Low appetite C ☐ P ☐	Spitting up blood C ☐ P ☐	Hemorrhoids C ☐ P ☐
	Constipation C ☐ P ☐	Straining C ☐ P ☐	Loose/narrow stool C ☐ P ☐
	Diarrhea C ☐ P ☐	Abdominal pain C ☐ P ☐	Gas C ☐ P ☐
	Nausea/vomiting C ☐ P ☐	Ulcer C ☐ P ☐	Bloating C ☐ P ☐
	Gallbladder disease C ☐ P ☐	Liver disease C ☐ P ☐	Mucous in stool C ☐ P ☐
	Blood in stool C ☐ P ☐	Black stool C ☐ P	Undigested food C ☐ P ☐
	How many BMs › per day?_____		› per week? _____

URINARY Urgency C ☐ P ☐ | Increased frequency C ☐ P ☐ | Cloudy urine C ☐ P ☐
Blood in urine C ☐ P ☐ | Hesitancy C ☐ P ☐ | Dribbling urination C ☐ P ☐
Frequent infections C ☐ P ☐ | Pain or burning C ☐ P ☐ | Unusual urine color C ☐ P ☐
Incontinence C ☐ P ☐ | Kidney stones C ☐ P ☐ | Urinating at night C ☐ P ☐

MUSCULOSKELETAL | Joint pain C ☐ P ☐ | Stiffness C ☐ P ☐
Broken bones C ☐ P ☐ | Arthritis C ☐ P ☐ | Weakness C ☐ P ☐
Gout C ☐ P ☐ | Muscle spasms C ☐ P ☐ | Muscle cramps C ☐ P ☐
Muscle twitching C ☐ P ☐

PERIPHERAL VASCULAR | Easy bleeding C ☐ P ☐ | Easy bruising C ☐ P ☐
Deep leg pain C ☐ P ☐ | Varicose veins C ☐ P ☐ | Blood clots C ☐ P ☐
Leg cramping C ☐ P ☐ | Cold hands/feet C ☐ P ☐ | Anemia C ☐ P ☐
Past transfusions C ☐ P ☐

IMMUNE Chronic infections C ☐ P ☐ | Autoimmune disease C ☐ P ☐ | Slow healing C ☐ P ☐

ENDOCRINE Diabetes C ☐ P ☐ | Hypo/hyperthyroid C ☐ P ☐ | Blood sugar issues C ☐ P ☐
Excess thirst C ☐ P ☐ | Cravings C ☐ P ☐ | Excess sweating C ☐ P ☐
Chronic fatigue C ☐ P ☐ | Heat intolerance C ☐ P ☐ | Cold intolerance C ☐ P ☐

NEUROLOGIC Fainting C ☐ P ☐ | Paralysis C ☐ P ☐ | Numbness or tingling C ☐ P ☐
Memory loss C ☐ P ☐ | Seizures C ☐ P ☐ | Tremors/twitches C ☐ P ☐
Easily stressed C ☐ P ☐ | Loss of balance C ☐ P ☐ | Nerve pain C ☐ P ☐

SKIN Rashes C ☐ P ☐ | Acne, boils, sores C ☐ P ☐ | Mole changes C ☐ P ☐
Lumps, bumps C ☐ P ☐ | Eczema C ☐ P ☐ | Hives C ☐ P ☐
Itching C ☐ P ☐ | Hair loss C ☐ P ☐

MENTAL EMOTIONAL | Mood swings C ☐ P ☐ | Considered suicide C ☐ P ☐
Attempted suicide C ☐ P ☐ | Poor concentration C ☐ P ☐ | History of abuse C ☐ P ☐
Depression C ☐ P ☐ | Anxiety C ☐ P ☐ | Tension C ☐ P ☐
Major traumas C ☐ P ☐ | Binge eating C ☐ P ☐ | Anorexia C ☐ P ☐

REPRODUCTIVE | Sexually active C ☐ P ☐ | STI C ☐ P ☐
Birth control C ☐ P ☐ › What type? _____ | Difficulty conceiving C ☐ P ☐
Sexual difficulties C ☐ P ☐ › Please specify: _____
Genital sores/lumps C ☐ P ☐ | Genital discharge C ☐ P ☐ | Genital itching C ☐ P ☐

FEMALE REPRODUCTIVE Age of first menses _____ Age of final menses_____
Length of cycle_____days › Flow: Heavy ☐ Medium ☐ Light ☐
Heavy flow C ☐ P ☐ | Menstrual irregularity C ☐ P ☐ | Painful menses C ☐ P ☐
PMS C ☐ P ☐ › Explain symptoms: _____
Vaginal dryness C ☐ P ☐ | Bleeding between cycles C ☐ P ☐ | Endometriosis C ☐ P ☐
Cervical dysplasia C ☐ P ☐ | Hysterectomy Yes ☐ No ☐ › If so, date of surgery _____
Genital herpes C ☐ P ☐ | Uterine fibroids C ☐ P ☐ | Ovarian cysts C ☐ P ☐
Discharge between cycles C ☐ P ☐ | Duration of menses _____ days

Contraception methods used? _____ Current method used? _____
Date of last mammogram_____ Date of last PAP/exam _____
# of pregnancies _____ # of live births_____ # of cesarians_____
Breast tenderness C ☐ P ☐ Breast lumps C ☐ P ☐ Nipple discharge C ☐ P ☐
Other female concerns not addressed above _____
_____

MALE REPRODUCTIVE Hernia C ☐ P ☐ Testicular pain C ☐ P ☐
Erectile dysfunction C ☐ P ☐ Impotence C ☐ P ☐ Discolored urine C ☐ P ☐
Excessive urination C ☐ P ☐ Decreasing urination C ☐ P ☐ Painful urination C ☐ P ☐ Prostate concerns C ☐ P ☐ Testicular lumps C ☐ P ☐
Other male concerns not addressed above _____
_____

FLOURISH OF LIFE MEDICINE POLICIES AND REQUESTS

Initial each item to acknowledge that you have read and understand the cancellation, payment, and sensitivity policies of Flourish of Life Medicine.

_____ **Payment:** We require payment in full for all services rendered at the time of visit.

_____ **Cancellation Notice:** If you are unable to keep your appointment, you must give at least two days notice. If you fail to keep your appointment or cancel without a two day prior notice, you will be billed for half the cost of the appointment.

_____ **Sensitivities:** Many patients are extremely sensitive to perfumes and scents. Please refrain from wearing them during your office visits. Thank you.

STATEMENT OF FINANCIAL RESPONSIBILITY AND FOR TREATMENT

I, the undersigned, certify that I am financially responsible for all charges for provided to me (or my dependent) by Flourish of Life Medicine. In addition, I acknowledge that payment is due at the time of each visit. In the event that my account becomes more than ninety days past due, I agree to pay interest at the rate of 1.5% per month, or a minimum of $10.00 per month until such time my account is paid in full. I also agree to pay for any reasonable attorney fees and expenses incurred in collecting all sums not paid when due. I acknowledge that Flourish of Life Medicine will not bill my insurance company directly and that I am entitled to submit insurance claims independently. Should my insurance company need my health care information to process my claim, I hereby authorize Flourish of Life Medicine to release any and all information necessary to secure the payment of benefits to me. My signature is an acknowledgement that (1) I have read the policies listed above and agree to abide by the same, and (2) that I voluntarily consent to receive treatment from Ryan McLaughlin, L.Ac. of Flourish of Life Medicine.

_____ _____
Signature (PATIENT, PATIENT REPRESENTATIVE OR LEGAL GUARDIAN) Date

_____ _____
Printed Name (PATIENT, PATIENT REPRESENTATIVE OR LEGAL GUARDIAN) Relationship

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I hereby consent to the use and disclosure of my protected health information by Ryan McLaughlin, L.Ac of Flourish of Life Medicine for the purposes of treatment, payment and healthcare operations, or as otherwise required by law. Flourish of Life Medicine has their Notice of Privacy Practices available upon request, which provides more detailed information about the usage and disclosure of my protected health care information. I have the right to review the Notice prior to signing this consent and to receive a printed copy of the Notice.

• My "protected health information" means any health information including demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical and/or mental health or condition that identifies me, or has a reasonable basis to believe the information may identify me.

• I have the right to request restrictions regarding the use and disclosure of my protected health information.

• I have the right to review the Hai Shan Clinic Notice of Privacy Practices prior to signing this document.

• I have the right to revoke this consent in writing at anytime. Revocations will be honored effective the date they are received by Ryan McLaughlin, L.Ac. of Flourish of Life Meicine.. I am aware that Flourish of Life Medicine reserves the right to change the terms of their Notice of Privacy Practices and to make new notice of Privacy Practices provisions effective for all protected health care information that they maintain. In the event of any amendments, Flourish of Life Medicine will make available a revised Notice of Privacy Practice for my review.

_____ _____

Signature (PATIENT, PATIENT REPRESENTATIVE OR LEGAL GUARDIAN) Date

_____ _____

Printed Name (PATIENT, PATIENT REPRESENTATIVE OR LEGAL GUARDIAN) Relationship

NOTICE OF PATIENT PRIVACY Health Insurance Portability and Accountability Act (HIPPA)

[Effective Date: October 20, 2017]

Ryan McLaughlin, L.Ac. of Flourish of Life Medicine is dedicated to preserving your "Protected Health Information" (PHI). I am required by law to protect your health information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information. This Notice of Privacy Practices describes your rights and my responsibilities with respect to your Protected Health Information. Flourish of Life Medicine may use or disclose your PHI for the purpose of diagnosing or providing medical treatment, obtaining payment for health care bills or to conduct health care operations. I may be required by law to use and disclose your medical information for other purposes without your consent or authorization. Your PHI means health information, including your demographic information, collected by us, other health care providers, a health care clearinghouse, or an employer. This protected medical and health care information relates to your past, present or future physical or mental health or condition and identifies you, or there is a reasonable basis to believe the information may identify you. You have the right to inspect and receive a copy of your medical information that we maintain. You may amend or correct that information, obtain a record of our disclosures of your medical information, and request that we communicate with you confidentially. You may also request that we restrict certain uses and disclosures of your health information, and file a complaint if you think your rights have been violated. All requests and complaints must be made in writing. We have available a detailed NOTICE OF PRIVACY PRACTICES (long form) which fully explains your rights and our obligations under law. You have the right to receive a copy of our most current NOTICE in effect. Please ask and we will provide you with a copy. We may revise our NOTICE from time to time. The Effective Date at the top left hand side of this page indicates the date of the most current NOTICE in effect. You may contact our Privacy Officer, Ryan McLaughlin, L.Ac. at (971) 220-8839 if you have any questions, concerns or complaints or seek further information about the complaint process. By signing this form you are acknowledging that you have been provided information regarding our privacy practices pertaining to your "Protected Health Information."

_____ _____

Signature (PATIENT, PATIENT REPRESENTATIVE OR LEGAL GUARDIAN) Date

_____ _____

Printed Name (PATIENT, PATIENT REPRESENTATIVE OR LEGAL GUARDIAN) Relationship

ACUPUNCTURE CONSENT TO TREAT

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by Ryan McLaughlin, L.Ac. and/or other licensed acupuncturists who now or in the future treat me while employed by, working or associated with or serving as back-up for the acupuncturist named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I understand that methods of treatment may include, but are not limited to, acupuncture, moxibustion, cupping, cranial sacral, bodywork, electrical stimulation, Tui-Na/Shiatsu/Sotai (Oriental massage techniques), Chinese herbal medicine, and nutritional counseling. I understand that the herbs may need to be prepared and the teas consumed according to the instructions provided orally and in writing. The herbs may have an unpleasant smell or taste. I will immediately notify Ryan McLaughlin, L.Ac. of Flourish of Life Medicine of any unanticipated or unpleasant effects associated with the consumption of the herbs. I have been informed that acupuncture is a generally safe method of treatment, but that it may have some side effects, including bruising, numbness or tingling near the needling sites that may last a few days, and dizziness or fainting. Burns and/or scarring are a potential risk of moxibustion and cupping, or when treatment involves the use of heat lamps. Bruising is a common side effect of cupping. Unusual risks of acupuncture include spontaneous miscarriage, nerve damage and organ puncture, including lung puncture (pneumothorax). Infection is another possible risk, although Ryan McLaughlin, L.Ac. uses sterile disposable needles and maintains a clean and safe environment. I understand that while this document describes the major risks of treatment, other side effects and risks may occur. The herbs and nutritional supplements (which are from plant, animal and mineral sources) that have been recommended are traditionally considered safe in the practice of Chinese Medicine, although some may be toxic in large doses. I understand that some herbs may be inappropriate during pregnancy. Some possible side effects of taking herbs are nausea, gas, stomachache, vomiting, headache, diarrhea, rashes, hives, and tingling of the tongue. I will notify Ryan McLaughlin, L.Ac. if I am or become pregnant. While I do not expect the clinical staff to be able to anticipate and explain all possible risks and complications of treatment, I wish to rely on the clinical staff to exercise judgment during the course of treatment which the clinical staff thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed. I understand that Ryan McLaughlin, L.Ac. of Flourish of Life Medicine will review my patient records and lab reports, but all my records will be kept confidential and will not be released without my written consent. By voluntarily signing below, I show that I have read, or have had read to me, the above consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Signature (PATIENT, PATIENT REPRESENTATIVE OR LEGAL GUARDIAN) Date

_____ _____

Printed Name (PATIENT, PATIENT REPRESENTATIVE OR LEGAL GUARDIAN) Relationship

ARBITRATION AGREEMENT

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

_____ _____

Signature (PATIENT, PATIENT REPRESENTATIVE OR LEGAL GUARDIAN) Date

_____ _____

Printed Name (PATIENT, PATIENT REPRESENTATIVE OR LEGAL GUARDIAN) Relationship