Alertive
Healthcare Medical Group

NEW PATIENT REGISTRATION

Last Name	First Name		Middle Initial	Social Security Number	
Street Address	City	State	Zip Code	Date of Birth	Age
Primary Phone #	Email Address*				

*By providing your contact information, you are electing to receive all forms of communication along with voice messages from Alertive Healthcare Medical Group and its affiliates.

☐ Male ☐ Female ☐ Non-Binary ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow

Primary language: _____ Race: _____

EMPLOYER

Name: _____

Address: _____

City, State Zip: _____

Occupation: _____

Phone: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone 1: _____

Phone 2: _____

May we share personal medical information? ☐ Yes ☐ No

I hereby give my permission to contact the above mentioned individual if I cannot be reached. I further give my permission for any treating physician or physician's representative to speak with this person regarding me or my medical condition including but not limited to lab / pathology / diagnostic test result.

☐ YES ☐ NO

PRIMARY INSURANCE

Holder: _____

Insurance Co: _____

Group #: _____

Policy/ID #: _____

Phone: _____

SECONDARY INSURANCE (if applicable)

Holder: _____

Insurance Co: _____

Group #: _____

Policy/ID #: _____

Phone: _____

I hereby assign my insurance benefits to be made directly to my physician and any assisting physicians, for services rendered. I hereby attest that the above insurance information is accurate and that I am an eligible member and understand that I am responsible for knowing my benefits / coverage and tests ordered by my physician may NOT be covered. I will be financially responsible for all charges that are not covered by my insurance company. I understand that I will be charged a 1% per month finance charge on all accounts over 90 days. I also hereby authorize the release of all information to other physicians and insurance carriers upon request for the purpose of payment for the medical serviced and further treatment of care by another physician. I further agree that a photocopy of this agreement shall be as valid as the original. Payment is due at the time services are rendered. Al charges are the direct responsibility of the patient. Alertive Healthcare Medical Group cannot render services on the assumption that the charges will be paid by the Insurance Company. Insurance is an agreement between you and your insurance company. If Alertive Heathcare Medical Group has problems collecting payment from you, we will also add attorney's fees, collection agency costs and any related fees to your bill. I here- by acknowledge that I have read, understand and agree to hereby give consent for treatment.

_____ _____

Patient / Guardian Signature *(If guardian, write name please)* Date

Alertive
Healthcare Medical Group

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____

Previous Primary Care Physician: _____

City: _____ Phone: _____ Fax: _____

ALLERGIES: Any known drug allergies? ☐ **YES** ☐ **NO**

Please list all allergies including food, medications and environmental and reaction.

_____

PREFERRED PHARMACY: _____

Address: _____ Phone number: _____

Do you currently take any **medications** on a regular basis? ☐ **YES** ☐ **NO**

If yes, please list any medications that you currently take on a regular basis (include non-prescriptions).

MEDICATION	**DOSE**	**FREQUENCY**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Note: If you are currently taking more medications than the space above allows, please list the additional medications on the back of this form.

MEDICAL HISTORY:

Illness and Conditions	**Surgical History OR Hospitalizations**
_____	_____
_____	_____
_____	_____

AUTHORIZATION TO OBTAIN INFORMATION FROM OUTSIDE HEALTH CARE PROVIDERS

This authorization allows the healthcare provider(s) named below to release confidential medical information and records regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis, or prognosis, including x-rays, correspondence and/or medical records by means of mail, fax, or other electronic methods to:

Alertive Healthcare Medical Group
Fax: 951-848-9606
4500 Brockton Ave, Ste 305
Riverside, CA 92501
Ph: 951-466-6628

The medical information/records are being requested for the purpose of continuity of patient care.

I hereby authorize: _____
Physician/Healthcare Facility Phone Number

To release the below indicated medical information:

☐ Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment unless marked below)
☐ Limited to the followings: _____

I also consent to the specific release of the following records:

Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

☐ Drug Alcohol/Substance Abuse
☐ Psychiatric/Mental Health
☐ Test results for Genetic Testing
☐ HIV/AIDS Diagnosis/Treatment
☐ Test results for antibodies to HIV/AIDS

DURATION: This authorization shall be effective immediately and remain in effect for one year from the date of signature below or until: _____

RESTRICTIONS:
Permissions for future use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such a disclosure is specifically required or permitted by law.
A photocopy of this facsimile for authorization shall be considered as effective and valid as the original.
I have been advised of my right to receive a copy of this authorization.

_____ _____ _____
Signature of Patient or *legal/personal representative* Date *Relationship if other than patient*

_____ _____
Patients Name (PRINT) DOB

PLEASE COMPLETE THE PHQ-9 AND GAD-7

Patient Name: _____ DOB: _____ Date of Referral: _____

PHQ9		**0**	**1**	**2**	**3**
Over the last two weeks how often have you been bothered by the following problems?		**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
A	Little interest or pleasure in doing things	☐	☐	☐	☐
B	Feeling down, depressed, or hopeless	☐	☐	☐	☐
C	Trouble falling or staying asleep, sleeping too much	☐	☐	☐	☐
D	Feeling tired or having little energy	☐	☐	☐	☐
E	Poor appetite or overeating	☐	☐	☐	☐
F	Feeling bad about yourself - or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
G	Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
H	Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
I	Thoughts that you would be better off dead or ofhurting yourself in some way	☐	☐	☐	☐
Severity score	Mild depression = 5-10; Moderate depression = 10-18; Severe depression= 19-27	Total score:			
	If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

GAD7	**0**	**1**	**2**	**3**
Over the last two weeks how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious, or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it's hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Total Score (add your column scores)	☐	☐	☐	☐
If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things athome, or get along with other people?	Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

_____ _____

Providers signature Date

TUBERCULOSIS (TB) RISK ASSESSMENT

Date/*Fecha*: _____

Patient Name/*Nombre del Paciente*: _____

DOB/*Fecha de Nacimiento*: _____

Do you have a history of positive TB test or TB disease? ☐ **YES/SÍ** ☐ **NO**
¿Tiene antecedentes de prueba de TB positiva o enfermedad de TB?

If yes/*En caso afirmación*	**YES/SÍ**	**NO**
Have you had a chest x-ray in the last 6 months? / *¿Se ha hecho una radiografía de tórax en los últimos 6 meses?*	☐	☐
Did you receive treatment? / *¿Recibió tratamiento?*	☐	☐
Are you experiencing any signs and symptoms of TB? (prolonged cough, coughing up blood, fever, night sweats, weight loss or excessive fatigue) / *¿Está experimentando algún signo y síntoma de TB? (tos prolongada, tos con sangre, fiebre, sudores nocturnos, pérdida de peso o fatiga excesiva)*	☐	☐
Have you had close contact with someone who has TB? / *¿Ha tenido contacto cercano con alguien que tiene un diagnóstico confirmado o sospechoso de TB?*	☐	☐
Are you from Asia, Africa, Central America, or South America? / *¿Eres de Asia, África, América Central o América del Sur?*	☐	☐
Do you live in a facility (nursing home, rehab...)? / *¿Vives en un centro (residencia de ancianos, rehabilitación...)?*	☐	☐
Have you traveled to an area of high TB prevalence? (Asia, Africa, Central or South America) / *¿Ha viajado a un área de alta prevalencia de TB? (Asia, África, América Central o del Sur)*	☐	☐
Have you or anyone you live with been incarcerated in the last 5 years? / *¿Usted o alguien con quien vive ha estado encarcelado en los últimos 5 años?*	☐	☐
Do you live with, or are you frequently exposed to anyone who is homeless, a migrant farm worker, user of street drugs or a resident in a facility? / *¿Vive con, o está frecuentemente expuesto a cualquier persona sin hogar, un trabajador agrícola migrante, usuario de drogas callejeras o residente en una instalación?*	☐	☐

You may be at increased risk for TB if you answered YES to any of the above questions. Persons at increased risk for TB should have a yearly TB test. Testing can be done by either skin test or blood work. A positive test for either of these should be followed by a CXR.

Usted puede estar en mayor riesgo de TB si respondió SÍ a cualquiera de las preguntas anteriores. Las personas con mayor riesgo de TB deben hacerse una prueba anual de TB. Las pruebas se pueden realizar mediante un análisis de la piel o un análisis de sangre. Una prueba positiva para cualquiera de estos debe ser seguida por una radiografía de tórax.

Date of last TB screening / *Data de la última prueba de detección de la tuberculosis*: _____

☐ Unknown / *Desconocido* ☐ No previous testing / *Sin pruebas previas*

Last screening done by / *Última evaluación realizada por*:

☐ PPD skin test / P*rueba cutánea* ☐ Chest X-Ray / Ra*diografía de tórax* ☐ Blood draw / *Extracción de sangre*

Results were/ *Los resultados fueron*:

☐ Positive / *Positivo* ☐ Negative / *Negativo*

NOTICE OF PRIVACY PRACTICE under HIPAA

Alertive Healthcare Medical Group
This Notice is effective July 1, 2023

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

We are required by law to protect the privacy of medical information about you and that identifies you. This medical information may be about information about healthcare we provide to you or payment for healthcare provided to you. It may also be information about your past, present or future medical conditions.

This information is to help you understand your rights under federal privacy regulations, the Health Insurance Portability and Accountability Act, or HIPAA. This page focuses on your right to receive a HIPAA Notice of Privacy Practices.

What is a HIPAA Notice of Privacy Practices?
The HIPAA Notice of Privacy Practices describes Alertive Healthcare Medical Groups practices. It describes how we use or disclose your medical or health information. It also explains your rights as a patient under privacy regulations, as well as Alertive Healthcare Medical Group's responsibilities regarding your information.

Why do I need a Notice of Privacy Practices?
We are required by federal regulations to maintain the privacy of your medical and health information.
We create a record of the care and services you receive at Alertive Healthcare Medical Group. We need this record to provide you with quality care and to comply with certain legal requirements. The HIPAA Notice of Privacy Practices will help you understand how to exercise your rights regarding your health information.

How do I get a copy of the Notice of Privacy Practices?
At your first visit at Alertive Healthcare Medical Group, staff will provide you with the opportunity to review and request a copy of the Notice of Privacy Practices. Or, you may call Alertive Healthcare Medical Group and we will send you a copy in the mail. You may also download a copy from our website at AlertiveHealthcare.org under the patients section.

We may change the terms of this notice in the future. We reserve the right to make changes and to make the new Notice effective for all medical information that we maintain.

If we make changes to the notice we will:

Post the new Notice of Privacy Practices in our waiting area and have copies of the new Notice available upon request.

HIPAA NOTICE OF PRIVACY PRACTICES

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services. Office of Civil Rights, about violations of the provisions of the notice or the policies and procedure of our office. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint you may contact:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
1-800-368-1019
www.hhs.gov

PATIENT'S RIGHTS & RESPONSIBILITIES

Rights	Responsibilities
• To receive service in a reasonable period of time. • To receive medically necessary service. • To be treated with respect and courtesy. • To receive available information about your care and treatment, including risks and options. • To have your medical coverage explained to you. • To participate in treatment decisions. • To refuse treatment. • To receive impartial access to treatment. • To receive a second opinion regarding any treatment plan. • To review or to receive a copy of your medical record subject to legal restrictions and reasonable copying charges. • To request review of your medical record by the physician, and to request corrections if necessary. • To be given information on how to file a compliant/grievance. • To formulate an advance directive if you have a life-threatening illness or injury.	• Having appropriate identification, insurance membership cards, etc at the time of appointment. • Keeping appointments or contacting the office in advance to cancel an appointment. • Fulfilling financial obligations at the time of service such as deductible or co-pay fees. • Providing complete and accurate information. • Following the health plan you and the physician agree on. • Being considerate of others. • Providing legal documentation of guardianship for a minor being treated. • Providing a list of person(s) who may receive medical information about you, on your behalf, in an emergency.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES AND PATIENTS RIGHTS AND RESPONSIBILITES

The Alertive Healthcare Medical Group Notice of Privacy Practices provides detailed information about how we may use and disclose your protected health information. It also describes your right to request restrictions on how we use and disclose this information. You are being given a copy of the Notice of Privacy Practices and Patients Right and Responsibilities, at this time and we encourage you to read it in full. These policies may change from time to time. You may request a copy of these forms at any time. Our Notice of Privacy Practices and Patients Rights and Responsibilities are also available for viewing on our website at AlertiveHealthcare.org. Additional copies may be obtained by our office at 951-466-6628. By signing below, l acknowledge that I have been given a copy of the Alertive Healthcare Medical Group Notice of Privacy Practices and Patients Rights and Responsibilities.

_____ _____

Patients Name DOB

_____ _____

Patient or *Authorized Representatives Signature* Date

_____ _____

If Other Than Patient, Name of Person Signing Relation to patient

I authorize contact from this office to confirm my appointments, treatment and billing information via the contact information provided on my registration form.

I choose to opt out of receiving confirmation notices ☐

I authorize contact from this office to be informed about special services, events, fund raising efforts or new health information via the e-mail address provided on my registration form.

I choose to opt out of receiving promotional and health information notices ☐

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge a n d consent.

Office Use Only

As Privacy Officer,

_____ I have entered into patients electronic health record their preferred choices, or

I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- ☐ It was emergency treatment, and I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because
- ☐ Other (please describe) _____

_____

Signature of Privacy Officer

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION TO OTHERS

Patients Name _____ DOB _____

I give permission for Alertive Healthcare Medical Group to provide my personal health information checked below:

- ☐ Scheduling/Appointment information
- ☐ Medical information, including symptoms, diagnosis, medications, and treatment plan
- ☐ Health information, including symptoms, diagnosis, medications, and treatment plan regarding
  *(*items below must be checked, or this information cannot be given)*
  - ☐ Substance abuse ☐ Behavioral health ☐ Developmental disability ☐ HIV/AIDS
- ☐ Lab/Test results
- ☐ Billing and payment information
- ☐ Al health information (*Protected health information items must be checked to give this information) to the below named individuals/companies):

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Name: _____ Relation to patient: _____

Authorization expires one year from the date of signature unless an alternate date is given.
Alternate date of expiration: _____

I understand that my signature is required to release my personal information, to include photo identification, social security number, insurance information, demographics and medical history and treatment to others except in those circumstances where Alertive Healthcare Medical Group is permitted or required by law to release this information. For example, Alertive Healthcare Medical Group may release copies of this information to other health care providers, health plans, governmental agencies, and workers compensation carriers. Additionally, I understand that Alertive Healthcare Medical Group is required by law to report certain diagnosis to the California Department of Public Health such as seizures, cancer, and the diagnosis of a communicable disease(s).

- I understand that this permission will remain in effect until the date stated above or until such time as I revoke it in writing (an updated agreement form will also revoke the validity of this specific agreement).

_____ _____

Patient or *Authorized Representatives Signature* Date

_____ _____

If Other Than Patient, Name of Person Signing Relation to patient

Alertive
Healthcare Medical Group

OFFICE FINANCIAL POLICY

Primary Insurance (Policy Holder) Information ☐ **Self**

Insurance Name:	Subscriber Name:
Subscribers Date of Birth:	Relation to patient:
Subscriber ID:	Group Number:

Secondary Insurance (Policy Holder) Information ☐ **Self**

Insurance Name:	Subscriber Name:
Subscribers Date of Birth:	Relation to patient:
Subscriber ID:	Group Number:

Responsible Party (Guarantor) ☐ **Self**

Last Name, First Name:	Relationship:
Date of Birth:	Social Security Number:
Phone:	

OFFICE FINANCIAL POLICY

The above information is complete and correct. I hereby authorize release of information necessary to file a claim with my insurance company. I assign benefits otherwise payable to me to *Alertive Healthcare Medical Group, APC.* Financing and financial assistance is available if needed, please speak with our office manager if you need to make arrangements for payment.

For those who are paying cash, payment must be paid in full at the time of service, unless arrangements have been made prior. If all necessary information required to bill your insurance is not received than your account will be managed the same as cash pay. We need a copy of both the front and back of al insurance cards on file.
Al HMO patients must be assigned to either Dr. Shuja Ayouby or NP Julie Ayouby If you are not assigned to our office, you will be responsible for the charges should your insurance deny payment.

- I understand that I am financially responsible for all charges for medical services rendered regardless of insurance coverage.
- I understand that I am responsible for any office visit copayment/deductible and this amount is due at the time of service.
- I understand that I must immediately pay any amounts over 60 days past due by an insurance company.
- I understand that amounts over 90 days past due are subject to collection procedures which could include small claims court or a 1-12% service charge per month on the unpaid balance.
- If this account is assigned to an attorney for collection and/or suit, a copy of the signature is valid as the original. Accounts sent to a collection agency will include an additional $10.00 transferring fee and proof of payment to the collection agency must be shown prior to additional services being rendered.

_____ _____

Patient or *Authorized Representatives Signature* Date

_____ _____

If Other Than Patient, Name of Person Signing Relation to patient

OFFICE POLICIES

Appointments:

- New patients are required to be in our office 30 minutes prior to their scheduled appoint time and returning patients 15 minutes prior to their scheduled appointment time. This allows our staff to complete the check-in process and obtain vital signs to ensure the patient is ready to be seen by their provider at their scheduled time.
- We set aside designated time for urgent and same day appointments. Please call as early as possible to obtain such an appointment when needed. If all same day appointments are filled, staff may direct you to an urgent care and/or the emergency room if necessary.
- If you are more than 15 minutes late to your scheduled appointment time, your appointment may need to be rescheduled to a different time and/or day to ensure other scheduled patients are seen in a timely manner.
- If you fail to keep your appointment and do not notify the office by phone at least 24 hours in advance of your scheduled appointment time you will be required to pay a No- Show fee of $25.00.

Behavior:

- We do not tolerate rude or disrespectful behavior toward our staff or other patients, such as yelling and/or the use of profanity. Anyone behaving in such a manner will be asked to leave the office.
- Failure to comply and/or repeated incidents may result in termination of patient care from our office.
- You are encouraged to discuss your health concerns and review any questions regarding your plan of care with your provider. However, repeated non-compliance with agreed upon plan of care recommendations may result in termination of patient care.

After Hours:

If you need to be seen outside of our office hours you may go to the local emergency department or urgent care facility. You can also call our office and follow the prompts given in the message or visit our website, AtigaFamilyPractice.com, and go to the "About" tab to find "After Hours Instructions". Please only call the on-call doctor for advice on **urgent matters**. I have read and understand the office policies.

I agree to comply with the listed policies. I understand that failure to comply may result in termination of relationship with the office.

_____ _____

Patient Name Patient or *Authorized Representatives Signature*

_____ _____

If Other Than Patient, Name of Person Signing Date

PHYSICIAN-PATIENT 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 California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether bron or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any if them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must communicate 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 of a demand for a neutral arbitrator by either party. 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 or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, nit supplant, any other applicable statutory or common law.

Either party shall have the absolute right ti arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which 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 California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once 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 California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed, patient should initial:
Effective as of the date of first medical services rendered.

If any provision if 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, 1 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.

Physician's Signature or Authorized Representative's	Date
Patient or Patient *Representatives Signature*	Date
Print Patient's Name	Date
(If Representative, Print Name and Relationship to Patient)	

A signed copy of this document is to be given to patient. Original is to be filed in Patient's medical records.