

Financial Policy and Agreement

Thank you for choosing us for your dental needs. We are committed to providing you with excellent care. Our convenient financial arrangements are based on an open and honest discussion of recommended treatment options, respective fees and patient's financial capabilities.

Payment

Payment in full is due at the time of service unless financial arrangements are made prior to the date of your appointment. Unpaid accounts over 90 days will be turned over to a Collection Agency of our choosing. Payment options include:

Cash, Checks, VISA, MasterCard, AMEX and Discover

No interest monthly payment plans through CareCredit

Initial _____

Down Payment

You may be asked to pay a portion of your visit as a deposit upon scheduling treatment. Initial _____

Insurance

Our office is committed to helping patients maximize their benefits. Because insurance policies vary greatly, we can **estimate** your coverage in good faith, but **cannot guarantee it**. As a service to our patients, we will be happy to manage all dental claim submissions for up to two dental insurance policies and follow up on your behalf. If you have any questions, our courteous staff is always available to answer them. Please be aware some and possibly all of the services provided may NOT be covered by your insurance provider. Services, which are not covered, downgraded, or are considered not medically necessary by your insurance company are your responsibility. Initial _____

Minors

Payment for services for the treatment of minors can be made by check, cash, or credit card and is the responsibility of the adult accompanying that minor at the time of service. Initial _____

Missed Appointments

Once an appointment has been made, that time is reserved specifically for you. Patients who do not show up for an appointment or cancel with less than **48 business hours notice are subject to a \$25 late cancel fee**. You may be asked to make a deposit before being reappointed. Initial _____

Service Charges

The policy of this office is to charge 2% interest monthly (24% annual percentage rate) to all accounts over 90 days past due. There will also be a \$25 fee for all returned checks. Initial _____

Financial Consent

The patient (account holder) agrees to be fully responsible for TOTAL payment of treatment performed in this office. Initial _____

I understand and agree to this Financial Policy and Agreement

X _____
Signature of Patient/Responsible Party

X _____
Date

Important Dental Insurance Information

Understanding your insurance coverage can be quite challenging. Our goal is to assist you in maximizing your benefits. There are differences in coverage and benefits among plans. We do our best to **estimate** coverage for you, but ultimately the contract is between you and your insurance company.

Our office is contracted as a preferred provider with most commercial insurance companies. Please inquire with your insurance company or one of our front office team members regarding our status with your insurance company. We encourage you to become familiar with your policy exclusions, deductibles and required co-insurance payments.

Our courtesy service to you includes:

- Filing your insurance claim for up to two policies within 48 hours of your visit and requesting payment of your insurance benefits to our office.
- Electronically filing your insurance for short turnaround, when possible
- Estimating covered services and benefits
- Following the American Dental Association guidelines for coding procedures and insurance billing.

Our expectations of you as the owner of the policy:

- Payments of fees not covered by your insurance company are to be paid at the time the services are rendered. **Initial** _____
- To understand that the insurance policy belongs to you and we have no leverage to obtain payment from your insurance carrier. **Initial** _____
- To recognize that dental insurance policies restrict payment for some services, and exclude some procedures based on prior conditions or length of time on the plan, or many other reasons listed in your benefit booklet. All restrictions are based on the premium paid for insurance, not our fees or recommended treatment. **Initial** _____
- To take responsibility for payment if the insurance company does not pay our office within **90 days**. **Initial** _____
- If you have dual coverage, please call both companies to have then coordinate benefits and check to see if your insurance has a **non-duplication of benefits clause**. If it does, please become familiar with the restrictions. You may receive a **reduced benefit** from your secondary insurance. **Initial** _____
- To keep our office informed of any changes in your insurance coverage or employment. **Initial** _____
- To be aware some and possibly all of the services provided may NOT be covered by your insurance provider. Services, which are not covered, downgraded, or are considered not medically necessary by your insurance company are your responsibility. **Initial** _____

Thank you for your cooperation with your dental insurance coverage. Please sign the space below and have your insurance card ready for us to copy for our file.

*I hereby authorize Oregon Smile Care Center to release to my insurance company any information acquired in the course of my dental care. I hereby authorize benefits to be paid directly to Oregon Smile Care Center. I understand that estimates given to me by Oregon Smile Care Center regarding my insurance are **not a guarantee of payment**. I am responsible for any unpaid balance after my insurance pays.*

X _____

Signature of Patient/Guardian

X _____

Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

I would like to allow the following people access to my medical information:

X _____ X _____
X _____ X _____

Patient Name: X _____

Relationship to Patient: X _____

Signature: X _____

Date: X _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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Health History Form



American Dental Association
www.ada.org

E-mail: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:			Home Phone: <i>Include area code</i>		Business/Cell Phone: <i>Include area code</i>	
_____ Last	_____ First	_____ Middle	()	()	()	()
Address:			City:		State: Zip:	
_____ Mailing address						
Occupation:			Height:		Weight:	
					Date of birth: Sex: M F	
SS# or Patient ID:		Emergency Contact:		Relationship:		Home Phone: Cell Phone:
						() () <i>Include area codes</i>

If you are completing this form for another person, what is your relationship to that person?

Your Name _____ Relationship _____

Do you have any of the following diseases or problems:	<i>(Check DK if you Don't Know the answer to the question)</i>			Yes	No	DK
Active Tuberculosis.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough greater than a 3 week duration.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough that produces blood.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been exposed to anyone with tuberculosis.....				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Dental Information *For the following questions, please mark (X) your responses to the following questions.*

	Yes	No	DK		Yes	No	DK
Do your gums bleed when you brush or floss?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or neck pains?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive to cold, hot, sweets or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any clicking, popping or discomfort in the jaw?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does food or floss catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you brux or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your mouth dry?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or ulcers in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any periodontal (gum) treatments?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had orthodontic (braces) treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you participate in active recreational activities?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any problems associated with previous dental treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had a serious injury to your head or mouth?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is your home water supply fluoridated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Date of your last dental exam:			
Do you drink bottled or filtered water?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	What was done at that time?			
If yes, how often? Circle one: DAILY / WEEKLY / OCCASIONALLY				Date of last dental x-rays:			
Are you currently experiencing dental pain or discomfort?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
What is the reason for your dental visit today?							
How do you feel about your smile?							

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK		Yes	No	DK
Are you now under the care of a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a serious illness, operation or been hospitalized in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physician Name: _____ Phone: <i>Include area code</i>				If yes, what was the illness or problem?			
Address/City/State/Zip: _____				Are you taking or have you recently taken any prescription or over the counter medicine(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you in good health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If so, please list all, including vitamins, natural or herbal preparations and/or diet supplements:			
Has there been any change in your general health within the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____			
If yes, what condition is being treated?				_____			
Date of last physical exam:				_____			

Medical Information Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

(Check DK if you Don't Know the answer to the question)			Yes No DK				Yes No DK							
Do you wear contact lenses?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use controlled substances (drugs)?.....			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you use tobacco (smoking, snuff, chew, bidis)?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Date: _____ If yes, have you had any complications? _____						If so, how interested are you in stopping? (Circle one) VERY / SOMEWHAT / NOT INTERESTED								
Are you taking or scheduled to begin taking either of the medications, alendronate (Fosamax®) or risedronate (Actonel®) for osteoporosis or Paget's disease?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you drink alcoholic beverages?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia® or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If yes, how much alcohol did you drink in the last 24 hours? _____								
Date Treatment began: _____						If yes, how much do you typically drink in a week? _____								
Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.			Yes No DK				Yes No DK							
Local anesthetics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Metals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Aspirin _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex (rubber) _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Penicillin or other antibiotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Barbiturates, sedatives, or sleeping pills _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/seasonal _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sulfa drugs _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Animals _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Codeine or other narcotics _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.														
			Yes No DK				Yes No DK				Yes No DK			
Artificial (prosthetic) heart valve			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Autoimmune disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Previous infective endocarditis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid arthritis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Damaged valves in transplanted heart			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Systemic lupus erythematosus.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Congenital heart disease (CHD)						Asthma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Unrepaired, cyanotic CHD			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Repaired (completely) in last 6 months			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Repaired CHD with residual defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
						Tuberculosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<i>Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.</i>						Cancer/Chemotherapy/ Radiation Treatment			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			Yes No DK				Yes No DK				Yes No DK			
Cardiovascular disease.			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain upon exertion			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Angina			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic pain			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Arteriosclerosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Type I or II			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Congestive heart failure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eating disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Damaged heart valves			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malnutrition			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart attack			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Heart murmur			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	G.E. Reflux/persistent heartburn			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Low blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
High blood pressure			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Other congenital heart defects			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Hepatitis, jaundice or liver disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Fainting spells or seizures			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neurological disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
If yes, specify: _____						Sleep disorder			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Mental health disorders			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent Infections			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Specify: _____						Type of infection: _____								
Kidney problems			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Night sweats			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Osteoporosis			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent swollen glands in neck			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Severe headaches/ migraines			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe or rapid weight loss			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Sexually transmitted disease			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive urination			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
Name of physician or dentist making recommendation:						Phone:								
Do you have any disease, condition, or problem not listed above that you think I should know about?												<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Please explain:														

NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:	Date:
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FOR COMPLETION BY DENTIST

Comments: _____

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 restore 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 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 fee 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 the arbitration of any person or entity that would otherwise be a proper addition 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 laws, 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 the 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 the 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 a neutral arbitration and you are giving up your right to a jury or court trial. See Article 1 of the contract.

Patient Signature: x _____

Date: x _____