Confidential Patient Health Record

Today's Date: ___/____/_____

How did you hear about us? ☐ Family _____ ☐ Friend _____ ☐ Co-Worker _____
☐ Close to home/work ☐ Dr. _____ ☐ Yellow pages ☐ Drove by ☐ Insurance Plan ☐ Internet/Website
☐ Health Fair ☐ Other: _____

Personal Information

Last: _____ First: _____ Middle: _____
Birth Date: ___/___/_____ Age: _____ Sex: ☐ Male ☐ Female
Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____
Email Address: _____
Preferred contact method: ☐ Home Phone ☐ Cell Phone ☐ Email
Address: _____Apt # _____
City: _____ State: _____ Zip: _____ Country: _____ County: _____
Primary Language: ☐ English ☐ French ☐ German ☐ Spanish ☐ other: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Emergency Contact

Last: _____ First: _____ Middle: _____
Address: _____Apt # _____
City: _____ State: _____ Zip: _____ Country: _____ County: _____
Relationship: ☐ Spouse ☐ Relative ☐ Friend ☐ Other: _____
Email Address: _____
Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Insurance Information:

Who Is Responsible for Your Bill? YOU and… (mark appropriate box(es)) ☐ Myself ONLY
☐ Spouse ☐ Worker's Comp ☐ Auto Insurance ☐ Medicare ☐ Medicaid ☐ Other (be specific): _____

YOU MAY <u>PROVIDE US A COPY</u> OF YOUR INSURANCE CARD IN LIEU OF FILLING THIS SECTION OUT

Insurance Company: _____ Health ID Card #: _____
Policy Holder's Name: _____ Group/Policy #: _____
Policy Holder's Date of Birth: _____ Relationship to Policy Holder: _____
Policy Holder's Social Security #: _____-_____-_____ Policy Holder's Phone #: _____

*If you are **USING INSURANCE BENEFITS** to cover services, please read and sign below:*

I hereby instruct the insurance company listed above to pay by check made out to and mailed directly to the following address. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

ARIZONA CHIROPRACTIC & HOLISTIC HEALTH CENTER
20831 N. SCOTTSDALE RD, SCOTTSDALE, AZ 85255

For the professional or medical expense-benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I understand that I am financially responsible for all charges whether or not paid by insurance. I further understand that I will· be responsible for payment to any other facilities and/or health care providers that I may be referred to by Arizona Chiropractic and Holistic Health Center and any emergency transporting that may be required thereto. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in the case. I hereby authorize the physician to release all information necessary, including diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Patient [or Parent/Guardian] Signature: _____ Date: _____

---------- **OR** ----------

*If you **DO NOT HAVE INSURANCE** that cover services, please read and sign below:*

I hereby acknowledge that I have no insurance that covers services, and I understand that all services are payable when treatment is rendered. I further understand that I will be responsible for payment to any other facilities and/or health care providers that I may be referred to by Arizona Chiropractic and Holistic Health Center and any emergency transport that may be required thereto.

I further acknowledge that the fees I am paying are discounted from the usual and customary fees for services and the discounted fees I am paying are being applied to the usual fees. In the event that my insurance status changes and/or I elect to use a third-party payer, the standard fees may apply.

Patient [or Parent/Guardian] Signature: _____ Date: _____

REVIEW OF SYSTEMS - (Currently have)

Below is a list of symptoms that may seem unrelated to the purpose of your appointment; however, these questions must be answered carefully as the problems can affect your overall course of care.

Constitutional:

☐ fever
☐ chills
☐ fatigue
☐ daytime drowsiness
☐ weakness
☐ unintended weight loss
☐ unintended weight gain

Eyes/Vision:

☐ blindness
☐ blurred vision
☐ cataracts
☐ change in vision
☐ double vision
☐ eye pain
☐ field cuts
☐ glaucoma
☐ itching
☐ photophobia
☐ tearing
☐ wear glasses/contacts

Ears, Nose and Throat:

☐ bleeding
☐ sore throat
☐ dentures
☐ difficulty swallowing
☐ hoarseness
☐ frequent sore throats
☐ ear drainage
☐ ear pain
☐ tinnitus (ringing in ears)
☐ hearing loss
☐ discharge
☐ altered taste
☐ history of head injury
☐ fainting
☐ dizziness
☐ headaches
☐ TMJ problems
☐ snoring
☐ nosebleeds
☐ postnasal drip
☐ rhinorrhea (runny nose)
☐ loss of sense of smell
☐ sinus infections
☐ nasal congestion

Respiration:

☐ asthma
☐ cough
☐ coughing up blood
☐ shortness of breath
☐ sputum production
☐ wheezing

Cardiovascular:

☐ chest pain
☐ chest pressure
☐ chest discomfort
☐ palpitations
☐ heart problems
☐ ulcers
☐ high blood pressure
☐ low blood pressure
☐ swelling of legs
☐ claudication (leg pain/ache)
☐ varicose veins
☐ heart murmur
☐ shortness of breath with exertion or exercise
☐ angina (chest pain or discomfort)
☐ paroxysmal nocturnal dyspnea (waking at night w/ shortness of breath)
☐ orthopnea (difficulty breathing lying down)
☐ racing heart beat

Gastrointestinal:

☐ nausea
☐ vomiting
☐ abdominal pain
☐ diarrhea
☐ constipation
☐ black - tarry stools
☐ hemorrhoids
☐ rectal bleeding
☐ abnormal stool caliber
☐ jaundice
☐ indigestion
☐ heartburn
☐ vomiting blood
☐ abnormal stool color
☐ abnormal stool consistency
☐ belching

Female:

☐ birth control
☐ breast lumps/pain
☐ burning urination
☐ cramps
☐ frequent urination
☐ hormone therapy
☐ irregular menstruation
☐ pregnancy
☐ urine retention
☐ vaginal bleeding
☐ vaginal discharge

Male:

☐ burning urination
☐ erectile dysfunction
☐ frequent urination
☐ hesitancy/ dribbling
☐ prostate problems
☐ urine retention

Endocrine:

☐ cold intolerance
☐ heat intolerance
☐ excessive appetite
☐ excessive sweating
☐ excessive hunger
☐ excessive thirst
☐ abnormal frequency of urination
☐ night sweats
☐ goiter
☐ hair loss
☐ unusual hair growth
☐ voice changes
☐ diabetes

Skin:

☐ changes in nail texture
☐ changes in skin color
☐ history of skin disorders
☐ hair loss
☐ Eczema
☐ Dermatitis
☐ itching
☐ rash
☐ skin lesions / ulcers
☐ varicosities

Nervous System:

☐ dizziness
☐ facial weakness
☐ tremor
☐ clumsiness
☐ limb weakness
☐ loss of consciousness
☐ unsteadiness of gait/loss of balance
☐ change in bowel/bladder control
☐ numbness/tingling in hands/feet
☐ seizures
☐ sleep disturbance
☐ fainting
☐ headache
☐ migraines
☐ slurred speech
☐ History of stroke
☐ stress
☐ loss of memory

Psychologic:

☐ depression
☐ anxiety
☐ bi-polar disorder
☐ mood swings
☐ memory loss
☐ anhedonia (no desire)
☐ behavioral change
☐ convulsions
☐ confusion
☐ insomnia (unable to sleep)

Allergy:

☐ anaphylaxis
☐ food intolerance
☐ itching
☐ acute nasal congestion
☐ chronic nasal congestion
☐ rash
☐ frequent sneezing
☐ hives

Hematologic:

☐ anemia
☐ bleeding
☐ blood clotting
☐ blood transfusion
☐ bruising easily
☐ fatigue
☐ lymph node swelling

PAST HEALTH HISTORY

Fill out carefully as these problems can affect your overall course of care.

Previous Care for this Same Condition:

Have you seen other doctors for THIS CONDITION? ☐ Yes ☐ No. If yes, Who? (Name) _____
Type of Treatment: _____ Were you satisfied with the results of your treatment? ☐ Yes ☐ No
Explain: _____

Current Medication (s): List ANY/ALL medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition?	How long have you been taking this?

Current Vitamins, Herbs, Supplements: List ANY/ALL non-prescription items you are CURRENTLY taking.

Medication	Dosage	For What Condition?	How long have you been taking this?

Allergies: Mark all that apply below.

☐ Bactrim
☐ Cipofloxacin
☐ Codeine
☐ Oxycodone
☐ Hydrocodone
☐ Sulfa drugs
☐ other: _____

☐ adhesive tape
☐ animals
☐ bee sting
☐ feathers
☐ latex
☐ mold
☐ newsprint

☐ perfumes
☐ smoke
☐ soap
☐ pollen
☐ chocolate
☐ dairy
☐ eggs

☐ food coloring
☐ nuts
☐ peanuts
☐ shellfish
☐ soy
☐ wheat
☐ other: _____

Label the NUMBER (#) of the TYPE of reaction you have to EACH allergy immediately AFTER the allergy above:

1. angioedema
2. anaphylaxis
3. GI disturbance
4. headache
5. joint pain
6. rash
7. shortness of breath
8. unspecified reaction

Surgery (ies): LIST All Surgical Procedures. Write the DATE of the Procedure immediately afterward.

☐ ear tubes
☐ Lasik
☐ Cataract Surgery
☐ tonsils
☐ adenoids
☐ dental surgery
☐ wisdom teeth
☐ thyroid
☐ pacemaker
☐ cardiac catheterization

☐ coronary artery bypass
☐ cardiac valve replacement
☐ angioplasty
☐ gastric bypass
☐ appendectomy
☐ abdominal aortic aneurysm
☐ gallbladder
☐ hernia repair
☐ hemorrhoidectomy
☐ mastectomy

☐ hysterectomy
☐ D & C
☐ cesarean section
☐ transplant
☐ spinal fusion
☐ discectomy level
☐ laminectomy
☐ shoulder
☐ carpal tunnel
☐ ganglion cyst

☐ knee repair
☐ bunionectomy
☐ joint reconstruction
☐ joint replacement
☐ cosmetic - facelift
☐ cosmetic - nose
☐ cosmetic - tummy tuck
☐ breast reduction
☐ breast enlargement
☐ other:

Females ONLY: Ob/Gyn Mark all that apply below.

If you have been pregnant in the past, please fill in the appropriate information below.

_____ Number of complicated pregnancies
_____ Number of uncomplicated pregnancies
_____Number of C-sections
_____ Number of vaginal deliveries
_____ Number of miscarriages
_____ Number of terminated pregnancies
☐ I am currently pregnant
☐ I am NOT currently pregnant

Menstrual History.

I… ☐ currently have menses
☐ currently DO NOT have menses.
My menses… ☐ are regular
☐ are NOT regular
_____ Age of first menses
_____ Age when menopause began
Date of last menses: _____/_____/_____

Injuries/Hospitalizations: Mark or List All Injuries. Write the DATE of the Injury immediately afterward.

☐ car accident
☐ multiple car accidents
☐ motorcycle accident
☐ boating accident
☐ slip and fall
☐ multiple slip and falls
☐ industrial accident
☐ head injury (no loss of consciousness)
☐ head injury (loss of consciousness)
☐ broken bones
☐ fracture
☐ joint injury
☐ laceration (severe)
☐ soft tissue injury
☐ back injury
☐ disability (ies)
☐ Blood transfusions
☐ other:

Adult Illness (es): LIST all health conditions. CIRCLE all CURRENT conditions.

☐ Alzheimers
☐ Parkinson's disease
☐ seizures
☐ epilepsy
☐ anorexia
☐ bulimia
☐ anemia
☐ depression
☐ suicide attempt(s)
☐ psychiatric problems
☐ ADHD
☐ CVA (stroke)
☐ multiple sclerosis
☐ Polio
☐ Systemic lupus
☐ discoid lupus
☐ cerebral palsy
☐ eye problems
☐ vertigo
☐ shingles
☐ chicken pox
☐ influenzal pneumonia
☐ AIDS/HIV
☐ STD's (unspecified)
☐ hepatitis
☐ thyroid problems
☐ CRPS (RSDS)
☐ fibromyalgia
☐ cancer
☐ eczema
☐ psoriasis
☐ arthritis
☐ osteoporosis
☐ herniated disc
☐ hernia
☐ scoliosis
☐ hypertension
☐ heart disease
☐ asthma
☐ pneumonia
☐ emphysema
☐ bronchitis
☐ unspecified pleural effusion
☐ lung disease
☐ liver disease
☐ diabetes (non-insulin)
☐ diabetes (insulin dep)
☐ crohn's/colitis
☐ kidney disease
☐ past history of similar symptoms
☐ other:

Social History: Mark all that apply below.

Alcohol: ☐ never used alcohol ☐ do not drink alcohol ☐ social consumption only ☐ Recovering alcoholic
☐ Drink the following regularly: ☐ beer ☐ liquor ☐ wine ☐ other:_____
quantity of _____ oz./glasses per ☐ day ☐ week ☐ month

Tobacco: ☐ never used tobacco ☐ Do not use tobacco ☐ Do not smoke cigars, cigarettes or pipe
☐ Live with a smoker ☐ Quit smoking
☐ Smoke: # _____ per ☐ Day ☐ Week ☐ Month ☐ Chew: #_____cans per ☐ Day ☐ Week ☐ Year

Substance: ☐ never used recreational drugs ☐ have not used recreational drugs since _____.
☐ never used IV drugs ☐ used recreational drugs for _____ (how long?) ☐ Recovering drug addict

Family History: Mark all that apply below.

Have any immediate or secondary family members ever been diagnosed with?				Family Member(s) Diagnosed:
Auto-immune Disease	☐ yes	☐ no	☐ unknown	
Alzheimer's/Dementia	☐ yes	☐ no	☐ unknown	
Arthritis	☐ yes	☐ no	☐ unknown	
Alcoholism	☐ yes	☐ no	☐ unknown	
Asthma	☐ yes	☐ no	☐ unknown	
Blood Disorders	☐ yes	☐ no	☐ unknown	
Bone Disorders	☐ yes	☐ no	☐ unknown	
Cancers	☐ yes	☐ no	☐ unknown	
Diabetes	☐ yes	☐ no	☐ unknown	
Epilepsy/Seizures	☐ yes	☐ no	☐ unknown	
High Blood Pressure	☐ yes	☐ no	☐ unknown	
High Cholesterol	☐ yes	☐ no	☐ unknown	
Kidney Disease	☐ yes	☐ no	☐ unknown	
Liver Disease	☐ yes	☐ no	☐ unknown	
Heart Attack/Disease	☐ yes	☐ no	☐ unknown	
Mental Health Disorder	☐ yes	☐ no	☐ unknown	
Stroke or Blood Clots	☐ yes	☐ no	☐ unknown	

X-ray Questionnaire:

Our consultation and examination may indicate that x-rays are necessary to diagnose and analyze your condition accurately. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

☐ There is a possibility that I may be pregnant at this time.
☐ Yes, I am definitely pregnant
☐ No, I am definitely not pregnant at this time
☐ Date of last menstrual period:
☐ I request that x-ray films not be taken because:_____

Patient [or Parent/Guardian] Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*:*

I acknowledge that I can view the Notice of Privacy Practices of Arizona Chiropractic and Holistic Health Center, which describes the practice policies and procedures regarding the use and disclosure of any of my Protected Health Information created, received, or maintained by the practice online at https://azholistichealthcenter.com/about-us/notice-of-privacy-practices. I have had the summary explained to me and understand the Practice will explain any questions I have regarding the complete privacy notice.

Patient [or Parent/Guardian] Signature: _____ Date: _____
Printed Name _____

CHIROPRACTIC INFORMATION & INFORMED CONSENT

The doctor of chiropractic evaluates the patient using standard examination and testing procedures. A chiropractic adjustment involves the application of a quick, precise force directed over a very short distance to a specific vertebra or bone. There are a number of different techniques that may be used to deliver the adjustment, some of which utilize specially designed equipment. Adjustments are usually performed by hand but may also be performed by hand-guided instruments. In addition to adjustments, other treatments used by chiropractors include physical therapy modalities (heat, ice, ultrasound, soft-tissue manipulation), nutritional recommendations, and rehabilitative procedures.

Chiropractic treatments are one of the safest interventions available to the public demonstrated through various clinical trials and indirectly reflected by the low malpractice insurance paid by chiropractors. While there are risks involved with treatment, these are seldom great enough to contraindicate care. Referral for further diagnosis or management to a medical physician or other health care provider will be suggested based on history and examination findings.

Listed below are summaries of both common and rare side-effects/complications associated with chiropractic care:

Common [1, 2]

- Reactions most commonly reported are local soreness/discomfort (53%), headaches (12%), tiredness (11%), radiating discomfort (10%), dizziness, the vast majority of which resolve within 48 hours

Rare [3, 4]

- Fractures or joint injuries in isolated cases with underlying physical defects, deformities or pathologies
- Physiotherapy bums due to some therapies
- Disc herniations
- Cauda Equina Syndrome [(2)] (1 case per 100 million adjustments)
- Compromise of the vertebrobasilar artery (i.e. stroke) (range: 1 case per 400,000 to 1 million cervical spine adjustments [manipulations]). This associated risk is also found with consulting a medical doctor for patients under the age of 45 and is higher for those older than 45 when seeing a medical doctor.

Please indicate to your doctor if you have headache or neck pain that is the worst you have ever felt [(3)]

I understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. I also understand that my condition may worsen and referral may be necessary if a course of chiropractic care does not help or improve my condition.

Reasonable alternatives to these procedures have been explained to me including prescription medications, over-the-counter medications, possible surgery, and non-treatment. Listed below are summaries of concerns with the associated alternative procedures.

- Long-term use or overuse of medication carries some risk of dependency with the use of pain medication and the risk of gastrointestinal bleeding among other risks
- Surgical risks may include unsuccessful outcome, complications such as infection, pain, reactions to anesthesia, and prolonged recovery [(5)].
- Potential risks of refusing or neglecting care may result in increased pain, restricted motion, increased inflammation, and worsening of my condition [(6)]

Neck and back pain generally improve in time, however, recurrence is common. Remaining active and positive improves your chances of recovery.

1. Thiel HW, Bolton JE, Docherty S, Portlock JC. Safety of chiropractic manipulation of the cervical spine: a prospective national survey. *Spine,* Oct 1 2007; 32(21):2375-2378; discussion 2379.
2. Rubinstein SM, Leboeuf-Yde C, Knol DL, de Koekkoek TE, Pfeifle CE, van Tulder MW. The benefits outweigh the risks for patients undergoing chiropractic care for neck pain: a prospective, multicenter, cohort study. *J Manipulative Physiol Ther.* Jul-Aug 2007; 30(6):408-418.
3. Cassidy JD, Boyle E, Cote P, et al. Risk of vertebrobasilar stroke and chiropractic care: results of a population-based case-control and case-crossover study. *Spine.* Feb 15 2008; 33(4 Suppl):S176-183,
4. Boyle E. Cote P, Grier AR, Cassidy JO. Examining vertebrobasilar artery stroke in two Canadian provinces. *Spine.* Feb 15 2008; 33(4 Suppl):S170-175.
5. Carragee EJ, Hurwitz EL, Cheng I, et al. Treatment of neck pain: injections and surgical interventions: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders, *Spine,* Feb 15 2008; 33(4 Suppl):S153-169.
6. Carroll LJ, Hogg-Johnson S, van der Velde G, et al. Course and prognostic factors for neck pain in the general population: results of the Bone and Joint Decade 2000-2010 Task Force on Neck Pain and Its Associated Disorders, *Spine,* Feb 15 2008; 33(4 Suppl):S75-82.

Please answer the following questions to help us determine possible risk factors:

QUESTION	YES	NO	DOCTOR'S COMMENTS
GENERAL			
Have you ever had an adverse (i.e. bad) reaction to or following chiropractic care?	☐	☐	
BONE WEAKNESS	**YES**	**NO**	**DOCTOR'S COMMENTS**
Have you been diagnosed with osteoporosis?	☐	☐	
Do you take corticosteroids (e.g. prednisone)?	☐	☐	
Have you been diagnosed with a compression fracture(s) of the spine?	☐	☐	
Have you ever been diagnosed with cancer?	☐	☐	
Do you have any metal implants?	☐	☐	
VASCULAR WEAKNESS	**YES**	**NO**	**DOCTOR'S COMMENTS**
Do you take aspirin or other pain medication on a regular basis?	☐	☐	
If yes, how much do you take daily? _____			
Do you take warfarin (Coumadin), heparin, or other similar "blood thinners"?	☐	☐	
Have you ever been diagnosed with any of the following disorders/diseases?			
• Rheumatoid arthritis	☐	☐	
• Reiter's syndrome, ankylosing spondylitis, or psoriatic arthritis	☐	☐	
• Giant cell arteritis (temporal arteritis)	☐	☐	
• Osteogenesis imperfecta	☐	☐	
• Ligamentous hypermobility such as with Marfan's disease, Ehlers-Danlos syndrome	☐	☐	
• Medial cystic necrosis (cystic mucoid degeneration)	☐	☐	
• Bechet's disease	☐	☐	
• Fibromuscular dysplasia	☐	☐	
Have you ever become dizzy or lost consciousness when turning your head?	☐	☐	
SPINAL COMPROMISE OR INSTABILITY	**YES**	**NO**	**DOCTOR'S COMMENTS**
Have you had spinal surgery?	☐	☐	
If yes, when? _____			
Have you been diagnosed with spinal stenosis?	☐	☐	
Have you been diagnosed with spondylolisthesis?	☐	☐	
Have you had any of the following problems?	☐	☐	
• Sudden weakness in the arms or legs?	☐	☐	
• Numbness in the genital area?	☐	☐	
• Recent inability to urinate or lack of control when urinating?	☐	☐	

I have read the previous information regarding the risks of chiropractic care and my doctor has verbally explained my risks (if any) to me and suggested alternatives when those risks exist. I understand the purpose of my care and have been given an explanation of the treatment, the frequency of care, and alternatives to this care. All of my questions have been answered to my satisfaction. I agree to this plan of care understanding any perceived risk(s) and alternatives to this care.

Patient [or Parent/Guardian] Signature: _____ Date: _____

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 Arizona 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. Further, the parties will not have the right to participate as a member of any class of claimants, and there shall be no authority for any dispute to be decided on a class action basis. An arbitration can only decide a dispute between the parties and may not consolidate or join the claims of other persons who have similar claims.

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 binds 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 healthcare provider and/or other licensed healthcare 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 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 the patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), the 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 Name: _____ Signature: _____ Date: _____
Parent or Guardian: _____ Signature: _____ Date: _____
Witness Name: _____ Signature: _____ Date: _____