Doctors Center
Family and Urgent Care

Summerlin Location	Henderson Location	Southwest Location
2801 N Tenaya Way, Ste C	1371 W Warm Springs Rd, #100	6120 S Fort Apache Rd, #100
Las Vegas, NV 89128	Henderson, NV 89014	Las Vegas, Nv 89148
PH: (702) 684 – 7800	PH: (702) 998 – 5549	PH: (702) 602 – 5444
Fax: (702) 684 – 7878	Fax: (702) 463 – 9268	Fax: (702) 602 – 5454

Patient Information

Last Name: _____ First Name: _____
Sex: _____ DOB: _____ Age: _____
Address: _____ City: _____ State: _____ Zip: _____
Cell Phone: _____ Alt. Phone: _____
Work phone: _____ Occupation: _____
Employer: _____ Marital Status: _____
Email Address: _____
Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Insurance: _____ Member ID: _____ Group Number: _____
Policy Holder: _____ DOB: ____/____/_____ SSN: _____
Secondary Insurance: _____ Member ID: _____ Group Number: _____
Policy Holder: _____ DOB: ____/____/_____ SSN: _____

Primary Pharmacy Name/Address: _____
Mail Order Pharmacy Name/Number: _____

Reason for today's visit: _____
_____

Past Medical History:

☐ No known Medical History
☐ Gastric Reflux ☐ Asthma/COPD
☐ Allergies ☐ Heart Disease
☐ High Cholesterol ☐ High Blood Pressure
☐ Thyroid Disorder ☐ Anxiety
☐ A-Fib ☐ Depression
☐ Diabetes: Type: _____
☐ Cancer (specify): _____

Other:
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

Past Surgical History:

☐ Appendectomy ☐ Hemorrhoidectomy ☐ Tonsillectomy / Adenoidectomy
☐ Bladder Surgery ☐ Hernia Repair/Type: _____
☐ Breast Surgery ☐ Hysterectomy/Type: _____
☐ Tubal Ligation ☐ Vasectomy ☐ Gallbladder
☐ Colon Resection ☐ Cesarean section
☐ Other _____

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Social History

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Separated
Children: ☐ Yes ☐ No
Alcohol Use: ☐ Yes ☐ No → Number of Drinks/ Frequency: _____
Tobacco Use: ☐ Never ☐ Current Smoker: _____ Packs Per Day for _____ years.
☐ Previous smoker → Quit: _____ ☐ Chew
Caffeine: ☐ None ☐ 1-3 servings/day ☐ 4-6 servings/day ☐ > 6 servings/day
Drug Use: ☐ None ☐ Marijuana ☐ Cocaine ☐ Heroin ☐ Other: _____
Exercise: ☐ None _____ x's per week Type of Exercise: _____

Allergies: ☐ No known drug allergies

Medication	Reaction

Current Medication:

Medication Name	Dose	Frequency	Refills needed?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Screenings:
Last Pap Smear: _____ Last Mammogram: _____ Last Bone Density: _____
Last Colonoscopy: _____ Last PSA: _____ Last Eye Exam: _____
Last Breast Exam: _____ Last Diabetic Eye Exam: _____

Vaccines: (year)
☐ Pneumonia: _____ ☐ Influenza: _____ ☐ Shingles: _____ ☐ Tetanus: _____

Organ Donor: ☐ Yes ☐ No
Do you have an Advance Directive or Living Will? ☐ Yes ☐ No
Have you ever been exposed to **Toxic Substances,** such as asbestos, DES, radiation, chemicals? ☐ Yes ☐ No
If yes, please explain: _____

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Family Medical History

	Father	Mother	Sister	Brother	Grandparent	Other
Diabetes						
Glaucoma						
Cancer (list type)						
Angina/TIA/Stroke						
High Blood Pressure						
High Cholesterol						
Alcoholism and/or Drug Abuse						
Depression						
Mental Illness (please specify)						
Suicide						
Other Health Problems (please specify)						

☐ **UNKOWN**

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Authorization for Release of Medical Records

Please note, there may be a fee for copies of medical records

_____ _____

Patients name **Birthdate**

_____ _____ _____

Home Phone **Work Phone** **Mobile Phone**

_____

Address **City** **State** **Zip**

THE AFORMENTIONED PATIENT AUTHORIZES THE FOLLOWING HEALTHCARE FACILITY TO DISCLOSE THE REQUESTED RECORDS

_____

FACILITY NAME

_____ _____ _____

Doctor's Name **Facility Phone** **Facility Fax**

_____

Address **City** **State** **Zip**

DATES & TYPES OF INFORMATION TO DISCLOSE

___ ONE (1) YEAR PRIOR TO LAST DATE SEEN WITH LABS, IMAGES, ETC.

___ SPECIFIC INFORMATION: _____

___ OTHER: _____

PURPOSE OF THE REQUESTED DISCLOSURE

___ CHANGE OF PHYSICIAN OR INSURANCE

___ CONTINUATION OF CARE (EX: PAIN MGMT)

RESTRICTIONS: ONLY MEDICAL ORIGINATED THROUGH THIS HEALTH CARE FACILITY WILL BE COPIED UNLESS OTHERWISE REQUESTED IN WRITING BY PATIENT. THIS AUTHORIZATION IS VALID ONLY FOR THE RELEASE OF MEDICAL INFORMATION DATED PRIOR TO AND INCLUDING THE DATA ON THIS AUTHORIZATION UNLESS DATES ARE SPECIFIED.

***FURTHERMORE,** I UNDERSTAND MY HEALTH RECORDS MAY INCLUDE (BUT ARE NOT LIMITED TO) INFORMATION RELATING TO SEXUALLY TRANSMITTED DISEASES, ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR HUMAN IMMUNODEFICIENCY VIRUS (HIV). IT MAY ALSO INCLUDE INFORMATION ABOUT BEHAVIORAL OR MENTAL HEALTH SERVICES AND TREATMENT FOR ALCOHOL AND/OR DRUG ABUSE.

THIS INFORMATION MAY BE DISCLOSED AND USED BY THE FOLLOWING FACILITY

DOCTORS CENTER AT RED ROCK

PHONE: (702) 684 – 7800 ***PLEASE FAX RECORDS TO: (702) 684 – 7878**

I MAY REVOKE THIS AUTHORIZATION AT ANY TIME WITH A WRITTEN LETTER OF REVOCATION DELIVERED TO THE HEALTHCARE FACILITY'S RECORD DEPARTMENT. I UNDERSTAND REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION OR APPLY TO INSURANCE COMPANY WHEN THE LAW PROVIDES MY INSURER WITH THE RIGHT TO CONTEST A CLAIM UNDER MY POLICY. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION EXPIRES ON THE FOLLOWING DATE, EVENT OR CONDITIONS: _____. UNLESS SPECIFIED THIS AITHORIZATION WILL EXPIRE ONE (1) YEAR FROM THE DATE SIGNED.

I ACKNOWLEDGE THAT I HAVE READ THE AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND AM AWARE OF AND FULLY UNDERSTAND THE TERMS & CONDITIONS OF THIS AUTHORIZATION.

_____ _____ _____

PRINT NAME OF PATIENT OR GUARDIAN **SIGNATURE OF PATIENT OR GUARDIAN** **DATE**

Doctors Center
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NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect (April 14, 2003) and will remain in effect until we replace it.

We reserve the right to change our privacy practices and terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. You may request a copy of notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose your health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative, or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgement and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

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National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, e-mails, or text messages).

PATIENT RIGHTS Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable duplication fee for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure).

Disclosure Accounting: You have a right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing). Your request must specify the alternative means or location and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended). We may deny your request under certain circumstances.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Leo J Capobianco, DO, FAAEM
Telephone: (702) 684 – 7800
Email: doctorscenterlv@gmail.com

Address: 2801 N Tenaya Way
STE C
Las Vegas, NV 89128

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HIPAA CONSENT & PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or have a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of their home.

I wish to be contacted in the following manner (please check all that apply).

___ HOME PHONE: _____
- **__ OK to leave a message with details**
- **__ Leave message with call-back number only**

___ MOBILE PHONE: _____
- **__ OK to leave a message with details**
- **__ Leave message with call-back number only**

___ WORK PHONE: _____
- **__ OK to leave a message with details**
- **__ Leave message with call-back number only**

___ MAIL CORRESPONDENCE: _____
- **__ OK to mail to my home address**
- **__ OK to mail to my work/office address**

___ OK to fax – FAX NUMBER: _____

___ I give authorization to Doctors Center to leave a message in my absence with:

Name: _____

Number(s): _____

Relationship: _____

for matters regarding the following:

__ my appointment reminders

__ my account – such as bills & amount due

__ my treatment & test results

I acknowledge that I have read a copy of the Notice of Privacy Practices for HIPAA.

_____ _____

PRINT PATIENT'S NAME **PATIENT'S DATE OF BIRTH**

_____ _____

PATIENT OR GUARDIAN SIGNATURE **TODAY'S DATE**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of PHI disclosures and requests to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records on PHI disclosures. Information provided below, if completed properly, will constitute an adequate record.

RECORDS OF DISCLOSURES OF PROTECTED HEALTH INFORMATION

(This section below is to be completed by Office Staff only when disclosing records.)

(1) Check for authorized disclosures

(2) Type: T = Treatment Records
P = Payment information
O = Healthcare Operations

(3) Mode: F = Fax
P = Phone
E = Email
O = Other

DATE	DISCLOSED TO WHOM / ADDRESS OR FAX #	DESCRIPTION OF DISCLOSURE / PURPOSE OF DISCLOSURE	BY WHOM DISCLOSED	1	2	3

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PATIENT FINANCIAL AGRREMENT

- **CO – PAYMENTS:** Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit.
- **Deductible Payments:** If your insurance requires you to meet a deductible before services are covered, a balance due will be calculated based on your insurance plan and a payment must be made at the time of service. Please note that this calculated payment does not constitute payment in full and any additional balance must be paid upon receiving notification from our practice.
- **Claims Submission:** We will submit your claims and assists in any way reasonable to get claims paid. Payment from your insurance company is expected within 45 days. After 45 days, we will look to you for payment in full. You will be responsible for all non-covered services according to Medicare guidelines. We require a copy of your current primary and any secondary insurance cards or supplemental you have. Accounts that are 90 days past due are subject to being sent to a collection agency or small claims court for the unpaid bills. If we receive notification that you are not eligible for coverage or we are not contracted with your insurance, you will be responsible for all charges incurred. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with your request.
- **Preventative Care Services:** Routine exams are not always covered by your insurance. Please be aware that if an additional problem is addressed at the time of your visit, a co-pay, deductible, or office visit fee may be charged. If payment for services is denied by your insurance or you have failed to provide us with your correct insurance information, you will be responsible to pay for these services.
- **Cash Pay Patients:** The amount paid for today's scheduled office visit may not be your final payment. Additional costs from today's appointment may include (but are not limited to); lab tests, x-rays, injections, special procedures and/or additional office charges.
- **Laboratory Bills:** Any laboratory procedures ordered during today's visit will be billed to you directly by the laboratory. Please contact the laboratory directly for any questions you may have.
- **Financial Hardship:** If at any time you should experience financial hardship and need to request special payment arrangements; please contact our billing department.
- **Cancellation / No Show Policy:** Our goal is to provide quality medical care in a timely manner. In order to do so, we have implemented an appointment/cancellation policy. This policy enables us to better utilize available appointments for our patients in need of medical care. A "no-show" is someone who misses an appointment without canceling it within 24 hours of the scheduled appointment. This "no-show" will result in a $25 fee, which will **NOT** be covered by your insurance. Please keep in mind that in order to fully cancel your appointment, you must speak *directly* to a member of our staff; leaving a voicemail does not guarantee that we have canceled your appointment.

Assignment of Benefits: Authorization is hereby granted to release information as may be necessary to process and complete my insurance claim for all services rendered. Payment of medical benefits is to be paid directly to:

____ "Doctors Center at Red Rock" – Office: 702.684.7800
____ "Doctors Center Henderson" – Office: 702.998.5549
____ "Doctors Center Southwest" – Office: 702.602.5444

Initials: _____

I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT. I ALSO UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY ACCOUNT AND AGREE TO COMPLY WITH THE FINANCIAL POLICIES OF THE OFFICE.

Patient Name: _____ Date of Birth: _____
Signature of Patient/Guardian: _____ Date: _____

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A BRIEF LOOK AT ARBITRATION

Introduction: Arbitration – An alternative dispute resolution procedure that has been endorsed by such groups as the California Medical Association and a favored method of resolving disputes by the U.S. Supreme Court. The Supreme Court has, in fact, previously held that arbitration is strongly favored as an expeditious and economical alternative to the court system. If you are unfamiliar with arbitration, the information included here provides some of the basic principles.

What is Arbitration? Instead of taking your disagreement through a long expansive court litigation process, all parties involved agree in advance to submit any dispute to an arbitrator for determination. Arbitrators (are mutually agreed to) are retired judges available and qualified to serve on such matters. After a hearing, which is usually less formal than a court proceeding, the arbitrators make a decision (award). Although a different procedure, generally the same measure of damages and laws which apply to court proceedings; also apply to arbitration.

Does Arbitration prevent from filing a claim? *NO.* By selecting arbitration as a means to resolve the disagreement, all you are essentially doing is moving the claim to a different forum to hear and ultimately decide your claim.

May an attorney of my choice represent me? *YES.* An attorney of choice may represent either party at their own expense. The arbitrator will hear facts and make a determination whether or not lawyers are present from either party.

Who is bound by the agreement? If you choose to sign this agreement, you agree to bind yourself and anyone who could sue in connection with treatment or services provided to you. If you sign on behalf of a family member or person from whom you have responsibility; you will bind that person as well as anyone who could sue in connection with the treatment or services provided to that person. Likewise, the doctor or anyone suing on behalf of the doctor would also be bound to the agreement.

What does Arbitration cost? Usually, arbitration is less costly than court actions. The parties ordinarily share the costs equally. The amount of fees will depend upon the complexity and length of the case.

If either party disapproves of the results; could there still be a jury trial? Generally, the answer is **NO.** The purpose of arbitration is to avoid the expense, delay, and inconvenience of going to court. Arbitration Awards may be reviewed and potentially reversed by a court in certain circumstances.

A Message to our Patients about Arbitration

An Arbitration Agreement is attached and by signing this agreement, we are agreeing to resolve any dispute arising from the medical services you receive in binding arbitration rather than in a court of law. Lawsuits are something no one anticipates, and everyone hopes to avoid. Arbitration has long been recognized and approved by the courts, and we believe this method of resolving disputes is one of the fairest systems for both patients and physicians. You may still call witnesses and present evidence. Each party selects an arbitrator; the two then select a third neutral arbitrator; these three hear the case. This agreement generally helps to limit the legal cost for both parties. Furthermore, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

ULTIMATELY, OUR GOAL IS TO PROVIDE MEDICAL CARE TO YOU IN SUCH A WAY AS TO AVOID ANY SUCH DISPUTES. WE FEEL MOST ISSUES BEGIN WITH A LACK OF COMMUNICATION; THEREFORE, PLEASE DIRECT ANY QUESTIONS OR CONCERNS TO ANY OF OUR STAFF.

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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 Nevada law, and not by a lawsuit or resort to court process except as Nevada law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are voluntarily 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 binding arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all existing or subsequent claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born 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 both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A notice or demand for arbitration must be communicated in writing by U.S. mail; postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses, and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select an arbitrator to preside over the matter who was previously a court judge. Both parties agree the arbitration shall be governed pursuant to Nevada Revised Statutes (NRS) 38.206 – 38.248, 41A.035, .045, .097, .100, .110, .120, 42.005 and .021 and the Federal Arbitration Act (9 U.S.C. §§ 14), and that they have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. The parties shall bear their own costs, fees and expenses, along with a pro rata share of the arbitrator's fees and expenses, and hereby waive the provisions of NRS 38.238.

Article 4: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by patient.

Article 5: Severability Provision: In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with Nevada and federal law.

Article 6: Condition of Treatment: I understand that signing this arbitration agreement is not a condition of my receiving medical treatment. I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO WAIVE 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).

_____ INITIAL HERE TO INDICATE THAT YOU HAVE BEEN GIVEN THE DOCUTMENT TITLED: "A BRIEF LOOK AT ARBITRATION"

By: _____
Physician or Duly Authorized Representative Signature

By: _____
Print or Stamp Name of Physician

By: _____
Signature of Translator (Date)

By: _____
Patient's Signature (Date)

By: _____
Print Patient's Name

By: _____
Print Name & Relationship to Patient (Date)