



Full Legal Name _____ Today's Date ____/____/____

Male ____ Female ____ Single ____ Married ____ Widow ____ Divorced ____

How you prefer to be addressed _____ Birthdate _____ Social Security # ____-____-____

Street Address _____ City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Phone Carrier _____ E-Mail Address _____

Referred to our office by _____

Emergency Contact Name _____ Phone Number _____

Employer Information

Employer's Name _____ What do you do there? _____

Employer's Address _____

Years with present employer? _____ Work Phone _____ Ok to call you at work? YES NO

Insurance Information Is your current condition the result of an accident/injury? Yes ____ No ____ If yes: Work ____ Auto ____ Slip/Fall ____

Primary Insurance Company

Insurance Company Name _____ ID# _____

Insureds Name & Relation _____ Insureds DOB _____ Insureds SS# _____

Ins. Co. Address _____

Ins. Co. Phone Number _____

Secondary Insurance Company

Insurance Company Name _____ ID# _____

Insureds Name & Relation _____ Insureds DOB _____ Insureds SS# _____

Ins. Co. Address _____

Ins. Co. Phone Number _____

Patient Acknowledgement

By my signature, I understand and acknowledge that **Banks Chiropractic**, its Physicians and agents, will treat my condition as they deem necessary through the use of chiropractic manipulative therapy and adjunctive therapies. I also understand that all original documents and original X-rays created as a result of the performance of examinations will remain the property of **Banks Chiropractic**, its Physicians and agents, will not be held responsible for any undisclosed pre-existing conditions. As the parents, guardian, or parentally authorized agent, I hereby authorize **Banks Chiropractic**, its Physicians and agents, to administer care to this minor.

Signature of Patient/Responsible Party _____ Date ____/____/____

Banks Wellness; Scott Banks, DC, IFMCP, PC 755 New York Ave., Suite 308; Huntington, N.Y. 11743; 631-271-0770



Name: _____ Date: _____

Please check the appropriate box(es) for any of the following symptoms of ill health which you may now have or have had previously. In order to provide necessary chiropractic care we need to know all the facts related to your health. This is a Confidential Health Report.

Have you ever?

Yes No

- Been Knocked Unconscious?
- Used Crutches or other Support?
- Been Treated for Spine Problems?
- Been Treated for any Nerve Disorder?
- Had a Fractured/Broken Bone?
- Had Surgery?
- Been Hospitalized for Other than Surgery?

Date of Last: (approximate)

- _____ Physical Examination
- _____ Blood Test
- _____ Urine Test
- _____ Chest X-ray
- _____ Spine X-ray
- _____ Dental X-ray
- _____ Other

Habits:

Have you in the past or do you currently use:

- Alcohol: If yes how often? _____
- Coffee: How many cups per day? _____
- Tobacco: how many packs per day? _____

Is there a Family History of?

- Heart Disease Arthritis
- Cancer Diabetes
- Stroke _____

Your Current Problem

What are you current symptoms? 1. _____ 2. _____
3. _____ 4. _____

What level of intensity would you rate your pain? (10=severe) 1 2 3 4 5 6 7 8 9 10

What is the frequency of your symptoms? Occasional / Episodic / Intermittent / Frequent / Constant

Do your symptoms affect your personal life? (Hobbies, sports, etc) _____

Do your symptoms affect your job / occupation?(missed days, inability to stand, sit, lift, drive) _____

How long have you suffered from these symptoms? _____

Have you suffered from these symptoms before? Yes No

What makes your symptoms worse? _____

What makes your symptoms better? _____

What home remedies have you tried? _____

Have you been to any other type of doctor for this problem? _____

Have you been to a Chiropractor before? Yes No If Yes, Who? _____

After completing this questionnaire your signature will verify that all information you have given is accurate to the best of your knowledge

Signed: _____ Date: _____



Name: _____ Date: _____

HEALTH HISTORY

<p><u>General</u></p> <ul style="list-style-type: none"> <input type="radio"/> Chills <input type="radio"/> Depression <input type="radio"/> Dizziness <input type="radio"/> Fainting <input type="radio"/> Fever <input type="radio"/> Forgetfulness <input type="radio"/> Headache <input type="radio"/> Loss of sleep <input type="radio"/> Loss of weight <input type="radio"/> Nervousness <input type="radio"/> Sweats <p><u>Eyes</u></p> <ul style="list-style-type: none"> <input type="radio"/> Crossed eyes <input type="radio"/> Double vision <input type="radio"/> Vision – Flashes <input type="radio"/> Vision – Halos <input type="radio"/> Blurred Vision <p><u>Ears/Nose/Throat</u></p> <ul style="list-style-type: none"> <input type="radio"/> Earache <input type="radio"/> Ear discharge <input type="radio"/> Ringing in ears <input type="radio"/> Loss of hearing <input type="radio"/> Hay fever <input type="radio"/> Sinus problem <input type="radio"/> Nose bleeds <input type="radio"/> Bleeding gums <input type="radio"/> Hoarseness <input type="radio"/> Difficulty swallowing <input type="radio"/> Persistent cough <p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="radio"/> Shortness of breath <input type="radio"/> Cough <input type="radio"/> Congestion <input type="radio"/> Distress <input type="radio"/> Sputum <p><u>Genito-Urinary</u></p> <ul style="list-style-type: none"> <input type="radio"/> Blood in urine <input type="radio"/> Frequent urination <input type="radio"/> Lack of bladder control <input type="radio"/> Painful Urination <p><u>Endocrine</u></p> <ul style="list-style-type: none"> <input type="radio"/> Weight gain <input type="radio"/> Weight loss <input type="radio"/> Hoarseness <input type="radio"/> Heat intolerance <input type="radio"/> Cold intolerance <input type="radio"/> Breast changes <input type="radio"/> Hair changes <input type="radio"/> Extreme thirst 	<p><u>Gastrointestinal</u></p> <ul style="list-style-type: none"> <input type="radio"/> Poor appetite <input type="radio"/> Bloating <input type="radio"/> Bowel changes <input type="radio"/> Constipation <input type="radio"/> Diarrhea <input type="radio"/> Excessive hunger <input type="radio"/> Gas <input type="radio"/> Hemorrhoids <input type="radio"/> Indigestion <input type="radio"/> Nausea <input type="radio"/> Rectal bleeding <input type="radio"/> Stomach pain <input type="radio"/> Vomiting no blood <input type="radio"/> Vomiting bleeding <p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="radio"/> Chest pain <input type="radio"/> High blood pressure <input type="radio"/> Irregular heart beat <input type="radio"/> Low blood pressure <input type="radio"/> Poor circulation <input type="radio"/> Rapid heart beat <input type="radio"/> Swelling of ankles <input type="radio"/> Varicose veins <p><u>Integumentary</u></p> <ul style="list-style-type: none"> <input type="radio"/> Bruise easy <input type="radio"/> Hives <input type="radio"/> Changes in moles <input type="radio"/> Sores not healing <input type="radio"/> Itching <input type="radio"/> Unusual swelling <input type="radio"/> Sores/ulcers <input type="radio"/> Rash <input type="radio"/> Scars <p><u>Neurological</u></p> <ul style="list-style-type: none"> <input type="radio"/> Seizures <input type="radio"/> Vertigo <input type="radio"/> Hand trembling <input type="radio"/> Loss of sensations <input type="radio"/> Loss of facial expression <input type="radio"/> Weak grip <input type="radio"/> Paralysis <input type="radio"/> Difficulty speaking <input type="radio"/> Tingling <input type="radio"/> Loss of memory <input type="radio"/> Numbness <p><u>MEN Only</u></p> <ul style="list-style-type: none"> <input type="radio"/> Breast lumps <input type="radio"/> Erection difficulties <input type="radio"/> Lump in testicles <input type="radio"/> Penis discharge <input type="radio"/> Sore on penis 	<p><u>WOMEN Only</u></p> <ul style="list-style-type: none"> <input type="radio"/> Abnormal Pap Smear <input type="radio"/> Bleeding btwn periods <input type="radio"/> Breast lumps <input type="radio"/> Menstrual pain <input type="radio"/> Hot flashes <input type="radio"/> Nipple discharge <input type="radio"/> Painful intercourse <input type="radio"/> Vaginal discharge <input type="radio"/> Other _____ <input type="radio"/> Date of last menstrual period _____ <input type="radio"/> Date of last Pap Smear _____ <input type="radio"/> Date of last mammogram _____ <input type="radio"/> Are you pregnant? _____ <input type="radio"/> Number of children _____ <p><u>Muscle/Joint/Bone</u></p> <ul style="list-style-type: none"> <input type="radio"/> Arms <input type="radio"/> Hips <input type="radio"/> Back <input type="radio"/> Legs <input type="radio"/> Feet <input type="radio"/> Neck <input type="radio"/> Hands <input type="radio"/> Shoulders <p><u>Psychiatric</u></p> <ul style="list-style-type: none"> <input type="radio"/> Hyperventilation <input type="radio"/> Insecurity <input type="radio"/> Depression <input type="radio"/> Trouble sleeping <input type="radio"/> Irritable <input type="radio"/> Anxiousness <input type="radio"/> Undecidedness <input type="radio"/> Timid <input type="radio"/> Hallucinations <input type="radio"/> Loss of memory <input type="radio"/> Alcoholism <input type="radio"/> Drug addiction <input type="radio"/> Drug dependency <input type="radio"/> Extreme worry <input type="radio"/> Sexual problems <input type="radio"/> Suicidal thoughts 	<p><u>Conditions</u></p> <ul style="list-style-type: none"> <input type="radio"/> AIDS <input type="radio"/> Alcoholism <input type="radio"/> Anemia <input type="radio"/> Anorexia <input type="radio"/> Appendicitis <input type="radio"/> Asthma <input type="radio"/> Bleeding disorders <input type="radio"/> Breast lumps <input type="radio"/> Bronchitis <input type="radio"/> Breath shortness <input type="radio"/> Bulimia <input type="radio"/> Cancer <input type="radio"/> Cataracts <input type="radio"/> Chemical dependency <input type="radio"/> Chicken pox <input type="radio"/> Diabetes <input type="radio"/> Emphysema <input type="radio"/> Epilepsy <input type="radio"/> Glaucoma <input type="radio"/> Goiter <input type="radio"/> Gonorrhea <input type="radio"/> Gout <input type="radio"/> Heart disease <input type="radio"/> Hepatitis <input type="radio"/> Hernia <input type="radio"/> Herpes <input type="radio"/> High cholesterol <input type="radio"/> HIV <input type="radio"/> Kidney disease <input type="radio"/> Liver disease <input type="radio"/> Measles <input type="radio"/> Migraines <input type="radio"/> Miscarriage <input type="radio"/> Mononucleosis <input type="radio"/> Multiple Sclerosis <input type="radio"/> Mumps <input type="radio"/> Pneumonia <input type="radio"/> Polio <input type="radio"/> Prostate problem <input type="radio"/> Rheumatic fever <input type="radio"/> Scarlet fever <input type="radio"/> Stroke <input type="radio"/> Suicide attempt <input type="radio"/> Thyroid fever <input type="radio"/> Ulcers <input type="radio"/> Vaginal infections <input type="radio"/> Venereal disease <input type="radio"/> Other _____
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MEDICATIONS: List medications you are currently taking

ALLERGIES: List ALL allergies

Patient Signature: _____ DATE: _____



755 New York Avenue Suite 308, Huntington, NY 11743
Tel (631) 271-0770 Fax (631) 271-0786

AUTHORIZATIONS & ACKNOWLEDGEMENTS

While it is never our intention to bring anything of a potentially negative bent into a health and healing relationship, we, along with other health care providers and hospitals, are obliged by the state of New York to ask that you read and sign the following:

TREATMENT AUTHORIZATION: I (print name) _____ authorize Chiropractic Care, including spinal adjustment, of myself or my minor child by the Doctors and staff at Scott J Banks, DC, PC

INFORMED CONSENT: Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care this Chiropractic office, a health history and physical examination will be completed. These procedures are performed to assess your specific condition, your overall health and, in particular, your spinal health. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

Chiropractic treatment, including spinal adjustment, has been the subject of government reports and multi-disciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic care contributes to your overall well being. The risk of injuries or complications from chiropractic treatment is substantially lower than that associated with many medical or other treatments, medications, and procedures given for the same symptoms.

PRIOR CHIROPRACTIC TREATMENT INFORMATION

Name of Chiropractor: _____ Location (city): _____

When was your last treatment? _____ Have you had x-rays taken? _____

MEDICAL DOCTOR: Scott J Banks, DC, PC believes your medical doctor is a vital part of your healthcare team. As such, upon your request, we will send evaluations and progress reports to the physician listed below.

NAME: _____ **SPECIALTY:** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP CODE:** _____

TELEPHONE: _____ **FAX:** _____

REFERRAL AUTHORIZATION: Your insurance carrier may require a referral from your primary care physician for our services. Please be aware that it is your responsibility to obtain all necessary referrals prior to therapy. If your insurance carrier requires an authorization for service, no service will be rendered until the authorization is obtained.

CANCELLATION AND/OR NO-SHOW POLICY: Scott J Banks, DC, PC urges you to keep every appointment, as consistent treatment provides optimal benefit. In the event you need to cancel an appointment, we require at least 24 hours notice, excluding Sunday. Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a \$50.00 charge for each occurrence. Arrival more than 15 minutes after the time of your scheduled appointment may be considered a failed appointment.

ASSIGNMENT OF BENEFITS: I authorize payment of my Medicare and/or Insurance benefits to be made directly to Scott J Banks, DC, PC on my behalf for services rendered. In the event my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me, I will endorse such payments to Scott J Banks, DC, PC within five (5) days of receipt of such payment.

FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL SCOTT J BANKS, DC, PC SERVICES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at or before each visit. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-pay, co-insurance, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I further understand, Scott J Banks, DC, PC will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for Scott J Banks, DC, PC to take action to secure payment of an outstanding balance owed.

FURTHER NOTICES AS TO POLICIES REGARDING MEDICARE: Scott J Banks, DC, PC is a participating provider of Medicare, as such we will handle all billing to Medicare and any secondary insurance. Medicare requires you to satisfy a yearly deductible before they will begin paying benefits. Medicare will deduct the deductible amount from the first claim they receive each calendar year. Unless you have satisfied your annual deductible with another Medicare provider’s office you are responsible to pay your deductible to Scott J Banks, DC, PC. After your deductible is satisfied Medicare will reimburse us 80% of their standard fee for Chiropractic Adjustments only. Therefore your payment responsibility is 20% of the standard Medicare fee for Chiropractic Adjustments, along with any additional products or services you have consented to and received.

I understand that, in certain circumstances, Medicare may find that chiropractic treatments are not “reasonable and/or medically necessary” for the illness, injury or condition for which I am seeking treatment. I understand that Medicare bases this ruling on the diagnosis provided by my physician and their standards for that diagnosis. I understand, in this case, I will be responsible for any and all charged incurred.

NO GUARANTEES: I recognize that the practice of chiropractic is as much an art as a science, and therefore acknowledge that no guaranties have been or can be made regarding the likelihood of success or outcome of any treatment and/or therapy rendered at New Life Chiropractic, PC

REVOCAION OF AUTHORIZATIONS: These authorizations may be revoked by me, in writing, at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGMENT: I certify that the information I provide to my doctors, therapists and insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

By signing and dating this form I acknowledge I have discussed, or have had the opportunity to discuss, with my doctor the nature and purpose of Chiropractic treatment in general and my treatment in particular (including my Individualized Plan of Care) as well as the contents of these Acknowledgements and Authorizations.

I consent to the chiropractic treatments offered or recommended to me by my Doctor. I intend this consent to apply to all my present and future Chiropractic care.

Patient’s Signature	Date
Witness	Date

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures, if indicated. Any examinations or tests conducted will be carefully performed, but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including, but not limited to, hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an arterial dissection that involves an abnormal change in the wall of an artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. This occurs in 3-4 of every 100,000 people, whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke. As chiropractic can involve manually and/or mechanically adjusting the cervical spine, it has been reported that chiropractic care may be a risk for developing this type of stroke. The association with stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name: _____ Signature: _____ Date: _____

Parent or Guardian: _____ Signature: _____ Date: _____

ALSO SIGN THE ARBITRATION AGREEMENT ON REVERSE SIDE

PATIENT NAME:

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 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 bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the healthcare 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 healthcare provider, including those working at the healthcare 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 healthcare provider, and/or the healthcare 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) and provide National Arbitration and Mediation ("NAM") with the party arbitrator's contact information within thirty days of the date Respondent files its initial responsive pleading. A third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties from a list of arbitrators supplied by National Arbitration and Mediation ("NAM") within thirty days thereafter. The list supplied by NAM shall be a list of between 5 and 10 arbitrators, depending upon availability. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's equal 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 damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that, where not in conflict with this agreement, the Healthcare Malpractice Dispute Resolution Rules and Procedures of NAM shall govern any arbitration conducted pursuant to this Arbitration Agreement. A copy of NAM rules are available on its website at <https://www.namadr.com> or by calling 1-800-358-2550 to request a copy of the rules.

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 healthcare provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment), patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Both parties agree that this agreement may be electronically signed, and that the electronic signatures appearing on this agreement are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

Patient Name (print): _____ Signature: _____ Date: _____

Parent or Guardian (print): _____ Signature: _____ Date: _____

Office Name: _____ Signature: _____ Date: _____

ALSO SIGN THE INFORMED CONSENT ON REVERSE SIDE