

## CONSENTS

***THIS PACKET CONTAINS NOTICES AND AGREEMENTS THAT  
NEED TO BE READ AND SIGNED PRIOR TO YOUR FIRST APPOINTMENT***

1. OFFICE PRACTICES AND POLICIES
2. PATIENT RESPONSIBILITIES
3. NOTICE OF PRIVACY PRACTICES
4. HEALTH INFORMATION DISCLOSURE
5. E-MAIL USE CONSENT
6. ARBITRATION AGREEMENT

Dr. McCann's intention is to provide you with the highest level of personalized integrative care. She is committed to working with you on your path to health and healing.

Please read the following consents and provide your agreement.

**Return all pages, including unsigned pages.**

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## 1. OFFICE PRACTICES AND POLICIES

### ***THIS SECTION DESCRIBES WHAT YOU CAN EXPECT FROM DR MCCANN AS YOUR DOCTOR AND WHAT SHE EXPECTS FROM YOU AS HER PATIENT***

#### **PATIENT HOURS**

We schedule patient visits Mondays, Tuesdays, Thursdays and Fridays from 9am to 5pm.

#### **AFTER OFFICE HOURS**

For medical questions after regular office hours, please call our office at 949.574-5800 to be connected to the after hours voice messaging service. Dr McCann may not always be immediately available to answer your questions after hours. Medical emergencies should always be attended to by calling 911 or visiting urgent/emergency care facilities.

#### **SAME DAY/URGENT APPOINTMENTS**

Dr. McCann understands that sometimes medical problems come up and you would like to be evaluated sooner than the next available appointment. Please let the staff know and we will try and accommodate you for a short visit on the same day or following day.

#### **EMERGENCIES**

In the event of an emergency you are responsible to obtain medical attention, call 911 or go to the nearest emergency room.

#### **MEDICATION REFILLS**

We do not want you to run out of your medications. Before you do, we ask that you notify your pharmacist to fax us a "refill request" to 949-612-2725. Please allow 3-4 working days for us to approve your request for additional medications.

#### **FORMS**

Please make an appointment if you have any forms that will require our doctors to fill out. Most forms require an evaluation and possible laboratory testing to com-

plete. These include physical examination forms, sports physicals, and disability forms. There may be additional fees if more time outside of the visit is necessary.

#### **MEDICAL CARE**

We are concerned about your health. In order for us to provide the best possible quality of care for you, we will need your cooperation in keeping your scheduled appointments, making follow up appointments, scheduling annual physical exams, and completing tests ordered for you. Please review the **Patient Responsibilities** form for details.

#### **CANCELING APPOINTMENTS**

Dr. McCann's patients are very important to her and so we do not overbook appointments. Missed appointments are costly and take away from valuable appointment time from others. Therefore we ask that you be aware of your commitment. **For new patients** who have scheduled 60 to 75 minutes, please make any changes 4 to 5 days in advance.

**For established patients**, we must ask that you **contact the office at least 2 working days prior** to your scheduled appointment for any changes or cancellation.

**There is a \$75 charge for late cancellations when you cancel less than 2 business days prior to your appointment. There is a \$125 charge for missed appointments.**

#### **TELEPHONE AND EMAIL CORRESPONDENCE**

Dr. McCann can provide patients with telephone consultations when desired. These phone calls may incur additional charges and will not be billed to insurance. Please call to schedule these 10 minute phone calls.

### 3. OFFICE PRACTICES AND POLICIES

*(continued)*

#### **BILLING/ INSURANCE**

Payment for the office visit or phone appointment is expected at the time of service and can be in the form of check, cash or credit card payments. All credit card payments will be processed the same day as the office or telephone appointment.

**For patients with PPO insurance** with whom Dr. McCann is a provider, insurance billing is provided as a courtesy service to our patients. If we are a panel provider, we will accept payments as stipulated by contract rates. All co-payments and deductibles are due at the time of service.

Patients who carry insurance understand that all insurance covered services furnished are charged to your insurance carrier, however the patient is ultimately responsible for payment of services. Patients are advised to understand their insurance policies and benefits.

There is a \$25 charge for all returned checks and declined credit cards.

#### **OTHER PHYSICIANS OR HEALTH CARE SPECIALISTS**

If you are seeking healthcare from other physicians in the community, we would like you to ask their office to send us a copy of their notes and studies. If you are seen in the Emergency Room or Urgent care, please request these records be sent to the office.

#### **COMMUNICATION**

We believe in having good communication between our office staff and our patients. We encourage you express any questions or concerns to us so we may better serve you.

#### **WEBSITE AND EMAIL**

Information about Dr. McCann and all relevant patient forms are available through her website:

[www.DrKellyMcCann.com](http://www.DrKellyMcCann.com).

#### **MEDICAL RECORDS**

Medical records can be released only with your authorization. A medical records release form is enclosed for your use. Please request previous medical records from your primary care or specialty physicians or health care providers.

#### **A MESSAGE ABOUT ARBITRATION**

The accompanying form binds both you and Kelly K. McCann, MD to a standard arbitration procedure in the event a complaint should ever arise. This equitable process avoids the delays, uncertainty and expense of jury trial. By signing this form you are not giving up your right as a patient to file a complaint or to seek damages. Rather, a board of qualified arbitrators will resolve any complaints which might arise.

**My signature below indicates I have received this notice and that I fully understand all its terms, including my responsibilities and assumed risks. I hereby give my consent and agree to all aspects of this agreement. I understand I am entitled to a copy of this agreement.**

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Print Patient's Name

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Patient's Signature or Signature of Legal Guardian, if applicable

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Date

## 4. PATIENT RESPONSIBILITIES

### **THIS SECTION DESCRIBES YOUR ROLE AS A PARTNER IN YOUR HEALTH CARE AND REQUEST YOUR AGREEMENT TO SPECIFIC RESPONSIBILITIES**

1. I will take charge of my health and make positive choices for my health including not smoking, not using illegal drugs, eating a healthy diet, and getting appropriate exercises. I will provide accurate health information to Kelly K McCann, MD and update her with any health changes.
2. I will schedule routine physical exams and other health maintenance exams recommended to me by Kelly K McCann, MD (pap smear, mammogram, bone density, colonoscopy, routine blood tests, immunizations, etc.). I put myself at risk for not detecting other medical diseases if I only see Kelly K McCann, MD for immediate problems. I will make appointments with Kelly K McCann, MD to discuss routine health screenings.
3. I will follow treatment plans recommended to me by Kelly K McCann, MD, including completing testing, making an appointment with a specialist, and taking my medications. I will be sure to clearly comprehend any treatment plan and ask questions when I do not understand. I understand that *not* following my treatment plans may put my health at risk.
4. I will keep my appointments and reschedule with adequate notice. I understand that Kelly K McCann, MD schedules these appointments to follow up on my response to treatment and to monitor my medical conditions. During these appointments Kelly K McCann, MD may order tests, refer me to a specialist, change my medications, and diagnose a medical problem. If I do not follow up, I may put my health at risk and may have medical conditions go undetected.
5. I understand that the goal of the office of Kelly K McCann, MD is to provide me with test results in a timely fashion. If I do not hear from the office, I will call the office for test results. I understand that not hearing from the office about a particular test does not necessary mean that the test result is normal.
6. I will inform Kelly K McCann, MD if my medical condition changes, does not improve, or worsens. This will allow Kelly K McCann, MD to re-evaluate my condition and make changes in treatment. If I do not inform Kelly K McCann, MD, I may put my health at risk.
7. I will treat all providers and office staff respectfully and courteously.
8. I will fulfill my financial obligations for care provided to me in a timely manner.
9. I will take responsibility to understand my Health Plan and be aware of my benefits, deductibles, and Health Plan limitations. I will ask my Health Plan if I have any questions regarding my health coverage.
10. If you need information or inquiring about Advance Directives (Durable Power of Attorney for Health Care, Natural Death Act Declaration or Living Will,) please call the Member Services Department of your Health Plan.

**My signature below indicates I have received this notice and that I fully understand all it's terms, including my responsibilities and assumed risks. I hereby give my consent and agree to all aspects of this agreement. I understand I am entitled to a copy of this agreement.**

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Print Patient's Name

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Patient's Signature or Signature of Legal Guardian, if applicable

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Date

## 5. NOTICE OF PRIVACY PRACTICES

***THIS SECTION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.***

### **OUR PLEDGE**

The protection of our patients' privacy and the confidentiality of their medical information has always been important to us. We understand that you trust us to safeguard your personal information and respect your right to privacy. This notice represents our commitment to maintain the privacy of your protected health information and to inform you of our legal duties and privacy practices, as well as your rights, as required by California and federal law. We are legally required to provide you a copy of this notice and to follow the terms of this notice currently in effect.

### **YOUR PERSONAL INFORMATION**

We keep records of the medical care we provide you and we may receive similar records from others. We use this information so that we, or other health care providers, can render quality medical care, obtain payment for services and enable us to meet our professional and legal responsibilities to operate our medical practice. We may store this information in a chart and in our computers. This information makes up your medical record. The medical record is our property; however this notice explains how we use information about you and when we are allowed to share that information with others.

### **OUR PRIVACY PRACTICES**

It is our policy to maintain reasonable and feasible physical, electronic and process safeguards to restrict unauthorized access to and protect the availability and integrity of your health information.

Our protective measures may include secured office facilities, locked file cabinets, managed computer network systems and password protected accounts.

Access to health information is only granted on a "need-to-know" basis. Once the need is established the access is limited to the minimum necessary information to accomplish the intended purpose.

Our staff are required to comply with the policies and procedures designed to protect the confidentiality of your health information. Any staff that violate our privacy policy are subject to disciplinary action.

### **HOW WE MAY USE OR SHARE YOUR INFORMATION**

The following categories describe situations where the law allows us to use and share your health information. We give examples for each category that illustrate that type of use or disclosure. Not every use or disclosure is listed, but the ways in which we are legally permitted to use and share your health information will fall into one of these categories.

### **TREATMENT**

We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.

We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

### **PAYMENT**

We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information

## 5. NOTICE OF PRIVACY PRACTICES

*(continued)*

to other healthcare providers to assist them in obtaining payment for services they provide you.

### **HEALTH CARE OPERATIONS**

We may use and disclose medical information about you to properly operate and manage our medical practice. For example, we may use and disclose this information to review and improve the quality of the care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud, waste and abuse detection, compliance programs and business planning and management.

We may also share your health information with our business associates, such as our billing service, that perform services for us. However we will not share your health information with them unless they agree in writing to protect the privacy of that information. Under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other providers, clearing houses or health plans that have a relationship with you, when they request this information to help them with their quality

assessment and improvement activities, their efforts to improve health or reduce healthcare costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud, waste and abuse detection and compliance efforts.

### **NOTIFICATIONS**

We may disclose information to someone who is involved with your care or helps pay for your care. We

may disclose your health information to notify, or assist in notifying, a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may also disclose information to a relief organization so that they may coordinate these notification efforts.

### **MARKETING**

We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you.

### **RESEARCH**

Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects, however, are subject to a special approval process.

### **SPECIAL CIRCUMSTANCES AND THE LAW**

Special situations and certain laws may require us to use or release your health information. For example, we may be required to release your health information to others for the following reasons:

Whenever we are required to do so by law; for example, to the extent your care is covered by Workers' Compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupation related injury or illness to the employer or Workers' Compensation insurer.

To report information to agencies that regulate our

## 5. NOTICE OF PRIVACY PRACTICES

*(continued)*

business, such as the U.S. Department of Health and Human Services and the California Department of Health and Managed Care.

To assist with public health activities; for example, we may report health information to the Food and Drug Administration for the purpose of investigating or tracking a prescription drug and medical device malfunctions.

To report information to public health agencies if we believe there is a serious threat to your health and safety or that of another person or the general public; this includes disaster relief efforts.

To report certain activities to health oversight agencies; for example, we may report activities involving audits, inspections, licensure and peer reviews.

To assist courts or administrative agencies; for example, we may provide information pursuant to a court order, search warrant or subpoena, or when required by the investigation of a duly authorized administrative agency.

To support law enforcement activities; for example, we may provide health information to law enforcement agents for the purpose of identifying or locating a fugitive, material witness or missing person.

To correctional institutions, law enforcement officials or military authorities that have you in their lawful custody.

To report information to a government authority regarding child abuse, neglect or domestic violence.

To share information with a coroner or medical examiner as authorized by law. We may also share information with funeral directors, as necessary to carry out their duties.

To use or share information for procurement, banking or transplantation of organs, eyes or tissues.

To report information regarding job-related injuries as required by your state workers' compensation laws.

To share information related to specialized government functions, such as military and veterans activities, national security and counter-intelligence purposes, or in support of providing protective services for the President, foreign heads of state and other designated persons

To a family member or friend under any of the following circumstances: (1) if you provide a verbal agreement to allow such a disclosure; (2) if you are given an opportunity to object to such a disclosure and you do not raise an objection; or (3) if it can be inferred from the circumstance, based on our professional judgment, that you would not object.

In the event that our practice is sold or merged with another organization, your medical record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

We may use or share your health information when it has been "de-identified." Health information is considered de-identified when it has been processed in such a way that it can no longer personally identify you.

We may also use a "limited data set" that does not contain any information that can directly identify you. This limited data set may only be used for the purposes of research, public health matters or health care operations. For example, a limited data set may include your city, county and zip code, but not your name or street address.

### **YOUR WRITTEN PERMISSION**

Except as described in this Notice of Privacy Practices, or as otherwise permitted by law, we must obtain your written permission – called an authorization – prior to

## 5. NOTICE OF PRIVACY PRACTICES

*(continued)*

using or sharing health information that identifies you as an individual. If you provide an authorization and then change your mind, you may revoke your authorization in writing at any time.

Once an authorization has been revoked, we will no longer use or share your health information as outlined in the authorization form; however you should be aware that we won't be able to retract a use or disclosure that was previously made in good faith based on what was then a valid authorization from you.

Except as specified above, under California law we may not share your health information with your employer or benefit plan unless you provide us an authorization to do so.

### **OTHER RESTRICTIONS**

In California there may be additional laws regarding the use and disclosure of health information related to HIV status, communicable diseases, reproductive health, genetic test results, substance abuse, mental health and mental retardation. Generally we will be bound by whatever law is more stringent and provides more protection for your privacy.

### **YOUR RIGHTS**

The following are your rights with respect to your health information. You have the right to:

Ask us to restrict how we use or share your health information for treatment, payment or health care operations. You also have the right to ask us to restrict health information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care. Please note that while we will try to honor your requests, we are not required by law to agree to these types of restrictions;

Request confidential communications of health information. For example, you may ask that we send informa-

tion to your work address. We will accommodate all reasonable requests submitted in writing; Inspect and copy your health information, with limited exceptions. To access your record, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We may charge you a reasonable fee for copies as allowed by law. Under certain circumstances we may deny your request. If we do deny your request, we will notify you in writing and may provide you the opportunity to have the denial reviewed;

Request an amendment to your health information that you believe is incorrect or incomplete. We may require your request be in writing and that you provide a reason for the request. If we make the amendment, we will notify you. If we deny your request, we will notify you of the reason in writing. This written notification will explain your right to file a written statement of disagreement. In return, we have a right to rebut your statement. Furthermore, you have the right to request that your initial written request, our written denial and your statement of disagreement be included with your health information for any future disclosures;

Receive an accounting of certain disclosures of your health information made by us during the six years prior to your request. We may require that your request be in writing. Your first accounting is free. Subsequently, you are allowed one free accounting request every 12 months. If you request an additional accounting within 12 months of receiving your free accounting, we may charge you a fee. Please note that we are not required to provide you with an accounting for any information:

Disclosed prior to March 1, 2008; Shared for treatment, payment or health care operations as described above; Previously disclosed to you; Shared as part of an authorization request; Incidental to a use or disclosure that is otherwise permitted; Provided for use in a facility directory; Provided to persons involved in your care or for other notification purposes; Shared for national security or counter-intelligence purposes; Shared or used as part

## 5. NOTICE OF PRIVACY PRACTICES

*(continued)*

of a limited data set for research, public health or health care operations purposes; Disclosed to correctional institutions, law enforcement officials, military authorities, or health oversight agencies.

### **CHANGES**

Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all the health information that we maintain, regardless of when it was created or received. We will provide you a copy of the revised notice and will post it publicly as required by law.

### **QUESTIONS OR COMPLAINTS**

If you have any questions regarding this notice of privacy practices, if you require additional information, or you believe your privacy rights have been violated, please contact us at 1831 Orange Avenue, Suite C, Costa Mesa, CA 92627.

No action will be taken against you and you will not be penalized in any way for filing a complaint with us. If you prefer, you may direct your complaints to the Secretary of the United States, Department of Health and Human Services.

**My signature below indicates I have received this notice and that I fully understand all its terms, including my responsibilities and assumed risks. I hereby give my consent and agree to all aspects of this agreement. I understand I am entitled to a copy of this agreement.**

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Print Patient's Name

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Patient's Signature or Signature of Legal Guardian, if applicable

Date

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## 6. HEALTH INFORMATION DISCLOSURE

***THIS SECTION REQUESTS YOUR CONSENT TO DISCLOSE YOUR PERSONAL HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.***

I hereby give my consent for Kelly K. McCann, MD, Inc. to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

The Notice of Privacy Practices provided by Kelly K. McCann, MD, Inc. describes such uses and disclosures more completely. I have the right to review the Notice of Privacy Practices prior to signing this consent.

Kelly K. McCann, MD, reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Kelly K. McCann, MD, 1831 Orange Avenue, Suite C, Costa Mesa, CA 92627.

With this consent Kelly K. McCann, MD, Inc and her designated assistants may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Kelly K. McCann, MD may mail to my home or other alternative location any items that

assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and any items pertaining to my clinical care, including laboratory test results, among others.

With this consent, Kelly K. McCann, MD may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements, and any items pertaining to my clinical care, including laboratory test results, among others.

I have the right to request that Kelly K. McCann, MD restrict how she uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Kelly K. McCann, MD to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Kelly K. McCann, MD may decline to provide treatment to me.

**My signature below indicates I have received this notice and that I fully understand all it's terms, including my responsibilities and assumed risks. I hereby give my consent and agree to all aspects of this agreement. I understand I am entitled to a copy of this agreement.**

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Print Patient's Name

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Patient's Signature or Signature of Legal Guardian, if applicable

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Date

## 7. E-MAIL USE CONSENT

### ***THIS SECTION DEFINES THE RISKS TO YOUR HEALTH INFORMATION WHEN USING E-MAIL AND REQUESTS YOUR CONSENT TO USE E-MAIL***

Kelly McCann, MD provides patients with the opportunity to communicate by e-mail. Transmitting confidential health information by e-mail however, has a number of risks, both general and specific, that should be considered before using e-mail.

General e-mail risks are the following; e-mail can be immediately broadcast worldwide and be received by many intended and unintended recipients; recipients can forward e-mail messages to other recipients without the original sender(s) permission or knowledge; users can easily misaddress an e-mail; e-mail is easier to falsify than hand written or signed documents; backup copies may exist even after the sender or the recipient has deleted his/her copy.

Specific e-mail risks are the following: e-mail containing information pertaining to diagnosis and/or treatment must be included in the protected personal health information; all individuals who have access to the protected health information will have access to the e-mail messages; patients who send or receive e-mail from their place of employment risk having their employer reading their e-mail.

It is the policy of Kelly McCann, MD that all e-mail messages sent or received which concern the diagnosis or treatment of a patient will be a part of that's patients protected personal health information and will treat such e-mail messages or internet communications with the same degree of confidentiality as afforded other portions of the protected personal health information. Kelly McCann, MD will use reasonable means to protect the security and confidentiality of e-mail communication. Because of the risks outlined above, she cannot, however guarantee the security and confidentiality of e-mail or internet communication.

You signing below, you are agreeing to consent to the use of e-mail for confidential medical information after having been informed of the above risks. Consent to the use of e-mail includes agreement with the following conditions:

All e-mails to or from you concerning diagnosis and/or treatment will be made part of the protected personal health information. As a part of the protected personal health information, other individuals, such as staff persons, insurance coordinators and upon written authorization other healthcare providers and insurers will have access to e-mail messages contained in protected personal health information.

Dr. McCann will endeavor to read e-mail promptly but can provide no assurance that the recipient of a particular e-mail will read the e-mail message promptly. Therefore e-mail must not be used in a medical emergency.

It is the responsibility of the sender to determine whether the intended recipient received the e-mail and when the recipient will respond.

Because some medical information is so sensitive that unauthorized disclosure can be very damaging, e-mail should not be used for communications concerning diagnosis or treatment of AIDS/HIV infection; other sexually transmittable or communicable diseases such as syphilis, gonorrhea and the like; behavioral health, mental health; or alcohol and drug abuse.

Dr. McCann cannot guarantee that electronic communications will be private. However, she will take reasonable steps to protect the confidentiality of the e-mail or internet communication but Kelly McCann, MD is not liable for improper disclosure of confidential information not caused by its employee's gross negligence or wanton misconduct.

If consent is given for the use of e-mail, it is your responsibility to inform Kelly McCann, MD of any types of information you do not want to be sent by e-mail.

Kelly McCann, MD is not liable for breaches of confidentiality caused by you. Any further use of e-mail initiated by you that discusses diagnosis or treatment constitutes informed consent to the foregoing.

## 7. E-MAIL USE CONSENT

*(continued)*

I understand that my consent to the use of e-mail may be withdrawn at any time by e-mail or written communication to Kelly McCann, MD. I have read this form carefully and understand the risks and responsibility associated with the use of e-mail. I agree to assume all risks associated with the use of e-mail.

**My signature below indicates I have received this notice and that I fully understand all its terms, including my responsibilities and assumed risks. I hereby give my consent and agree to all aspects of this agreement. I understand I am entitled to a copy of this agreement.**

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Print Patient's Name

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Patient's Signature or Signature of Legal Guardian, if applicable

Date



## 8. ARBITRATION AGREEMENT

***THIS SECTION ASKS YOU TO AGREE TO USE A NEUTRAL ARBITRATOR TO RESOLVE DISPUTES BETWEEN US AND TO RELEASE YOUR RIGHTS TO USE A COURT OF LAW***

### DOCTOR-PATIENT ARBITRATION AGREEMENT

#### ARTICLE 1

Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided on a court of law before a jury, and instead are accepting the use of arbitration.

#### ARTICLE 2

All Claims Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether 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 the mother and the mother's expected child or children.

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

compel arbitration of any malpractice claim.

#### ARTICLE 3

Procedures and Applicable Law: A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

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

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code

## 8. ARBITRATION AGREEMENT

### CONTINUED

Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil

Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

#### ARTICLE 4

General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

#### ARTICLE 5

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

#### ARTICLE 6

Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services. \_\_\_\_\_ Patient Initials

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.

My signature below indicates I have received this notice and that I fully understand all its terms, including my responsibilities and assumed risks. I am agreeing to have any issue of malpractice decided by neutral arbitration and I am giving up my right to a jury or court trial. I hereby give my consent and agree to all aspects of this agreement. I understand I am entitled to a copy of this agreement and have received a copy of this notice.

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Print Patient's Name

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Patient's Signature or Signature of Legal Guardian, if applicable

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Date