PALM BEACH medical

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All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name: ☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Widowed	
Previous or referring doctor:	**Date of last physical exam:**

OFFICE USE ONLY		
BLOOD PRESSURE _____ / _____	**HEIGHT:**	**WEIGHT:**

****WHAT IS YOUR REASONING FOR WANTING TO START ON HORMONE THERAPY & WHAT ARE YOUR INTENED GOALS?****

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio		
Immunizations and dates:	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion?	☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No

	If not trying for a pregnancy list contraceptive or barrier method used:		
	Any discomfort with intercourse?	☐ Yes	☐ No
	Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

MEN ONLY

Are you overweight?	☐ Yes	☐ No
Do you have a lack of energy?	☐ Yes	☐ No
Do you have a decrease in your strength and endurance?	☐ Yes	☐ No
Are you less active in social activities and/or sports	☐ Yes	☐ No
Are you sleeping too much or too little?	☐ Yes	☐ No
Are you forgetful?	☐ Yes	☐ No
Have you notice a decrease in your sex drive?	☐ Yes	☐ No
Do you frequently get up at night to urinate	☐ Yes	☐ No
If yes, # of times		

Any blood in your urine?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?		

WOMEN ONLY

Have you recently gained weight?	☐ Yes	☐ No
Are you overweight?	☐ Yes	☐ No
Have you lost height?	☐ Yes	☐ No
Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Do you have a lack of energy?	☐ Yes	☐ No
Do you feel stressed?	☐ Yes	☐ No
Do you experience restless sleep or insomnia?	☐ Yes	☐ No
Do you feel sad and/or grumpy?	☐ Yes	☐ No
Do you have mood swings?	☐ Yes	☐ No
Do you have difficulty concentrating?	☐ Yes	☐ No
Are you forgetful?	☐ Yes	☐ No
Do you have premenstrual symptoms?	☐ Yes	☐ No
Do you have pre- or postmenopausal hot flashes and/or night sweats?	☐ Yes	☐ No
Have you noticed a decrease in your sex drive?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

OTHER PROBLEMS

Check if you have or have had any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep

☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Please check to indicate "Yes" to the question:

☐ Decreased concentration	☐ Stiff joints in the morning	☐ Increased fat deposits
☐ Increased mood swings	☐ Progressive osteoporosis	☐ Increased muscles deterioration
☐ Increased stress levels	☐ Increased back pain	☐ Gynecomastia (male breast)
☐ Decreased personal drive	☐ Muscle aches and pain	☐ Hot flashes
☐ Depression	☐ Endocrine disorder	☐ Painful menstrual cycle
☐ Difficulties sleeping	☐ Prostate cancer	☐ Oral birth control or estrogen
☐ Decreased energy	☐ Decreased sociability	☐ Thinning pubic hair
☐ Decreased exercise	☐ Decreased short term memory	☐ Thin/dry skin
☐ Decreased skin elasticity	☐ Decreased long term memory	☐ Decreased bone mass
☐ Decreased libido	☐ Decreased sense of well being	☐ Increased joint pain
☐ Increased wrinkles	☐ Feeling less confident	☐ Gastrointestinal bleeding
☐ Decreased fatigue	☐ Decreased sex drive	☐ Poor wound healing
☐ Nipple sensitivity	☐ Decreased endurance	☐ Joint pain during exercise
☐ Heavy menstrual cycle	☐ Healing from exercise is long	☐ Hypertension
☐ Temperature intolerance	☐ Decreased testicle size	☐ Other Form of cancer
☐ Thinning or loss of hair	☐ Decreased skin tone	☐ Carpal Tunnel Syndrome
☐ Decreased muscles strength	☐ Sagging or loose skin	

Have you experienced problem with your joints?	☐ Yes	☐ No
If "Yes" please explain:		
Have you experienced muscles aches and pains?	☐ Yes	☐ No
If "Yes" please explain:		
Have you been on Hormone Therapy?	☐ Yes	☐ No
If "Yes" please explain:		
Have you been on a testosterone program?	☐ Yes	☐ No

CARDIOVASCULAR HEALTH QUESTIONNAIRE

Please check to indicate "Yes" to the question:

Do you have elevated blood pressure?	☐ Yes	☐ No
Do you have high cholesterol or triglyceride levels?	☐ Yes	☐ No
Do you have blood sugar issues?	☐ Yes	☐ No
Do you carry excess belly fat?	☐ Yes	☐ No
Do you have a stressful lifestyle?	☐ Yes	☐ No
Do you eat fried food frequently?	☐ Yes	☐ No
Do eat high amount of sugary foods?	☐ Yes	☐ No
Do you feel like you should eat a more heart-healthy diet?	☐ Yes	☐ No
Do you find it difficult to exercise?	☐ Yes	☐ No

BLOOD SUGAR AND INSULIN FUNCTION QUESTIONNAIRE

Please check to indicate "Yes" to the question:

Do you have blood sugar (glucose) level issues?	☐ Yes	☐ No
Do you have insulin concerns?	☐ Yes	☐ No
Do you have high triglycerides?	☐ Yes	☐ No
Do you have low HDL ("good") cholesterol?	☐ Yes	☐ No
Do you have high LDL ("bad") cholesterol?	☐ Yes	☐ No
Do you have high blood pressure?	☐ Yes	☐ No
Do you carry excess belly fat?	☐ Yes	☐ No
Are you overweight?	☐ Yes	☐ No
Do you find it difficult to exercise?	☐ Yes	☐ No
Are you physically inactive?	☐ Yes	☐ No
Do you feel like you should eat a healthier diet?	☐ Yes	☐ No

IMMUNE SYSTEM FUNCTION QUESTIONNAIRE

Please check to indicate "Yes" to the question:

Are you susceptible to viruses and/or infections?	☐ Yes	☐ No
Do you frequently have itchy eyes or nose?	☐ Yes	☐ No
Do you have a chronic runny or stuffy nose?	☐ Yes	☐ No
Do you frequently experience an itchy mouth or throat?	☐ Yes	☐ No
Are you sensitive to chemicals?	☐ Yes	☐ No
Do you have frequent skin rashes?	☐ Yes	☐ No
Do you have reactions to certain foods?	☐ Yes	☐ No
Do you experience fatigue not helped by rest?	☐ Yes	☐ No
Do you feel like you should eat a healthier diet?	☐ Yes	☐ No
Are you lacking adequate sleep and relaxation?	☐ Yes	☐ No
Do you have a stressful lifestyle?	☐ Yes	☐ No

JOINT HEALTH QUESTIONNAIRE

Please check to indicate "Yes" to the question:

Do you have aches or pains in any of your joins, such as your knees, back, or else?	☐ Yes	☐ No
Have you experienced joint pains over weeks, months, or years?	☐ Yes	☐ No
Have you been taking medications for join pain?	☐ Yes	☐ No
Do you have an old joint injury that's been acting up?	☐ Yes	☐ No
Do you have back problems?	☐ Yes	☐ No
Do you have difficulty walking?	☐ Yes	☐ No
Have you experienced a decrease in your ability to reach without pain?	☐ Yes	☐ No
Has your range of motion decreased?	☐ Yes	☐ No
Do you experience pain relief with regular strength and range of motion exercise?	☐ Yes	☐ No
Are you overweight? (This can cause pressure on your knees.)	☐ Yes	☐ No

Please check to indicate "Yes" to the question:

Do you have low bone density or osteoporosis?	☐ Yes	☐ No
Do you have a family history of osteoporosis?	☐ Yes	☐ No
Have you lost height?	☐ Yes	☐ No
Do you suffer from general poo health?	☐ Yes	☐ No
Do you take any long-term medication known to increase the risk of osteoporosis (e.g., corticosteroids, heparin, and anti-seizure medications)?	☐ Yes	☐ No
Do you suffer from immobility?	☐ Yes	☐ No
Do you have hyperparathyroidism or hyperthyroidism?	☐ Yes	☐ No
Do you have a gastrointestinal issue a cause malabsorption?	☐ Yes	☐ No
Do you consume excess caffeine or alcohol?	☐ Yes	☐ No
Do you smoke?	☐ Yes	☐ No
Do you eat an unhealthy diet?	☐ Yes	☐ No
Is your diet low in calcium?	☐ Yes	☐ No
Do you have low vitamin D intake and limited sun exposure?	☐ Yes	☐ No
Are you a woman with a thin or small body frame?	☐ Yes	☐ No
Are you a woman with amenorrhea (loss of the menstrual period)?	☐ Yes	☐ No
Are you a woman with low estrogen level?	☐ Yes	☐ No
Are you a postmenopausal woman?	☐ Yes	☐ No

COGNITIVE AND EMOTIONAL HEALTH QUESTIONNAIRE

Please check to indicate "Yes" to the question:

Do you feel sad and/or grumpy?	☐ Yes	☐ No
Do have less interest in normal activities?	☐ Yes	☐ No
Do you wake up repeatedly during the night?	☐ Yes	☐ No
Do you have difficulty turning off your thoughts when you lay down to sleep?	☐ Yes	☐ No
Do you feel tense and have trouble relaxing?	☐ Yes	☐ No
Are you forgetful?	☐ Yes	☐ No

Do you have difficulty concentrating?	☐ Yes	☐ No
Do you have difficulty leaning new thins?	☐ Yes	☐ No
Do you feel overly active and compelled to do things, like being driven by a motor?	☐ Yes	☐ No
Do you have a short attention span?	☐ Yes	☐ No

PRIMARY PHYSICAN INFORMATION

Primary physician name:	**Phone:**
Date of last physical exam with your physician:	

Family History: Does an immediate family member currently have or ever had any of the following? Please check to indicate "Yes" to the question:

Any known deficiency including mineral and electrolytes	☐ Yes	☐ No
Blood disorder	☐ Yes	☐ No
Endocrine disorder	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Lipid disorder	☐ Yes	☐ No
Other forms of cancer	☐ Yes	☐ No
Prostate cancer	☐ Yes	☐ No
Other illnesses	☐ Yes	☐ No

If "Yes" please explain:

Diagnosed history of disease: Do you currently have or ever had any of the following? If "Yes", please check and explain below:

☐	Any known deficiency including mineral and electrolytes	☐	Use of medication (list hem in the below)
☐	Blood disorder	☐	Immune disorders
☐	Cancer	☐	Chemical dependency
☐	Capral tunnel syndrome	☐	Lung disorder
☐	Orthopedic o muscle disorder including fracture or join disorder	☐	Heart disease including Atherosclerosis, Angina, Heart Failure, Heart Attack
☐	Allergies o medication	☐	Upper respiratory
☐	Edema/excess fluid retention	☐	Poor wound healing
☐	Emotional disorders/depression	☐	Renal disease
☐	Genital – urinary disorder	☐	Hypertension
☐	Hyperlipidemia	☐	Arthritis
☐	Neurological disorders, thyroid, diabetes or other endocrine disorder including insulin resistance	☐	Rheumatism
☐	Bursitis	☐	Other illnesses
☐	Sport injuries		

If "Yes" please explain:

CONSENT FOR HORMONE REPLACEMENT THERAPY

Background: You have been diagnosed with or have an increased risk of having a hormone deficiency (ies) and your Provider has recommended treatment with hormone replacement therapy (HRT). Some of the hormone preparations that may be prescribed for you are regulated by pharmacy compounding laws, which follow the State appropriate guidelines, laws and provisions.
The use of this therapy as it relates to your diagnosis, while common in alternative practices, may be debated in the traditional medical community. You have the right, as a patient, to be informed about your condition and the recommended conventional, integrative, complementary, alternative, non-conventional or non-standard procedures to be used so that you make an informed decision whether or not to undergo the procedures after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but to simply inform you so you have the information needed to give or withhold your consent to the procedure or treatment.

NOTICE: Refusal to consent to the innovative, integrative, complementary or non-standard procedure shall not affect your right to future care or treatment.

Therapeutic Basis: Many individuals have inadequate hormone levels despite technically normal blood tests. Some individuals suffering symptoms related to menopause or andropause or inability to lose weight may also benefit from these therapies. HRT can be used to augment hormone levels in a number of conditions where diminished hormone levels are evident.
○ Estrogen therapy can maintain vaginal and urethral function and slow the progression of osteoporosis. It may also improve sleep, decrease hot flashes and night sweats, decrease pain and perhaps cognitive function, and improve libido and overall well-being. This therapy may contain one or any combinations of the following medications: estriol, estradiol, and/or estrone.
○ Progesterone hormone replacement therapy can offer protection from endometrial cancers, treatment of irregular menstruation, and other low progesterone conditions. It also can improve sleep quality and decrease anxiety. For males, low dose progesterone therapy in conjunction with testosterone therapy can maximize the hormone ratios, reducing side effects.
○ Testosterone replacement therapy is used to treat symptoms or lab tests suggesting suboptimal hormone levels as determined by your provider. Low testosterone is associated with elevated cholesterols, high blood pressure, diabetes, and prostate problems. Other low testosterone symptoms include excessive fatigue, abdominal weight gain, irritability and decreased sexual drive and function.

Objectives: HRT is implemented to optimize hormone levels in the blood, helping to reduce symptoms associated with low levels of these hormones. Potential Risks: Safety of any of these hormones during pregnancy cannot be guaranteed. Notify your provider if you are pregnant, suspect that you are pregnant, or are planning to become pregnant during this therapy.
○ Estrogen Therapy: estrogens are available in various forms including oral capsules, troches, patches, pellets and topical creams. Adverse reactions may include bloating, breakthrough bleeding, breast swelling and tenderness, fluid retention, weight gain, liver cysts, death (e.g.-from blood clots or cancer) and mood swings. High potency conjugated estrogens (e.g. Premarin) have been associated with an increased risk of breast cancer and blood clots (the latter especially in smokers). Estriol may carry a lower risk of breast cancer and may even protect against breast cancer. Nonetheless, the whole area of estrogen replacement is undergoing further evaluation. Do not take estrogen if you have breast cancer.
○ Progesterone Therapy: progesterone is available in various forms including oral capsules, troches, vaginal or rectal suppositories, and topical creams or gels. Progesterone therapy may be sedating, so it is recommended to coordinate dosing with sleep cycle. Adverse reactions may include bloating, breakthrough bleeding, missed menstrual cycles, breast swelling and tenderness, fluid retention, weight gain, sedation, and depression.
○ Testosterone Therapy: testosterone therapy is available in various forms including sublingual drops, troches, topical creams, pellets and injection. Side effects include acne, chronic priapism (persistent, abnormal erection of the penis), change in libido, angina or heart attacks, hirsutism (facial hair growth) and scalp hair loss, clitoral engorgement, voice changes, or water retention. Because it may improve insulin resistance in males, diabetics who use insulin should monitor glucose levels closely, as less insulin may be needed. Check with your physician before adjusting your dose of insulin. If using a formulation of testosterone that is applied to the skin, a local irritation may occur. Although the use of hormone replacement therapy has been shown in many studies to be safer than synthetic hormone replacement therapy, the risk of cancer-related side effects is still possible. In fact, there are physicians who do not agree with use hormones

Statement of Patient: I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as not being treated. Those risks and potential complications have been explained to me. I have not been promised or guaranteed any specific benefit from the administration of these therapies and no warranty or guarantee has been made regarding the results of treatment.
I agree to proceed with treatment and to comply with recommended dosages. I agree to comply with requests for ongoing testing to assure proper monitoring of my treatments that may include laboratory evaluation of all aforementioned hormone levels or other diagnostic testing by a Palm Beach Medical provider, my primary care physician, or other specialist.
I agree to see my primary care physician, gynecologist, or other practitioner for regular monitoring and for preventative measures that may include but are not limited to complete physicals, rectal examinations and/or colonoscopy, EKG, mammograms, pelvic/breast exams, pap smears, prostate exams, PSA levels, etc. at least on a yearly basis.
I agree to immediately report to my physician any adverse reaction or problem that might be related to my therapy. I understand that along with the benefits of any medical treatment or therapies, there are both risks and potential complications to treatment, as well as to not being treated. Those risks and potential complications have been explained to me and I agree that I have received information regarding those risks, potential complications and benefits, and the nature of and other hormone treatments and have had all my questions answered.

Furthermore, I have not been promised or guaranteed any specific benefit from the administration of hormone therapy. I certify this form has been fully explained to me, that I have read it or have had it read to me and that I understand its contents. I agree not to undergo any treatments unless I fully understand the treatment and have discussed possible risks and benefits. I agree to the therapy described above. I have been educated on the benefits, risks, and possible adverse reactions associated with hormone replacement therapy. I agree all the above health information submitted on the questionnaire is complete and accurate.

Signature of Patient X_____ **Date**_____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, including 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 health care provider, including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers, preceptors, or interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages. This agreement is intended to create an open book account unless and until revoked.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days, and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration. The parties agree that 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 the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction, or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and, if not revoked, will govern all professional services received by the patient and all other disputes between the parties.

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

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE X