

PATIENT INFORMATION / INFORMACION DE PACIENTE

LAST NAME: _____ FIRST NAME: _____ MIDDLE INITIAL: _____
(Apellido) (Nombre) (Inicial)

ADDRESS: _____
(Dirección)

CITY: _____ STATE: _____ ZIP CODE: _____
(Ciudad) (Estado) (Código Postal)

TELEPHONE: _____ WORK: _____ CELL: _____
(Teléfono) (Teléfono del Trabajo) (Celular)

E-MAIL: _____
(Correo Electronico)

DATE OF BIRTH: _____ AGE: _____ SEX: _____ SOCIAL SECURITY: _____
(Fecha de Nacimiento) (Edad) (Sexo) (Seguro Social)

MARITAL STATUS: _____ REASON FOR VISIT: _____
(Estado Civil) (Razón de Su Visita)

EMPLOYER: _____ OCCUPATION: _____
(Empleador) (Ocupacion)

NAME OF SPOUSE, PARENT, OR GUARDIAN: _____ TELEPHONE: _____
(Nombre de Esposo/a, Padre o Guardián) (Teléfono)

WHO REFERRED YOU TO OUR OFFICE: _____ NAME: _____
(Por Quien Fue Referido) (NOMBRE)

YOUR FAMILY DOCTOR: _____ TELEPHONE: _____
(Su Medico De Cabecera) (Teléfono)

EMERGENCY CONTACT NAME: _____
(Nombre De Contacto de Emergencia)

EMERGENCY CONTACT No: _____
(Teléfono De Contacto de Emergencia)

FOR OFFICE USE ONLY: Checked forms: _____ Entered in I&E _____

“PHYSICIAN’S RELEASE AND ASSIGNMENTS”

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED BY ME, AND I AGREE THAT IN THE EVENT THAT THIS ACCOUNT IS REFERRED TO COLLECTIONS, I WILL PAY ALL THE COLLECTION EXPENSES, ATTORNEY FEES AND COURT COSTS.

I HEREBY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION REQUIRED BY MY INSURANCE CARRIER (S). A COPY OF THIS AUTHORIZATION MAY BE USED IN LIEU OF THE ORIGINALS. I FURTHER AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION AND HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS ANY INFORMATION NEEDED FOR THIS OR A RELATED MEDICARE CLAIM.

I REQUEST PAYMENT OF MEDICAL INSURANCE BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION, AND I AGREE THAT IN THE EVENT THAT THIS ACCOUNT IS REFERRED TO COLLECTIONS, TO PAY ALL COLLECTION EXPENSES, ATTORNEY FEES, AND COUR COSTS.

“LA LIBERACION DE MEDICO Y TAREAS”

YO COMPRENDO QUE SOY FINANCIERAMENTE RESPONSABLE POR TODOS LOS CARGOS CONTRAIDOS POR MI, Y YO CONCUERDO QUE EN EL CASO DE QUE ESTA CUENTA SEA REFERIDA A COLECCIONES, YO PAGARE TODOS LOS GASTOS DE COLECCIÓN, TODOS LOS GASTOS DE ABOGADO Y LOS COSTOS DE LA CORTE.

POR MEDIO DE LA PRESENTE Y COMO FUERA SOLICITADO POR MI COMPANIA DE SEGURO, CONCEDO ACCESO A CUALQUIER INFORMACION EN REFERENCIA A MI HISTORIAL CLINICO. UNA COPIA DE ESTA AUTORIZACION PUEDE SER USADA EN LUGAR DE LA ORIGINAL. PARA FINES DE SERVICIOS DE MEDICARE AUTORIZO A CUALQUIERA EN POSESION DE DICHA INFORMACION EL PODER DE COMPARTIRLA CON LA ADMINISTRACION DEL SEGURO SOCIAL Y LA ASOCIACION FINANCIERA DE ADMINISTRACION DE SALUD Y SUS INTERMEDIARIOS O DISTRIBUIDORES.

A SU VEZ SOLICITO EL PAGO DE BENEFICIOS DE SEGURO MEDICO A MI MISMO O A UN TERCERO. COMPRENDO QUE SOY RESPONSABLE FINANCIERAMENTE DE LOS CARGOS NO CUBIERTOS POR ESTA AUTORIZACION Y POR CARGOS DE ABOGADOS Y CORTES, EN CASO DE QUE ESTA CUENTA SEA REFERIDA A RECAUDADORES.

PATIENT SIGNATURE: _____ **DATE:** _____
(Firma De Paciente) (Fecha)

**“IF YOU DO NOT KNOW THE INFORMATION PLEASE WRITE “DO NOT KNOW” ON THE LINE PROVIDED”
(SI USTED DESCONOCE ESTA INFORMACION POR FAVOR ESCRIBA “NO LO SE” EN LA LINEA)**

PRIMARY PHYSICIANS NAME: _____
(Nombre de Medico de Cabecera)

ADDRESS: _____ TEL. No.: _____
(Dirección) (Teléfono)

ARE YOU CURRENTLY UNDER A PHYSICIAN’S CARE? _____ YES / SI NO
(Esta Usted Bajo Cuidado Medico Actualmente?)

SINCE WHEN? _____ WHY? _____
(Desde Cuando?) (Porque?)

WHEN WAS YOUR LAST COMPLETE PHYSICAL EXAM? _____
(Cuando Fue Su Ultimo Examen Físico?)

ARE YOU TAKING ANY MEDICATIONS OR SUBSTANCES? (IF YES, PLEASE LIST THEM) _____ YES / SI NO
(Esta Usted Tomando Medicamentos? (Si Su Respuesta es Si, Por Favor Menciónelas.)

DO YOU ROUTINELY TAKE HEALTH RELATED SUBSTANCES (VITAMINS, OR ALTERNATIVE MEDICINE? (IF YES, PLEASE LIST.)
(Toma Usted Rutinariamente Alguna Sustancia Relacionada Con Su Salud (Vitaminas, Medicinas Naturales? (Si Su Respuesta es Si, Por Favor Menciónelas.)
_____ YES / SI NO

ARE YOU ALLERGIC TO ANY MEDICATIONS OR SUBSTANCES? (IF YES, PLEASE LIST)
(Es Usted Alérgico/a a Alguna Medicina o Sustancia? (Si Su Respuesta es Si, Por Favor Menciónelas.)
_____ YES / SI NO

DO YOU HAVE ANY OTHER ALLERGIES? (IF YES, PLEASE LIST)

(Tiene Usted Algunas Otras Alergias? (Si Su Respuesta es Si, Por Favor Menciónelas.)

YES / SI NO

DO YOU HAVE ANY PROBLEMS WITH PENICILLIN, ANTIBIOTICS, ANESTHETICS, OR OTHER MEDICATIONS? (IF YES, PLEASE LIST)

(Tiene Usted Algún Problema Con Penicilina, Antibióticos, Anestésicos, o Con Otras Medicinas? (Si Su Respuesta es Si, Por Favor Menciónelas.)

YES / SI NO

ARE YOU SENSITIVE TO LATEX OR ANY METALS? _____ YES / SI NO
(Es Usted Sensible a Algún Metal o al Látex?)

ARE YOU PREGNANT OR SUSPECT YOU MAY BE? _____ YES / SI NO
(Esta Usted Embarazada o Sospecha Que Pueda Estarlo?)

DO YOU USE ANY BIRTH CONTROL MEDICATIONS? _____ YES / SI NO
(Utiliza Usted Algún Medicamento De Anticonceptivo?)

DO YOU HAVE REGULAR PERIODS? _____ YES / SI NO
(Tiene Usted El Periodo Regularmente?)

DO YOU HAVE MENOPAUSE OR DID YOU ALREADY HAVE MENOPAUSE? _____ YES / SI NO
(Tiene Usted o Tuvo Ya La Menopausia?)

HAVE YOU EVER BEEN TREATED FOR, OR BEEN TOLD YOU MIGHT HAVE HEART DISEASE? _____ YES / SI NO
(Ha Sido Tratado o Alguna Vez Le Han Dicho Que Pudiera Tener Alguna Enfermedad Cardiaca?)

HAVE YOU EVER TAKEN THE DIET PILL, PHEN-FEN? _____ YES / SI NO
(Alguna Vez Ha Tomado Usted La Píldora De Dieta, PHEN-FEN?)

DO YOU HAVE HIGH OR LOW BLOOD PRESSURE? _____ YES / SI NO
(Tiene Usted La Presión Baja o Alta?)

DO YOU HAVE A PACEMAKER, AN ARTIFICIAL HEART OR VALVE IMPLANT? _____ YES / SI NO
(Tiene Usted Un Marcapaso, Injerto Artificial De Corazón o Implante De Válvula?)

HAVE YOU EVER HAD RHEUMATIC FEVER? _____ YES / SI NO
(Ha Padecido Alguna Vez de Fiebre Reumática?)

ARE YOU AWARE OF ANY HEART MURMURS? _____ YES / SI NO
(Sabe Usted Si Tiene Algún Soplo En El Corazón?)

HAVE YOU EVER HAD A SERIOUS ILLNESS OR MAJOR SURGERY? (IF YES, PLEASE LIST.) _____ YES / SI NO
(Ha Experimentado Usted Alguna Enfermedad Grave o Cirugía Mayor? (Si Su Respuesta Es Si, Por Favor Liste Las.)

HAVE YOU EVER HAD A RADIATION TREATMENT, CHEMO TREATMENT FOR TUMOR, GROWTH, OR OTHER CONDITION?
(Ha Recibido Alguna Vez, Tratamiento De Radiación o Quimioterapia, sea por un Tumor o Alguna Otra Condición?) _____ YES / SI NO

DO YOU HAVE INFLAMMATORY DISEASES, SUCH AS ARTHRITIS OR RHEUMATISM? _____ YES / SI NO
(Padece Usted de Alguna Enfermedad Inflamatoria como Artritis o Reumatismo?)

DO YOU HAVE ANY ARTIFICIAL JOINTS or PROTHESIS? _____ YES / SI NO
(Tiene Usted Alguna Coyuntura Artificial o Prótesis?)

DO YOU HAVE ANY BLOOD DISORDERS, SUCH AS ANEMIA, LEUKEMIA, ETC? _____ YES / SI NO
(Padece Usted de Alguna Enfermedad De Sangre Tales Como Anemia o Leucemia Etc.?)

HAVE YOU EVER BLED EXCESSIVELY AFTER BEING CUT OR INJURED? _____ YES / SI NO
(Ha Usted Alguna Vez Sangrado Excesivamente Después De Haberse Cortado o Herido?)

DO YOU HAVE ANY STOMACH, KIDNEY, THYROID, OR LIVER PROBLEMS? _____ YES / SI NO
(Tiene Usted Algún Problema De Estomago, Riñones, Tiroides o Hígado?)

ARE YOU DIABETIC? _____ YES / SI NO
(Es Usted Diabético/a?)

DO YOU HAVE ASTHMA? _____ YES / SI NO
(Sufre Usted De Asma?)

DO YOU HAVE EPILEPSY OR SEIZURE DISORDERS? _____ YES / SI NO
(Padece Usted De Epilepsia o Ataques Epilépticos?)

DO YOU HAVE OR HAVE EVER HAD A VENEREAL DISEASE? _____ YES / SI NO
(Tiene Usted o Ha Tenido Alguna Vez Alguna Enfermedad Venérea?)

HAVE YOU BEEN TESTED FOR HIV? _____ YES / SI NO
(Se Ha Hecho Usted Alguna Vez La Prueba Para El Sida?)

DO YOU HAVE AIDS? _____ YES / SI NO
(Tiene Usted Sida?)

HAVE YOU HAD OR DO YOU TEST POSITIVE FOR HEPATITIS? _____ YES / SI NO
(Ha Padecido Alguna Vez o Padece Usted De Hepatitis?)

HAVE YOU EVER BEEN TREATED OR TOLD YOU HAVE LUNG DISEASE OR T.B.? _____ YES / SI NO
(Ha Sido Alguna Vez Diagnosticado Con Alguna Enfermedad Pulmonaria o Tuberculosis?)

DO YOU SMOKE, CHEW OR INHALE ANY OTHER FORMS OF TOBACCO, INCLUDING CIGARS? _____ YES / SI NO
(Fuma o Mastica Usted Algún Tipo De Tabaco?)

(IF YES, HOW MUCH DO YOU SMOKE?) _____
(Si Su Respuesta Es Si, Cuanto Fuma?)

DO YOU CONSUME ALCOHOLIC BEVERAGES? (IF YES, HOW MUCH?) _____ YES / SI NO
(Consumo Usted Bebidas Alcohólicas? (Si Su Respuesta Es Si, Que Tanto?)

DO YOU HABITUALLY USE CONTROLLED SUBSTANCES? _____ YES / SI NO
(Tiene Usted Por Habito El Uso De Sustancias Controladas?)

HAVE YOU HAD PSYCHIATRIC TREATMENT OR BEEN TREATED FOR MENTAL ILLNESS? _____ YES / SI NO
(Ha Sido Usted Alguna Vez Tratado Por Enfermedad Mental o Recibido Tratamiento Psiquiátrico?)

DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? (IF YES, PLEASE LIST)
(Padece Usted De Alguna Enfermedad, Condición o Problema Que No Haya Sido Mencionado? (Si Su Respuesta es Si, Por Favor Menciónelas.)
_____ YES / SI NO

“I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE”
(Yo Certifico Que La Información De Encima Esta Completa y Correcta.)

SIGNATURE REQUIRED: _____ **DATE:** _____
(Firma Del Paciente) (Fecha)

“YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE”

UNDER FLORIDA LAW, PHYSICIANS ARE GENERALLY REQUIRED TO CARRY MEDICAL MALPRACTICE INSURANCE OR OTHERWISE DEMONSTRATE FINANCIAL RESPONSIBILITY TO COVER POTENTIAL CLAIMS FOR MEDICAL MALPRACTICE. THIS IS PERMITTED UNDER FLORIDA LAW SUBJECT TO CERTAIN CONDITIONS. FLORIDA LAW IMPOSES PENALTIES AGAINST NON-INSURED PHYSICIANS WHO FAIL TO SATIFY ADVERSE JUDGEMENTS ARISING FROM CLAIMS OF MEDICAL MALPRACTICE. THIS IS PROVIDED UNDER PURSUANT TO FLORIDA LAW.

“SU DOCTOR HA DECIDIDO NO TENER SEGURO DE MALAPRACTICA”

BAJO LA LEY DEL ESTADO DE LA FLORIDA, SE REQUIRE QUE LOS DOCTORES EN MEDICINA TENGAN SEGUROS DE MALA PRACTICA O DE LO CONTRARIO DEBEN DEMOSTRAR QUE SON FINANCIERAMENTE REONSABLES PARA PODER CUBRIR RECLAMOS DE MALA PRACTICA MEDICA. ESTO ES PERMITIDO BAJO LA LEY DE LA FLORIDA BAJO CIERTAS CONDICIONES. LA LEY DE LA FLORIDA IMPONE PENALIDADES A LOS DOCTORES QUE NO ESTEN ASEGURADOS Y QUE NO SATISFAZGAN JURISDICCIONES ADVERSAS POR DEMANDAS EN SU CONTRA COMO RESULTADO DE UNA MALA PRACTICA MEDICA. ESTA NOTA ESTA BASADA BAJO LA LEY DE LA FLORIDA.

PATIENT SIGNATURE: _____ **DATE:** _____
(Firma Del Paciente) (Fecha)

PRINT NAME: _____
(Escriba Su Nombre)

“CONSENT FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION”

I HEREBY GIVE CONSENT TO JHONNY SALOMON, M.D., P.A. AND ALL HEALTH CARE PROVIDERS FURNISHING CARE WITHIN THE PRACTICE TO USE AND DISCLOSE MY PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS.

MY “PROTECTED HEALTH INFORMATION” MEANS THAT HEALTH INFORMATION, INCLUDING MY DEMOGRAPHIC INFORMATION, COLLECTED FROM ME AND CREATED OR RECEIVED BY MY PHYSICIAN, ANOTHER HEALTH CARE PROVIDER, A HEALTH PLAN, MY EMPLOYER, OR A HEALTH CARE CLEARINGHOUSE. THIS PROTECTED HEALTH INFORMATION RELATES TO MY PAST, PRESENT, AND FUTURE PHYSICAL AND MENTAL HEALTH CONDITION. IT IDENTIFIES ME OR THERE IS A REASONABLE BASIS TO BELIEVE THE INFORMATION MAY IDENTIFY ME.

PLEASE BE ADVISED THAT OUR NOTICE OF PRIVACY PRACTICES PROVIDES MORE DETAILED INFORMATION ABOUT HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION. YOU HAVE THE RIGHT TO REVIEW OUR NOTICE OF PRIVACY PRACTICES BEFORE YOU SIGN THIS CONSENT. WE RESERVE THE RIGHT TO REQUEST AND RESTRICT HOW WE USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR THE PURPOSES OF TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. WE ARE NOT REQUIRED TO GRANT YOUR REQUEST, BUT IF WE DO, THE RESTRICTION WILL BE BINDING ON US.

YOU MAY REVOKE THIS CONSENT AT ANY TIME. YOUR REVOCATION MUST BE IN WRITING, SIGNED BY YOU OR ON YOUR BEHALF, AND DELIVERED TO OUR PRESENT ADDRESS. YOU MAY DELIVER YOUR REVOCATION BY ANY MEANS YOU CHOOSE BUT IT WILL BE EFFECTIVE ONLY WHEN WE ACTUALLY RECEIVE THE REVOCATION. YOUR REVOCATION WILL NOT BE EFFECTIVE TO THE EXTENT THAT OTHERS ARE OR WE HAVE ACTED IN RELIANCE UPON THIS CONSENT.

“CONSENTIMIENTO PARA EL USO Y/O REVELACION DE LA INFORMACION DE SALUD PROTEGIDA”

YO DOY MI CONSENTIMIENTO AL DOCTOR JHONNY SALOMON, M.D., P.A. Y A TODOS SUS PROVEEDORES DE ASISTENCIA MEDICA QUIENES PROPORCIONAN EL CUIDADO MEDICO DENTRO DE LA PRACTICA A UTILIZAR Y REVELAR MI INFORMACION DE SALUD PROTEGIDA SI FUESE NECESARIO PARA TRATAMIENTOS, PAGOS Y OPERACIONES DE ASISTENCIA MEDICA.

MI “INFORMACION DE SALUD PROTEGIDA” SIGNIFICA E INCLUYE MI INFORMACION DEMOGRAFICA QUE FUE ENTREGADA Y CREADA POR MI Y RECIBIDA POR MI MEDICO, POR OTRO PROVEEDOR DE ASISTENCIA MEDICA, POR UN PLAN DE SALUD, POR MI EMPLEADOR, O POR UN BANCO DE LIQUIDACION DE ASISTENCIA MEDICA. ESTA INFORMACION PROTEGIDA DE SALUD ES RELACIONADA A MI PASADO, PRESENTE, Y EL FUTURO DE MI SALUD FISICA O MENTAL. ME IDENTIFICA, O HAY UNA BASE RAZONABLE DE CREER QUE LA INFORMACION ME IDENTIFICA.

ESTOY EN PLENO CONOCIMIENTO DE QUE LA NOTA DE PRACTICAS DE INTIMIDAD PROPORCIONA INFORMACION MAS DETALLADA SOBRE COMO ESTA PRACTICA UTILIZA Y PUDIERA REVELAR MI INFORMACION DE SALUD PROTEGIDA. TENGO LA OPCION Y EL DERECHO DE REVISAR LA NOTA DE PRACTICAS DE INTIMIDAD ANTES DE FIRMAR ESTE CONSENTIMIENTO. DR. JHONNY SALOMON, M.D. P.A. Y TODOS SUS PROVEEDORES SE RESERVAN EL DERECHO DE SOLICITAR Y RESTRINGIR EL USO QUE PUDIERAN DAR A MI INFORMACION DE SALUD PROTEGIDA CON EL PROPOSITO DE TRATAMIENTO, PAGO, O DE LAS OPERACIONES DE ASISTENCIA MEDICA.

USTED PUEDE REVOCAR ESTE CONSENTIMIENTO A CUALQUIER HORA. SU REVOCACION DEBE ESTAR EN ESCRITO, FIRMADA POR USTED O EN SU BENEFICIO, Y ENTREGADA A NUESTRO DOMICILIO ACTUAL. USTED PUEDE ENVIAR SU REVOCACION POR EL MEDIO QUE PREFIERA. SIEMPRE Y CUANDO SEA EFECTIVO Y NOSOTROS RECIBAMOS REALMENTE LA REVOCACION. SU REVOCACION NO SERA EFECTIVA HASTA QUE OTROS HAYAN ACTUADO O EN LA DEPENDENCIA DE ESTE CONSENTIMIENTO.

PATIENT SIGNATURE: _____ **DATE:** _____
(Firma De Paciente) (Fecha)

PRINT NAME: _____
(Escriba Su Nombre)

IF YOU ARE SIGNING AS THE PATIENT’S REPRESENTATIVE PRINT YOUR NAME AND DESCRIBE YOUR AUTHORITY:
(Si Usted Firma Como El Representante Del Paciente Escriba Su Nombre y Explique Su Autoridad)

SIGNATURE: _____ **DATE:** _____
(Firma) (Fecha)

I authorized the following individual(s) to receive information regarding my protected health information.

Name: _____
(Nombre)

PLEASE DO NOT WRITE BELOW. FOR OFFICE USE ONLY. THANK YOU.

(POR FAVOR NO ESCRIBA DEBAJO. PARA EL USO DE LA OFICINA SOLAMENTE. GRACIAS.)

Reviewed By: _____ **M.D.** **DATE:** _____
(Revisado Por) (Fecha)

Physician – Patient Arbitration Agreement

Preface:

I, Dr. Jhonny Salomon, have decided under Florida Law to practice without Malpractice insurance. Under this practice, this Arbitration Agreement (“Agreement”) should be read carefully and fully understood. If you have any questions before or after reading and signing this statement please ask the staff or my office manager. Please read this document clearly. Thank you for your consideration.

Article 1: Agreement to Arbitrate: It is understood that my dispute as to medical malpractice that is, as to whether any medical services rendered under this contract were unnecessary, authorized or were improperly, negligently, or incompletely rendered, will be determined by submission to arbitration as provided by the Florida Arbitration Code, Chapter 682, and not by a lawsuit except as Florida law provides for judicial review or arbitration proceeding. Both Parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in 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 related treatment or services provided by the physician including any spouse or heir of the patient or any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of a pregnant mother, the term “patient” herein shall mean both 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, associate, association, corporation or partnership, and the employees, agents and estates of any of them must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties and must be within the time frame set forth in F.S.95.11 dealing with medical malpractice. 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 demand for neutral arbitrator by either party. Each party to the arbitration shall pay such party’s prorated share of the expenses and fees to 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. Arbitration shall take place within 30 days after the completion of discovery as provided in the Florida Rules of Civil Procedures (Rules 1.0280-1.0390) and the decision of the arbitration panel shall be binding upon the parties for all purposes. The time to responding to discovery requests shall be 10 days. All discoveries shall be completed within 2 months after the appointment of the panel of arbitrators, unless the time for the discovery is extended for good cause by the panel. The arbitration panel shall decide any disputes regarding discovery. The arbitration panel is expressly authorized to award all reasonable fees and costs, including attorney’s fees, to the prevailing party against any part who has violated this Agreement. The parties agree that the arbitrators have the immunity of a judicial officer for civil liability when acting in the capacity of arbitrator under this contract. The immunity shall supplement, not supplant, any other applicable statutory or common law provisions.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages, upon written request 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 proper additional party in court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in on proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in civil action, would be barred by the applicable Florida 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 arbitrator shall be governed by the Florida Rules of Civil Procedure provisions relation to arbitration.

I have read and understood all information presented to me before signing. I understand that I have the right to receive a copy of this Arbitration Agreement.

(Patient's or Patient's Representative's Signature)

Date

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and effect and shall not be affected by the invalidity of any other provisions.

***** Cancellation Policy *****

As a courtesy to all, we ask that a twenty four-hour notice be given if you need to cancel or change your appointment with us. For a cancellation with less than twenty four-hour notification, guests will be charged 50% of the treatment fee. For no-show appointments, the full treatment fee will be charged.

Como norma de cortesía para todos, solicitamos que un aviso de veinticuatro horas sea dado en el caso de que necesite cancelar o cambiar su cita con nosotros. Una cancelación notificada con menos de veinticuatro horas, será cargada por el 50% del honorario del tratamiento y en el caso de no notificar en lo absoluto, será cargado el honorario del tratamiento completo.

***** Cancellation Policy for Surgery *****

A 10% deposit is required to schedule surgery – the minimum being \$500. This deposit is non-refundable, non-transferable and non-reusable.

Para las cirugías, un depósito de 10% es requerido- el minimo de \$500. Este deposito no es transferible ni es reembolsable y no es re-usable.

Patient's or Patient's Representative's Signature
(Firma Del Paciente o De Su Representante)

Date
(Fecha)