Julie A. Griffith M.D., M.S. B.C.I.P.
5 Bon Air Rd, Suite D219
Larkspur, CA 94939
Telephone (415) 925-1616
Facsimile (415) 962-
1303 mybrainhealth@comcast.net www.mybrainhealth.org

What is included:

Office policies
New Patient Registration Form
Neurological History and Physical Examination Form
Physician and other health provider name, address and phone list
Medication Summary
HIPPA letter
Predetermination of benefits
Referral form for your primary care provider to sign
Phone appointments & case management
My fees and services
Authorization of disclosure

Welcome to our Office!

Embarking on this neurological evaluation and treatment plan is not only a commitment to your child's present health, but more importantly it is an investment in your child's academic, vocational, emotional, physical, and social well-being. Frequently, early accurate diagnosis and treatment of neurological or neuropsychiatric disorders can positively and significantly alter a person's life pattern, enabling the person to pursue a wider scope of life choices. It is well established that early treatment or therapy for neuro-developmental disorders leads to a better outcome and can avoid the development of emotional, psychiatric or behavioral disorders, as well as juvenile delinquency or even criminality, in some cases.

The full service that I offer, including extra research or contact with other specialists, can provide needed information to positively affect your care. I prefer to get to the underlying problem and to use a comprehensive multidisciplinary therapeutic approach either to reach wellness or implement a program that would significantly enhance a person's quality of life. I would appreciate feedback to ensure that you are getting the service that you deserve

Prior to confirming the appointment, we must receive a referral to Dr. Griffith from your primary care physician, health care provider, therapist, employer or other professional, educational advocate, or therapist, who is not a family member.

Please complete all enclosed forms, especially the neurological history before your appointment. It takes approximately 45 minutes to complete all of the forms. On the form, please complete all that you know. Birth history and developmental history are important, since difficulties at these times may indicate that the neurological problem may have started at birth. You may wish to ask other family members about any family history of medical problems, especially if there were any neurological disorders in the family; it is helpful then, to get the name of a specific diagnosis or to have copies of their labs, imaging, genetic studies, or neurology consult notes faxed to Dr. Griffith,

since some neurological disorders run in the family. Sometimes it is helpful to have a spouse, a family member, or a friend attend the appointment, to provide you emotional support, to be an extra set of ears to auditorially "record" what Dr. Griffith says, and also to provide needed medical history, when applicable. Dr. Griffith welcomes and encourages tape recordings of the appointment so you can review information if you wish, after the appointment. The history from sleep partners or family members can be quite useful in a patient who has a sleep disorder, seizure disorder, and change in personality or cognition. I will complete the physical examination pages after I interview your child.

If you have difficulty completing this form, Michelle, our receptionist can assist you if you come a little early for child.

Please provide, in electronic form, when at all possible, the copy of the medical record. **If possible, please provide a detailed medication and supplement list, which is preferred to be electronic, when possible. Please be sure to fill out the medication form and list all medications (this includes herbs, vitamins, prescriptions, over the counter drugs and homeopathic remedies, food supplements, etc.). Please bring all prescription drugs and supplements, herbs, vitamins, etc. with you or a detailed list (including dosage in mg, times per day) to your first visit.**

It is important that you also bring all labs, diagnostic, educational, legal, or other reports. Again, please bring electronic record, when at all, possible. Use the Records Release form to obtain records from your health care provider and please have records sent to your home before bringing them to your appointment. Alternatively, my staff can attempt to obtain records before the appointment or my staff could attempt to retrieve the records during the appointment, but then there is a risk that I may not receive the records in a timely manner.

**** Patients may find it useful to put all medical records etc. in the car, so they do not forget them on the way to the doctor's appointment.**

Please bring us a copy of the medical records that we may keep.

Medical records that can be useful, if applicable, include the following:

Audiologic testing (audiogram and tympanogram)
Biophoton test results
BSAER (brainstem auditory evoked response)
Central auditory processing testing
Electrodermal test results
Genetic consultation
Kinesiology test results
Neurologic examination (s) from the past, if any
Neuropsychological or psychological (psychoeducational) evaluation(s)
Nutrition consult
Occupational therapy evaluation
Ophthalmologic consultation
Optometric (vision therapy) evaluation
Physical therapy evaluation
Psychiatric evaluation
Speech and language therapy evaluation
Hospital discharge summary from birth (only if there were medical problems, a complicated pregnancy or abnormal delivery/need for resuscitation).

Hospitalization discharge summary (especially for any neurologic or psychiatric cause) and emergency room notes for any head trauma or seizures (if unusual or unique). Growth charts for head circumference, height and weight will be useful if previously abnormal or if there is any concern.

Additionally, if any head imaging (head MRI or CT scan) and/or electroencephalogram (EEG) was completed in the past, then please bring the actual scan and/or EEG along with the typed report(s) to the appointment. You can request the scans from the imaging center where the scan was performed. You can arrange to either have the imaging center mail me the scan to the above address or you can pick it up from the center and hand carry it to the appointment. Your previous neurologist will not likely have the scan. You may want to request a copy of the scan for your personal use if you don't currently have a copy of the scan. The imaging center may destroy the scans after they hold them for a certain number of years (i.e. 7 years). **Please take the time to ensure that the images open on the CD before coming to the appointment, so Dr. Griffith will be able to view the images during the appointment.**

You will want to have the insurance provide you with the allowable amounts in the lines indicated on the allowable amounts form, so you will know whether or not the insurance will pay for my services. Some insurance companies do not provide this information, although I strongly feel it is good business policy on their part to provide you with this information. You could push them for it. They know the allowed amounts given the CPT code. If the insurance does not pay for these services, then you will be responsible for payment.

For your child:

Please have your child well - rested and well -fed for the appointment. Entertaining toys or children's magazines (often new ones, or ones not recently used will be the most interesting to your child), comforting objects, and snacks and juice can be helpful to make the experience as pleasant as possible for you and your child. If there is much history, many pages of medical reports for me to review, or if your child cannot tolerate prolonged doctor's appointments, then you may want to split the interview portion from the physical exam portion of the appointment (two separate dates). For instance, you may want to schedule the first appointment for parents or legal guardian to attend (the most knowledgeable about the past history and current status of the patient) with me. For insurance reasons, the physical examination needs to be performed on the first appointment. Remaining history or review of the medical record can be obtained during a follow-up appointment with one knowledgeable parent or guardian, not necessarily with the child (unless something needs to be reexamined at the follow-up appointment).

My services and fees:

In general, I have kept my fees average throughout the community; however, I bill differently than many general physicians because I provide a comprehensive and specialized service. Some insurance companies pay for this service. I think that comprehensive service is necessary to maintain the high quality of care needed for patients with neurological conditions, specifically. Due to the low reimbursement by insurance companies and the time and expense in billing them, I am now accepting only Blue Shield of California PPO and Cigna PPO.

Please see information about my fees below. My bookkeeper and I want to develop an appropriate financial plan that fits your needs. This will enable you to make a financial commitment to support your desire to improve or protect you or your child's health.

Please at least call, or feel free to meet in person, with Darren, my bookkeeper, Monday, Wednesday or Thursday, to discuss finances. Please discuss with her any limitations you have, and discuss expectations, how you plan to pay, etc. **All final financial arrangements must be finalized /authorized by Dr. Griffith**. **You are responsible for your bill, and you are responsible for understanding my billing rates for services provided. Please read all information regarding my billing. You are responsible to have read the contents of this letter._____initials.**

My services include an initial diagnostic neurological evaluation, case management which may include referring you or your child to different specialists for consultations, along with my impression and interpretation of the consultant's reports, and ongoing neurological care which includes prescriptions for medications, nutritional recommendations, etc. My bill rate is **$525.00/hr. prorated if paid with credit or debit card, or cash discounted price of $500/hr., prorated.** All other physician service, including phone calls, case management (phone calls to other physicians or arrangements for other tests or studies), research (as needed), will be billed **prorated** at $310.00/hr. if paid by credit or debit card or discounted cash price of **$300/hr., prorated**. I will not charge for my time spent streamlining the dictation regarding the information we have covered during the appointment. However, I do charge time for new work that is needed for the patient, such as writing additional lab slips, calling in or writing prescriptions, calling to coordinate the management plan with other physicians, reviewing abnormal lab results and contacting patients if there is any urgent management need, etc, since this is patient care/ medical care that extends beyond the initial appointment.

Insurance companies reimburse you for approximately 60 minute new patient appointments and 40 minute follow up appointments. **All additional time for service, such as additional time for appointments, phone calls, and case management may or may not be covered by your insurance. You will need to check with your insurance company to determine which services will be allowable or covered by your insurance. If the service is not a benefit or is not covered by your insurance, then you are responsible for payment of the bill.**

Dr. Griffith's office will provide a bill for the patient to submit to their medical insurance company (ies), which should be sent to the insurance company by the patient by no later than 60 days from the date of medical service. By HIPAA law, your medical insurance company should take no longer than 30 days to reimburse the patient. Additionally, the patient should get preauthorization (authorization before any service occurs), since insurance companies often refuse to pay for service that has already occurred without prior authorization. Insurance companies may not pay for educationally- based service, such as my attendance at IEP's (individualized educational plans) or for the writing of medical legal documents with an intention to acquire service or therapies for your child through the school district. Insurance companies also may not provide coverage for all of my services on legal cases. Patients or their parents/legal guardian(s) will be responsible for payments and for obtaining reimbursement to themselves by sending bills to the insurance company. My office will provide you with the needed diagnostic (ICD-10) and service (CPT) codes and two copies of the bill, one for the insurance company, and for the patient or paying family member. Additionally, we will provide you with the billing record which is an itemization of all prorated services.

***Please note:** For office appointments, the balance is due when the service is rendered and may be paid by cash. For telephone calls and case management services, we accept credit card payment only and charge on the same day as the service is provided. No checks please for case management.

****CANCELLATION POLICY****

There will be a $25.00 cancellation fee given to any appointments that are canceled less than 24 hours from the scheduled date and time.

Phone calls. My preference is that you schedule an appointment (either a phone appointment or office appointment) for medical questions. If you call when the line is busy or after hours, it is helpful if you leave a message for an appointment, giving my receptionist 2 or 3 specific dates and times so that she can call you back or leave a message with a secured appointment. If it is an emergency, such as if a child is having a seizure or if you or the patient are having a side effect to a medication, etc., then please call or text me at my cell phone (415) 279-1522. Please realize that I am on call 24 hours/day, 7 days/week and would appreciate that calls be restricted to true emergencies. During the day, always call the office number (415) 925-1616, first.

Medication refills.
I have started to request that patients call in to have their medications refilled 2 weeks in advance so that my office has time to fill the prescription, (especially when I leave for medical conferences, etc.). This will avoid any anxiety in possibly running out of the medications. I usually prescribe (refill) the medication for 6 months at a time (except for stimulant medications which is a maximum of 2 months - by law). Thus, when it is time to have a new prescription, it is also time for a follow-up appointment (to determine if the medication is still needed and to ensure safe administration). Thus, then please call in for an appointment two weeks before running out of the medicine, so that the medication can be refilled during the appointment.

Laboratory testing
Some laboratory tests are fasting. Please identify whether or not you need to be fasting for your laboratory testing (especially blood and some urine tests); this is true for all nutritional tests and some glucose testing.
Please see "Send out kit general instructions".

To make an appointment, please call us at (415) 925-1616
Or email us at mybrainhealth@comcast.net.
Check out our website at www.mybrainhealth.com

Signature showing that you have read, understand, and agreed to the above_____

Date _____

_____ _____

Printed Name Patient's full name (printed)

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PATIENT REGISTRATION FORM

PATIENT NAME **DATE OF BIRTH** **SEX**

ADDRESS **CITY** **STATE** **ZIP**

PHONE: DAY: (_____)_____EVE (_____)_____CELL (_____) _____ _____

BEST PHONE # TO REACH YOU (_____)_____ BEST TIME OF DAY TO CALL_____

FAX: HOME: (_____)_____WORK (_____) _____ E-M AIL_____

Social Security # _____

EMERGENCY Contact person (not living with you): Name:_____

Phone #_____Relationship _____

MOTHER'S NAME **DATE OF BIRTH** **SOCIAL SECURITY #** **PHONE NUMBER**

MOTHER'S ADDRESS, IF DIFFERENT

FATHER'S NAME **DATE OF BIRTH** **SOCIAL SECURITY #** **PHONE NUMBER**

FATHER'S ADDRESS, IF DIFFERENT

INSURANCE COMPANY **ADDRESS** **PHONE NUMBER**

POLICY NUMBER **GROUP NUMBER**

FINANCIALLY RESPONSIBLE PERSON FOR PAYMENT OF MEDICAL BILLS:

1) **Name: _____**

2) **Address: _____**

3) **Telephone number_____Social security number: _____**

4) **I own my home: YES NO**
Address:_____City_____State____Zip_____

5) **Employer:**
Name:_____Phone # _____

Address:_____City_____State_____Zip_____

6) **Bank account #_____Phone # _____**

Address_____City_____State____Zip_____

Please note that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance. I understand that I am financially responsible for all charges, and that there is no guarantee of health outcome or resolution of disease for service or product provided. I understand that I am financially responsible for any cost accrued for the collection of this charge, whether or not paid by said insurance. Interest will be charged on any overdue amount at 10% interest rate. $25.00 will be charged automatically to the credit card for any and every charge back, if initiated by the client. For MasterCard transactions, up to a $150.00 filing fee and or a $250.00 review fee will be charged to clients' credit card, if client pursues the chargeback and Dr. Griffith gets charged by the service provider. For Discover card's charge back, the client will be charged charge fees and arbitration fees, levied on Dr. Griffith by the service provider. Patients who have Medicare agree by signing below that they will not bill Medicare, since Dr. Griffith is not a Medicare Provider.

IN ORDER TO CONTROL YOUR COST OF BILLINGS, WE REQUEST THAT CHARGES FOR OFFICE VISITS BE PAID AT EACH VISIT. YOUR CREDIT CARD WILL BE CHARGED ON THE DAY OF SERVICE, UNLESS YOU CALL THE OFFICE TO OFFER ANOTHER FORM OF PAYMENT.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize release of all information necessary to secure payment, including disclosure of portions of the patient's records.

I agree that I am financially responsible for emergency care should the need for the patient arise, whether or not Dr. Griffith has my permission to proceed with emergency care or the payment of the emergency care, and whether or not I am reimbursed for the emergency care by the medical insurance. Emergency care may occur in the form of case management (phone calls, management of abnormal labs received, in office appointments, and calls made or taken from other physicians or health care providers). I agree that I am financially responsible for medical emergency care performed by Dr. Griffith for the patient until the patient is sufficiently transferred to an appropriate physician.

I AGREE:

1) **YOU CAN LEAVE CONFIDENTIAL MESSAGES ON ANY OF THE ABOVE PHONE NUMBERS OR FACSIMILE NUMBERS YES ☐ NO ☐**

2) **YOU CAN BROADCAST EMAIL, NEWSLETTERS AND MEDICAL DOCUMENTATION FROM DR. GRIFFITH, TO ME @ _____**

3) **INFORMATION SHOULD BE SENT ENCRYPTED ☐ OR NOT ENCRYPTED ☐**
(NOT ENCRYPTED IF IT IS TOO DIFFICULT TO OPEN. I AGREE TO RELEASE DR. GRIFFITH AND STAFF FROM ALL LIABILITIES IF THE INFORMATION SENT VIA EMAIL IS MISDIRECTED TO WRONG ADDRESS UNINTENTIONALLY OR IF SOMEONE HACKS THE ENCRYPTED OR UNENCRYPTED RECORDS AND GAINS ACCESS TO MY MEDICAL RECORDS.

4) **FOR THE CANCELLATION OF THE BROADCAST EMAIL, I WILL NOTIFY YOU IN WRITING EITHER VIA EMAIL, LETTER OR POSTAL MAIL.**

SIGNATURE_____DATE_____

PRINTED NAME_____RELATION TO PT_____

SPECIFY PHONE AND FACSIMILE NUMBERS TO WHICH YOU DO NOT WANT CONFIDENTIAL MESSAGES LEFT

PHONE:_____FACSIMILE_____

PRINTED NAME OF SECOND PERSON ALSO FINANCIALLY RESPONSIBLE FOR

MEDICAL CARE OF PATIENT _____

SIGNATURE OF SECOND PERSON _____

DATE: _____

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Neurological History and Physical

Patient's name*:* _____
Date of birth: _____
Date of examination: _____

Referring Practitioner: _____
Address:_____
City / State / Zip Code: _____
Phone Number: ( )_____Fax Number: ( ) _____

Mother's name_____Father's name _____

Legal guardian's name (if different than above) _____

How did you find out about us or who referred you to this practice?
_____

Identification:_____(nickname, if has one) is a right/left handed/ambidextrous

_____ grade_____yr_____mo old boy/girl

referred for evaluation of
_____
_____
_____

History of present illness:

Past medical history:

Pregnancy: medical problems during pregnancy: _____
medications taken during pregnancy: _____

tobacco, alcohol, cocaine, other drugs of abuse: _____
gestation_____wks, (full term is 40 wks) _____

Labor: _____hrs, artificial/spontaneous rupture of membranes

Delivery: _____birth wt,_____cm head circumference
childbirth was vaginal / induced/ by C-section
meconium (stool in amniotic fluid) yes/ no
vertex (head down, face back), or face up (occiput posterior)/ breech
heart rate abnormalities during delivery Yes No
Neonatal: Difficulties feeding/suck/swallow Yes No
Colicky/irritable infant Yes No

Past neurological history:

Headaches Yes/No If yes, describe: _____
Significant head trauma Yes/No If yes, loss of consciousness? vomiting? lethargy?
_____
Seizures Yes/No
Meningitis Yes/No

Developmental history:

Bowel trainingCompleted Yes/No By what age
Bladder training Completed Yes/No By what age

Please give ages in months or years when these milestones were acquired (as best approximated):

Motor

Gross ventral push up ____, sit _____, stand_____, **walk _____**, run runs alternating feet up stairs without holding rail _____, tricycle bicycle without training wheels_____,
frequent falls/clumsiness _____

Fine reaching_____, hand-to-hand_____, pincer_____, drawing _____ scissors_____. Quality of handwriting: _____

Language cooing_____, babbling_____, 1st word by_____mos/yrs,
2 wds together (noun/verb)_____, # word vocabulary by 2 yrs_____,
age when clearly understood by strangers_____, lisp _____
difficulties with drooling/handling secretions or in swallowing food
_____

Social good eye contact_____, appreciates affection/hugs _____
understands social cues of interaction appropriate for age Yes/No _____
aggressive? (bite/kick/hit, getting into fights)_____,
plays with children younger/same age/only much older or adults _____

Therapy received in past or currently getting:

Occupational____times/wk,____hrs/session, by whom_____, where_____,

began_____, issues now covering _____
Physical ____times/wk,____hrs/session, by whom_____, where_____,
began_____, issues now covering _____
Speech ____times/wk,____hrs/session, by whom_____, where_____,
began_____, issues now covering _____

Toxin exposure history please circle (and explain) any possible exposures including dates:
Chemical

1 heavy metal poisoning
a) lead
i. old pipes
ii. old paint
iii. lead in toys from China
b) mercury
i. dental amalgams in child in mother during gestation
ii. fish consumption of mother during gestation, or fish consumption by child
iii. vaccinations before or during 2002
iv. unfiltered water

2 fungiside, insecticide, pesticide exposure

3 Electrical poisoning
i. hybrid car
ii. heavy duty lap top
iii. c. many electrical items in bedroom or long time of exposure

Past medical history, Medical Problems:

1) _____ Date onset _____ Date resolved_____ treatment
_____ Date onset _____ Date resolved_____ treatment
2) _____ Date onset _____ Date resolved_____ treatment

Hospitalizations: for what_____, when _____

_____

Surgeries: _____, when _____

Medications: name of drug_____, dosage (mg)_____, # times/day ____

name of drug_____, dosage (mg)_____, # times/day ____

name of drug_____, dosage (mg)_____, # times/day ____

Allergies to medications:_____, what happened to body _____

Review of systems:
Dermatologic: white, brown or red birthmarks _____

Endocrine: heat or cold sensitive, hair thinning/falling out, dry skin _____

ENT: ear aches, problems with hearing _____

Genito: abnormal development of genitalia:_____
precocious puberty or abnormal menses:_____
difficulty with erection or ejaculation: _____
any concern of sexual abuse: _____

Gastrointestinal: difficulties with swallowing/appetite/eating problems _____
failure to thrive/obesity _____
stomach upset, belly pains, blood in stools _____

Heme: easy bruising or bleeding after injury _____

Immunologic: frequent infections (pneumonias, urinary tract infections, many ear infections, sinusitis) _____
any risk of HIV? (blood transfusion, IV drug abuse in parents or known exposure of parents?) _____
sexually active _____

Neuro: difficulties with attention_____,
hyperactivity_____,
impulsiveness_____
balance/coordination problems _____
conduct difficulties _____
excessive fatigue/taking naps during the day _____
muscle aching/cramping/twitching or fasciculating muscles, muscle weakness_____
oppositional/defiant symptoms_____
sleeping difficulties _____
unusual spells or behavior not mentioned anywhere above _____

Oncologic: unexplained weight loss, failure to thrive, fatigue

Orthopedic: significant accidents or traumas, bone aches, frequent fractures, scoliosis or abnormal back curvature _____

Psychiatric: emotionally labile, weepy, sad, depressed, unusual behavior
any concern of physical abuse _____

Ophthalmologic: difficulty with vision or with eye movements _____

Urinary: urinary urgency, frequency or new incontinence, bedtime enuresis

Other: _____

Educational history: Difficulties now? Yes /No If yes, please complete the following:

Schools in chronologic order:

Name of school	age	difficulties	type of help given	name of teacher #stud / # teachers
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____
_____	____	_____	_____	_____

Family history: (please ask each biologic parent, even grandparents)
Abnormal anatomy of any body parts

_____

Autoimmune disorder (lupus, diabetes mellitus, colitis, rheumatoid arthritis, other)

_____

Birthmarks (white, red, brown) _____

Genetic syndromes _____

Grey hair, prematurely by the 30's _____

Headaches or migraines _____

Head size, unusually large or small _____

Learning difficulties (held back in school a year, dyslexia, math problems)

_____

Left-handedness or ambidexterity _____

Mental retardation _____

Miscarriages/stillbirths, sudden infant death syndrome _____

Neurologic disease (multiple sclerosis, other) _____

Seizures _____

Early stroke or heart attack (before or at 55 yrs of age) _____

other diseases that run in the family _____

Social history:

Biologic parents are married/ living together/divorced/separated. There are_____children.

Child's name age

_____ _____
_____ _____
_____ _____

Mother's occupation: _____
Father's occupation: _____

Significant psychologic stressors include

_____
_____
_____
_____

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CONFIDENTIAL SECTION:

Drug abuse:
Circle if prenatal use or use during **pregnancy, current** use, in the **past** use
alcohol use _____Amount of use, drink of choice, amount/day or week or month, number of years drunk, _____Cocaine, heroine, marijuana, metamphetamines _____ Other drugs of abuse _____ tobacco # of packs/day, # years smoked _____

HIV testing: Testing: _____
Treatment: _____

Psychiatric:
symptoms_____

_____

Diagnoses:

_____

Treatment:

_____

_____

Family history of : _____

HIV positivity:_____

Drug abuse:

_____

_____

Psychiatric symptoms or diagnoses:

_____

_____

Thank you for referring_____to my office. If you have any questions or suggestions, please feel free to call me at (415) 925-1616.

Respectfully,

Julie A. Griffith, M.D., M.S., C.M.T.
Neurology

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Name of Patient:_____ Wt._____

Phone:_____Date of Birth_____Kg: _____

Pharmacy Tel:_____Fax: _____

Medication	Prescribing Dr.& Speciality	Dates Start & Stop	Dose in Mg.	Blood Level	Comments (worked for x problem side effects)

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MEDICATIONS/SUPPLEMENTS

Patient:	**DOB:**	**Wt. KG.**	

Pharmacy:	Phone:

Name	Mg / Mg /cc	AM	B	MM	L	MA	D	PM/ BT		Mg / Mg /cc	AM	B	MM	L	MA	D	PM/ BT
Medication									Supplements								

Patient Name:_____ **D.O.B:** _____

Physician and other health provider list:

PLEASE ASTERICK [*] IF OK TO SEND DICTATION TO PRIMARY MEDICAL DOCTOR

PROVIDER	NAME	PHONE	FAX	ADDRESS
Primary Care Physician				
Pharmacy				
Laboratory				
School				
Occupational Therapist				
Physical Therapist				
Speech Therapist				
Other Providers				

HIPAA Notice of Privacy Practices
From the office of …

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This Notice details how your protected health information "PHI" may be used and disclosed to third parties. This Notice also details your rights regarding how you can get access to this information. PLEASE REVIEW IT CAREFULLY.

This office/Practice is committed to maintaining the privacy of your protected health information ("PHI"), which includes information about your health condition and the care and treatment you receive from this practice. The creation of a record detailing the care and services you receive helps this office to provide you with quality health care.

I. IT IS MY LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

By law I am required to insure that your PHI is kept private. The PHI constitutes information created or noted by me that can be used to identify you. It contains data about your past, present, or future health or condition, the provision of health care services to you, or the payment for such health care. I am required to provide you with this Notice about my privacy procedures. This Notice must explain when, why and how I would use and/or disclose your PHI. Use of PHI means when I share, apply, utilize, examine, or analyze information within my practice; PHI is disclosed when I release, transfer, give, or otherwise reveal it to a third party outside my practice. With some exceptions, I may not use or disclose more of your PHI than is necessary to accomplish the purpose for which the use or disclosure is made; however, I am always legally required to follow the privacy practices described in this notice.

Please note that I reserve the right to change the terms of this Notice and my privacy policies at any time. Any changes will apply to PHI already on file with me. Before I make any important changes to my policies, I will immediately change this Notice and post a new copy of it in my office. You may also request a copy of this Notice from me, or you can view a copy of it in my office.

II. HOW I WILL USE AND DISCLOSE YOUR PHI.

I will use and disclose your PHI for many different reasons. Some of the uses or disclosures will require your prior written authorization, others, however, will not. Below you will find the different categories of my uses and disclosures, with some examples.

The Office/Practice may use and/or disclose your PHI for the following purposes:

(a) Treatment - In the course of treatment, my office uses the patient name on each chart instead of a numerical coding system; my office staff briefly attempted the numerical coding system, but found that this system too time-consuming to provide the *timely* service I feel is required. For instance, I want my staff to rapidly find the chart when the patient or parent is calling in with a question. Additionally, I have a list of patient names on my laptop when I am seeing patients. I have positioned the furniture and computers, laptop in such a way as to avoid patients seeing other patient names; however sometimes this is not able to be fully avoided. However, certainly no other patient name and diagnosis will be able to be viewed in the office by another patient.

(b) In order to provide you with the health care you require, this practice will provide your PHI to those health care professionals directly Involved in your care so that they may understand your health condition and needs. The health care professionals aforementioned may or may not be part of this practice. For example, a primary care physician treating you or your child for headaches may need to know the results of your or your child's latest physician examination performed by me. Payment - In order to get paid for services provided to you, the Office/Practice will provide your PHI, directly or through a billing service, to appropriate third party payers, pursuant to their billing and payment requirements. For example, the Practice may need to provide your insurance with information about health care services that you received from the Practice so that the Practice can be properly paid or so you may be reimbursed for payment to me. The Practice may also need to tell your insurance plan about the treatment you are going to receive so that it can determine whether or not your insurance will cover the treatment expense.

(c) Health Care Operations - In order for the Office/Practice to operate in accordance with applicable law and insurance requirements and in order for the Practice to continue to provide quality and efficient care, it may be necessary for the Practice to compile, use and/or disclose your PHI. For example, the Practice may use your PHI in order to evaluate the performance of the Practice's personnel in providing care to you.

The Office/Practice may also use and/or disclose your PHI without your specific authorization in the following additional instances:

(a) De-Identified Information - Information that does not identify you and, even without your name, cannot be used to identify you.

(b) Business Associate - To a business associate if the Office/Practice obtains satisfactory written assurance. in accordance with applicable law, that the business associate will appropriately safeguard your PHI. A business associate is an entity that assists the Practice in undertaking some essential function, such as a billing company that assists the office in submitting claims for payment to insurance companies or other payers.

(c) Personal Representative- To a person who, under applicable law, has the authority to represent you in making decisions related to your health care.

(d) Emergency Situations-

(i) for the purpose of obtaining or rendering emergency treatment to you if the opportunity for you to object cannot be obtained due to your incapacity or emergent treatment circumstances and the treatment is consistent with your prior expressed preferences and is in your best interest; or

(ii) to a public or private entity authorized by law or by its charter to assist in disaster relief efforts, for the purpose of coordinating your care with such entities in an emergency situation.

(e) Public Health Activities - Such activities include, for example, information collected by a public health authority, as authorized by law, to prevent or control disease.

(f) Abuse, Neglect or Domestic Violence - to a government authority if the Office/Practice is required by law to make such disclosure.

(g) Health Oversight Activities - Such activities, which must be required by law, involve government agencies and may include, for example, when compelled by a U.S. Secretary of Health and Human Services to investigate or assess my compliance with HIPAA regulations.

(h) Judicial and Administrative Proceeding - For example, the Office/Practice may be required to disclose your PHI in response to a court order or a lawfully issued subpoena. If an arbitrator or arbitration panel requires disclosure, medical records including or not including more confidential records (involving details of psychiatric, drug abuse history or laboratory results, etc) may be provided when it is lawfully requested by either party, i.e. a subpoena authorizing disclosure in a proceeding before an arbitrator or arbitration panel.

(i) Law Enforcement Purposes - In certain instances, your PHI may have to be disclosed to a law enforcement official. For example, your PHI may be the subject of a grand jury subpoena, or, the Practice may disclose your PHI if the Practice believes your death was the result of criminal conduct.

(j) Coroner or Medical Examiner. The Office/Practice may disclose your PHI to a coroner or medical examiner for the purpose of identifying you or determining your cause of death.

(k) Organ, Eye or Tissue Donation. If you are an organ donor, the Practice may disclose your PHI to the entity to whom you have agreed to donate your organs.

(l) Research- If the Office/Practice Is involved in research activities, your PHI may be used, but such use is subject to numerous governmental requirements intended to protect the privacy of your PHI.

(m) Averts Threat to Health or Safety - The Office/Practice may disclose your PHI if it believes disclosure is necessary to prevent or lessen a serious and eminent threat to the health or safety of a person or the public and disclosure is to an Individual who is reasonably able to prevent or lessen the threat.

(n) Specialized Government Functions- This refers to disclosure of PHI that relate primarily to military and veteran activity.

(o) Workers' Compensation~ If you are involved in a Workers' Compensation claim, the Office/Practice may be required to disclose to your PHI to an individual or entity that is part of the Workers' Compensation system.

(p) National Security and Intelligence Activities- The Office/Practice may disclose your PHI in order to provide authorized governmental officials with necessary intelligence information for national security activities and purposes authorized by law.

(q) Military and Veterans- If you are a member of the armed forces, the Office/Practice may disclose your PHI as required by the military command authorities.

(r)If disclosure is otherwise specifically required by law.

III. MY OFFICE CONTACTING YOU

APPOINTMENT REMINDER

The following appointment reminders are used by the Practice: a) a postcard mailed to you at the address provided by you; b) telephoning your home, cellular phone or work phone, depending on the time of day, and leaving a message on your answering machine or with the individual answering the phone and occasionally, by a letter to the address you have provided.

OFFICE STAFF OR I MAY CONTACT YOU

The Office/Practice may, from time to time, contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

IV. CERTAIN USES AND DISCLOSURES FOR WHICH YOU HAVE THE OPPORTUNITY TO OBJECT

(a). Disclosures to family, friends, or others**.** I may provide your PHI to a family member, friend, or other individual who you indicate is involved in your care or responsible for the payment for your health care, unless you object in whole or in part. Retroactive consent may be obtained in emergency situations.

V. **OTHER USES AND DISCLOSURES REQUIRE YOUR WRITTEN AUTHORIZATION** In any other situation not described above, I will request your written authorization before using or disclosing any of your PHI. Even if you have signed an authorization to disclose your PHI, you may later revoke that authorization, in writing, to stop any future uses and disclosures of your PHI by me.

VI. WHAT RIGHTS YOU HAVE REGARDING YOUR PHI

These are your rights with respect to your PHI:

(a). The Right to See and Get Copies of Your PHI. In general, you have the right to see your PHI that is in my possession, or to get copies of it; however, you must request it in writing. If I do not have your PHI, but I know who does, I will advise you how you can get it. You will receive a response from me within 30 days of my receiving your written request. Under certain circumstances, I may feel I must deny your request but if I do, I will give you, in writing, the reasons for the denial. I will also explain your right to have my denial reviewed. If you ask for copies of your PHI, I will charge you 25c/ page and $20 /hr for the work of reviewing the chart and in photocopying and mailing, in addition to storage retrieval fees, and Fed ex and mailing costs, as needed. For any attorney requesting medical records, I will charge them (rates by law), 10c/page, $20/hr for the work of reviewing the chart and in photocopying and mailing, for storage retrieval fees, Fed ex and mailing costs, as needed. I may see fit to provide you with a summary or explanation of the PHI as well as to the cost, but only if you agree to it in advance.

(b). The Right to Request Limits on Uses and Disclosure of Your PHI. You have the right to ask that I limit how I use and disclose your PHI. While I will consider your request, I am not legally bound to agree. If I do agree to your request, I will put those limits in writing and abide by them except in emergency situations or in situations which require me by law to do otherwise. You do not have the right to limit the uses and disclosures that I am legally required or permitted to make.

(c). The Right to Choose How I Send Your PHI to You**.** It is your right to ask that your PHI be sent to you at an alternate address (for example, sending information to your work address rather than your home address) or by an alternate method (for example. via facsimile instead of by mail). I am obliged to agree to your request providing that I can give you the PHI in the format you requested, without undue inconvenience. For privacy reasons, I will only receive email provided to me by patients, if patients choose to use this form of communication. I will not send a response to patients via email nor send medical records via email, due to the difficulty in maintaining security of those records.

(d). The Right to Get a List of the Disclosures I Have Made**.** You are entitled to a list *of* disclosures of your PHI that I have made. The list will not include uses or disclosures to which you have already consented, i.e. those for treatment, payment, or health care operations, sent directly to you, or to your family; neither will the list include disclosures made for national security purposes, to corrections or law enforcement personnel, or disclosures made before April 15. 2003, After April 15, 2003, disclosure records will be held for six years.

I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I give you will include disclosures made in the previous six years (the first six year period being 2003-2009) unless you indicate a shorter period. The list will include the date of the disclosure, to whom the PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. I will provide the list to you at no cost, unless you make more than one request in the same year, in which case I with charge you a reasonable sum based on a set fee for each additional request.

(e). The Right to Amend Your PHI**.** If you believe that there is some error in your PHI or that important information has been omitted, it is your right to request that I correct the existing information or add the missing information. Your request and the reason for the request must be made in writing. You will receive a response within 60 days of my receipt of your request. I may

deny your request, in writing, if I find that the PHI is (a) correct and complete, (b) forbidden to be disclosed, (c) not part of my records, or (d) written by someone other than me. My denial must be in writing and must state the reasons for the denial. It must also explain your right to file a written statement objecting to the denial. If you do not file a written objection, you still have the right to ask that your request and my denial be attached to any future disclosures of your PHI. If I approve your request, I will make the change(s) to your PHI, most likely by an addendum (rarely by a line through the original with a handwritten correction). Additionally, I will tell you that the changes have been made, and I will advise all others who need to know about the change(s) to your PHI.

(f). The Right to Get This Notice by Email**.** You have the right to get this notice by email. You have the right to request a paper copy of it, as well.

VII. HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If, in your opinion, I may have violated your privacy rights, or if you object to a decision I made about access to your PHI, you are entitled to send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Avenue S.W. Washington, D.C. 20201. If you file a complaint about my privacy practices, I will take no retaliatory action against you.

If you have any questions about this notice or any complaints about my privacy practices, please contact me at my address or phone number listed above.

VIII. EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on April 14, 2003.

I acknowledge receipt of this notice.

*Patient Name:*_____ *Signature:*_____ *Date:* _____

Legal guardian name:_____ Signature_____ Date: _____

Relationship to patient: _____

Legal guardian name:_____ Signature_____ Date: _____

Relationship to patient: _____

Julie A. Griffith M.D., M.S. B.C.I.P.
5 Bon Air Rd, Suite D219
Larkspur, CA 94939
Telephone (415) 925-1616
Facsimile (415) 962-
1303 mybrainhealth@comcast.net www.mybra
inhealth.org

Predetermination of benefits/ allowable amounts Form to obtain from your insurance company

Please call your insurance and have them help you in completing this from and bring it with you on the day of your appointment.

Date:_____

To Whom It May Concern:

Patient Name:_____DOB:_____
ID#:_____Group#:_____

Please mail or fax within 5 business days the usual and customary maximal allowance for the codes below for this patient's contract. I am in the process of billing this patient and need this information immediately. See copy of insurance card, front and back, attached.

Your maximum usual and customary allowance for the current year for the following codes:

_____$525.00 per hour 99205 initial office consult

_____$525.00 per hour 99354 Prolonged Service,

_____$310.00 per hour 99358 After or before face to face service, 1st hour.

Also, please send revised or updated amounts to me for allowable amounts EVERY TIME the allowable amounts change for this patient's contract. Please send a copy of every charge in the contract when changes are made.

Thank you for your attention to this matter.

You can also fax back to **(415) 259-4011**

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inhealth.org

REFERRALS & AUTHORIZATION REQUEST

I, Dr. _____

Of_____Medical Facility

Hereby refer my patient: _____

To: Dr. Griffith M.D., for Consultation re:_____

_____

For (please check ALL that apply)

1) ☐ Initial consultation
2) ☐ Consultation for re-evaluation & modification of plan & management as new questions arise regarding neurological issues.
3) ☐ Other_____

Patient's Primary Care Physician or Therapist not Parents or Family Members

Sign: _____

Dated: _____

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www.mybrainhealth.org

Re: Case Management and Phone appointments

Phone Appointments, and the medical service associated.

It is preferable to schedule in office appointments for medical care. For a brief question or two lasting only a few minutes, regarding how to complete the labs or the plan discussed in the prior office appointment, there will be no charge.

However, some fee for service patients prefer to pay for medical service provided by Dr. Griffith that occurs in between in office appointments, because this is less expensive than the in office appointments, and because this saves driving time and expense.

To better serve you, appointments by phone are offered patients who have medical issues not requiring a physical examination. The charge for these appointments is $310.00 per hour, prorated. Blue Shield and Cigna usually covers phone appointments.

At the beginning of the phone appointment, we ask that you provide us with your credit card number, the expiration date, the 3 digit security code on the back of the credit card, and your billing zip code. We do not keep credit cards on file, by law. At the end of the appointment, you will be charged for the phone time as well as any other time required by Dr. Griffith to complete tasks which arose based on the phone conversation. Dr. Griffith does charge for the time for reviewing medical records, if this is requested by the patient or patient's legal guardian, to be done separate from the phone appointment. Dr. Griffith will review medical records during the appointment with the patient, to be the most conservative financially for the patient, unless the patient specifically requests Dr. Griffith to review the records before or after the appointment, to free up the patient to not be on the phone during this time. If after the appointment, Dr. Griffith needs to implement the plan, such as writing prescriptions or lab requisitions, calling pharmacies or other physicians, etc., then there will be a charge for this case management time. Again, this time may extend beyond the time spent directly on the phone with Dr. Griffith.

I understand Dr. Griffith's policy regarding phone appointments and the associated medical service time for which Dr. Griffith charges, and agree to pay for these services.

Patient Name: _____ _____

Guaranteed payer name, Printed: _____

Signature of payer: x_____
Signing indicates that I agree to pay for services

I decline these services x_____

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Non face to face medical service

It is preferable to schedule in office appointments for medical care. For a brief question or two lasting only a few minutes, regarding how to complete the labs or for clarification of the plan which was discussed in the prior office appointment, there will be no charge.

However, if the medical service provided by Dr. Griffith, which is requested by the patient or the patient's legal guardian, lasts longer than a few minutes, there will be a charge for this service. Non face to face medical service includes generating a treatment plan from review of lab results, consulting other physicians, therapists, pharmacists, school teachers, psychologists, the laboratory, etc. on behalf of the patient. Also, the non-face to face medical service can includes research (as needed), to develop the impression and plan, especially if Dr. Griffith begins new work or makes new recommendations not previously covered during the in office appointment.

I will not charge for my time spent streamlining the dictation regarding the information we have covered during the appointment. However, I do charge time for work the patient and I have agreed I would pursue after the appointment, such as writing additional lab slips, writing or calling prescriptions, calling to coordinate the management plan with other physicians, reviewing abnormal lab results and contacting patients if there is any urgent management need, etc. The patient or patient's legal guardian would always be consulted or would be aware of Dr. Griffith's work, and would give approval, prior to Dr. Griffith beginning this work, or as Dr. Griffith is doing the work, or the same day of the work (if the medical care is emergent or urgent).

Non face to face medical service is billed at $310 per hour**.**

I understand Dr. Griffith's policy regarding non face to face medical service and agree to pay for these services.

Patient Name: _____ _____

Guaranteed payer name, Printed: _____

Signature of payer: x_____
Signing indicates that I agree to pay for services

I decline these services x_____

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My Services and Fees from August 15th 2014

Office visit	per	1 hour	$525.00
Case Management	per	1 hour	$310.00

Case management is any of the following

- Phone calls
- Phone call to other physicians or hospital staff
- Arrangements for tests and studies
- Conferences by phone with parents, teachers, counselors, lawyers, therapists, etc.
- Chart Maintenance, prescriptions and refills
- Literature search/ Research

Although I will give you a bill to submit to your insurance company, most insurance companies do cover the initial consultation and 45 minute follow up appointments.
They may or may not cover the extended in office appointments over 1 hour so please check with your insurance company.
Most insurance companies do not cover the cost of phone calls or case management.

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As required by the Health Information Portability and Accountability Act (HIPAA) and California law, a medical practice may not release or disclose individually identifiable health information without your authorization or as provided by the Notice of Privacy Practices. Your completion of this form means that you are granting permission for us to obtain and/or disclose your protected healthcare information as described below. Please review and complete this form carefully. An incomplete form is invalid*. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.*

Authorization:

I,_____(Name of patient) hereby authorize Dr. Julie Griffith with Neurology Health Center to obtain and/or release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To:_____Dept: _____

Phone:_____Fax:_____

The medical information/records will be used for the following purpose: Neurological Consultation/RX

Healthcare information to be released and disclosed:

____ Alcohol Abuse
____ Consult(s) Reports
____ Disability records (Dpt. Of Social Services)
____ Discharge Summary
____ Drug/Substance Abuse
____ Educational
____ EKG Results
____ Genetics/Genomics
____ History
____ HIV Records
____Immunization History
____Intelligence Quotient (IQ)
____Laboratory Reports
____Learning and behavioral disorders
____Legal (Patients in law suit)
____Legal (Patients involved with the law (juvenile probation, police, jail or sheriff)
____Mental Health
____Pathology Reports
____Psychiatric
____Physical Exam
____Pulmonary Funct. Test
____Psychological
____STD Records
____Summary
____Surgical Reports
____X – Ray Reports
____Out Patient Notes
____Other

I also consent to the specific release of the following records: (Please initial all that apply)

Drug/Alcohol/Substance Abuse____ Psychiatric/Mental Health_____ Tests for Antibodies to HIV____

HIV Diagnosis/Treatment_____ Genetic Information_____

DURATION: This authorization shall be effective immediately and remain in effect until_____

RESTRICTIONS: Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law. A photocopy of facsimile of this authorization shall be considered as effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient *or legal/personal representative* Relationship *(if other than patient)*

_____ _____
Patient's Name (PRINT) Date

_____ _____
Patient's Date of Birth Witness name/Signature

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: **Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. 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 or relate 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 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, associates, 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, wrongfu 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. However, following the assertion of any claim against the physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: **Procedures and Applicable Law:** A 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 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 Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators 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 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 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 of 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 signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's 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 o 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.

By: _____ _____
Physician's or Authorized Representative's Signature (Date)

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

A signed copy of this document is to be given to the Patient. Original is to be filed in Patient's medical records.

(2-08)