Patient's Medication List

Patient's Name_____Date_____

Medications	Dosage	Frequency

Drug Allergies

North Florida Eye Center
6831 N.W 11th Place, Suite 1
Gainesville, Fl 32605
Phone: 352-331-7337
Fax: 352-331-7552

NORTH FLORIDA EYE-CENTER

www.worldclasseyecare.com

Dr. M. Fanous, MD., FACS

North Florida Eye Center
410 North Main Street
Chiefland, FL 32626
Phone: 352-493-2634
Fax 352-493-2517

Name_____ Date:_____ Birthdate:_____
Address:_____ Age:_____ Sex: ☐M ☐F
City:_____ State:_____ Zip:_____ Phone:_____ Marital Status_____
Employer_____ Phone:_____ Social Security Number:_____
Emergency Contact:_____ Phone:_____ Relationship:_____
Referring Doctor:_____ Phone:_____ Family Doctor:_____ Phone:_____
May we contact either of the doctors for your past health records? YES__NO___Date of last physical:_____
List all Medications you take including dosage, how often it is taken, and the reason for taking (including eye medication):

_____

_____

Pharmacy:_____ Phone:_____
Do you have any allergies to medications or food?: YES____NO____
If YES, list medications_____
Are you allergic to latex? YES___NO___
Have you ever had a blood transfusion ? YES___NO___

REVIEWS OF SYSTEMS
Do you presently have any problems in the following areas? If, YES, please give an explanation:

	YES	NO	
EYES			
Loss of Vision	☐	☐	_____
Distorted Vision	☐	☐	_____
Double Vision	☐	☐	_____
Mucous discharge	☐	☐	_____
Sandy feeling	☐	☐	_____
Burning	☐	☐	_____
Excess tearing / watering	☐	☐	_____
Glare/ light sensitivity	☐	☐	_____
Infection of eye / lid	☐	☐	_____
Fluctuating vision	☐	☐	_____
Blurred vision	☐	☐	_____
Loss of side vision	☐	☐	_____
Dryness	☐	☐	_____
Reness	☐	☐	_____
Itching	☐	☐	_____
Foreign body sensation	☐	☐	_____
Occasional tearing	☐	☐	_____
Eye pain or soreness	☐	☐	_____
Sty, chalazion	☐	☐	_____
Tired eyes	☐	☐	_____
Are you having difficulty?			
Reading small print	☐	☐	_____
Reading in general	☐	☐	_____
Climbing stairs	☐	☐	_____
Driving in bright light	☐	☐	_____
Reading traffic signs	☐	☐	_____
Writing checks, cards	☐	☐	_____
Playing golf, tennis	☐	☐	_____
Doing hobbies	☐	☐	_____
Watching TV / movies	☐	☐	_____

	YES	NO	
CONSTITUTIONAL SYMPTOMS			
Fever	☐	☐	_____
Weight loss	☐	☐	_____
Fatigue	☐	☐	_____
EARS, NOSE, MOUTH, THROAT			
Hearing problems	☐	☐	_____
Sinus Congestion	☐	☐	_____
Runny nose	☐	☐	_____
Post-nasal drip	☐	☐	_____
Chonis cough	☐	☐	_____
Dry throat / mouth	☐	☐	_____
HEART			
Congestive heart failure	☐	☐	_____
Heart murmur	☐	☐	_____
Heart attacks	☐	☐	_____
Irregular / fast heartbeat	☐	☐	_____
Blood Pressure	☐	☐	_____
Chest pain / angina	☐	☐	
RESPIRATORY (Lungs/Breathing)			
Asthma	☐	☐	_____
Emphysema	☐	☐	_____
Tuberculosis	☐	☐	_____
Lung Cancer	☐	☐	_____
Sarcoidosis	☐	☐	_____
GASTROINTESTINAL (Stomach/Intestines)			
Jaundice / Hepatitis	☐	☐	_____
Ulcers / Bleeding	☐	☐	_____
Hiatal Hernia	☐	☐	_____
Acid Reflux	☐	☐	_____

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GENITALS/KIDNEY/BLADDER			
Kidney disease	☐	☐	
Prostate cancer	☐	☐	
Cervical/Uterine/Cancer	☐	☐	
Pregnant now?	☐	☐	
SKIN AND/OR BREAST			
Skin disease / rash	☐	☐	
Skin cancer	☐	☐	
Breast disease	☐	☐	
Breast cancer	☐	☐	
MUSCULO-SKELETAL			
Degenerative arthritis	☐	☐	
Rheumatoid arthritis	☐	☐	
Lupus	☐	☐	
Muscle / Joint pain	☐	☐	
NEUROLOGICAL			
Fainting	☐	☐	
Dizziness	☐	☐	
Migraines	☐	☐	
Convulsions	☐	☐	
Stroke / Paralysis	☐	☐	
Alzheimer's	☐	☐	

PSYCHIATRIC			
Depression	☐	☐	
Schizophrenia	☐	☐	
BLOOD DISORDERS			
Anemia	☐	☐	
Sickle Cell disease	☐	☐	
Bleeding disorder	☐	☐	
Leukemia	☐	☐	
Blood cancer	☐	☐	
ALLERGIC/IMMUNOLOGICAL			
Seasonal allergies	☐	☐	
Hay fever symptoms	☐	☐	
Immune problems	☐	☐	
General allergies	☐	☐	
ENDOCRINE			
Diabetes	☐	☐	
Cancer-pancreas	☐	☐	
Thyroid-problems	☐	☐	
Hormone Replacement	☐	☐	

PAST HISTORY

List any **ILLNESS AND INJURIES** you had in the past (i.e., diabetes, high blood pressure, arthritis, ect.)

_____

_____

_____

List any significant **EYE HISTORY** (i.e., cataracts, macular degeneration, glaucoma, lazy eye, retinal detachment) surgery or injury you have had:

_____

_____

_____

List any **ILLNESS OR INJURIES** you have had in the past including approximate date of surgery:

_____

_____

_____

FAMILY HISTORY

DISEASES	YES	NO	FAMILY RELATION
Blindness	☐	☐	
Cataract	☐	☐	
Glaucoma	☐	☐	
Macular degeneration	☐	☐	
Retinal detachment	☐	☐	
Color Blindness	☐	☐	
Arthritis	☐	☐	
Cancer	☐	☐	
Diabetes	☐	☐	

	YES	NO	FAMILY RELATION
Heart attacks	☐	☐	
High blood pressure	☐	☐	
Kidney disease	☐	☐	
Lupus	☐	☐	
Sjogren's Syndrome	☐	☐	
Stroke	☐	☐	
Thyroid	☐	☐	
Tuberculosis	☐	☐	

SOCIAL HISTORY

	YES	NO
Do you currently wear glasses?	☐	☐
Do you currently wear contacts?	☐	☐
Do you drive?	☐	☐
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
Do you use illegal drugs?	☐	☐

What is your occupation?_____

How long have you had your current pair of glasses?_____

How many packs in a day?_____ How many years?_____

How many glasses a day?_____

Patient's Signature_____

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PATIENT INFORMATION FORM

Today's Date:_____

Patient Name:_____

Date of Birth:_____ Social Security Number_____

Address:_____ Apt/Lot #:_____

City:_____ State:_____ Zip Code_____

Home Phone:(___)_____ Work Phone:(___)_____

HOW DID YOU HEAR ABOUT OUR OFFICE? ☐Gainesville Newspaper ☐Radio Advertisement

☐Referred by doctor ☐Television ☐Friend/Family ☐Phone Book ☐Other_____

Referring Physician:_____

Primary Insurance

Name of insurance compant:_____

Subscriber Name:_____ Relationsip to patient: ☐Self ☐Spouse ☐Parent

Subscriber Date of Birth:_____ Subscriber Social Security number:_____

Subscriber ID:_____ Group#_____

Please supply driver's license and all insurance ards to the receptionist for photocopying

AUTHORIZATION FOR SERVICES / RELEASE OF INFORMATION

I request the services Of Maher M. Fanous M.D., a physician duly licensed in the state of Florida, and all personnel, and consent to examination, diagnostic procedure and treatment which may need to be performed on my behalf. Dr. Fanous may at his own discretion disclose all or part of my medical records to any person or corporation which is or may be liable under contract to Dr. Fanous' office, or to the patient or his or her family member or employer for all part of Dr. Fanous charges. Such disclosure shall include the furnishings of said doctor's records.

INSURANCE ASSIGNMENT AND STATEMENT OF FINANCIAL RESPONSIBILITY

I hereby authorize direct payment to Dr. Fanous for all valid insurance benefits including all major medical benefits herein specified and otherwise payable to me for these services received. I understand I will be financially and legally responsible for charges not covered by this assignment. The undersigned further agrees to pay all costs associated with the collection of any such balance, including reasonable attorney's fees if necessary.

I certify that I have read the above authorizations and that I agree to the same and also certify that no guarantee or assurances has been made to the results that may be obtained.

Date:_____

_____

Patient Signature

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NOTICE OF DILATED EXAMS

In an effort to provide our patients with quality comprehensive care, it will be necessary to dilate your eyes in order for Dr. Fanous to do a complete eye exam. The frequency of necessity will be determined by Dr Fanous based on the individual needs of your eyes. Each person is affected differently by the effects of dilation. Some patients find it uncomfortable to drive after dilation but many do not. We do not make any recommendations on this matter. Your safety is our utmost concern. If you feel you will not be safe to drive, then you must come with someone to provide transportation for you. Please be aware when checking out if you will need a dilated exam on your next visit and be prepared for this.

Thank you,

Dr. Fanous and staff

I have read the above statement and will not . will require transportation when dilated exams are performed.

_____ _____

Printed name Signature

_____ _____

Witness Date/Time

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Financial Policy

We are happy to see patients who do not have any health insurance, however, a deposit of $200.00 is due at time of check-in. We are sorry for any inconvenience, however, this new policy is in effect due to non-payment by the majority of the self-pay patients referred to us.

We are participating in most insurance companies and are happy to file both primary and secondary insurance for our patients.

Any deductibles, co-payments, coinsurance and non-covered services are ***due at the time of service.***

Health insurance companies do not pay for refraction exams. This is the exam that is done for glasses, contact lenses, or determining change in vision. They consider this routine and do not cover it. The charge for a refraction exam is $48.00 and is ***due at the time of service.***

As an added convenience, we accept cash, checks, credit and debit cards and are happy to process payments over the phone for any unpaid balance.

There is a $25.00 fee for appointments not cancelled within 24 hours prior to the scheduled appointment time.

Thank you
NORTH FLORIDA EYE CENTER

I have read and understand the financial policy.

_____ _____

Patient Signature Date

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PATIENT ACKNOWLEDGMENT FORM

PLEASE READ, INITIAL, SIGN, DATE AND BRING BACK TO THE OFFICE

North Florida Eye Center, PA's "Notice of Privacy Practices" provides information about how we may use and disclose protected health information about you. Please acknowledge receipt of this document, or that you have read this office's **"Notice of Privacy Practices"** by initialing below:

_____
Patient's Initial

Our **"Notice of Privacy Practices"** states that we reserve the right to change the terms described. Should this happen, you will receive a revised copy.

_____
Patient's Initial

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

_____
Patient's Initial

I hereby authorize ***North Florida Eye Center, PA*** to release any of my treatment, payment or healthcare information to the family member(s) and or friend(s) listed in the spaces provided. If no one is listed below, none of this information will be discussed with anyone other than the patient.

_____ Name _____ Relationship

_____ Name _____ Relationship

_____ Name _____ Relationship

_____ None _____ Patient's Initial

By signing this form, you consent to our use of and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent in writing, except where we have already made disclosure in trust on your prior consent.

_____ Patient Signature (or legal guardian) _____ Date

A. Notifier: NORTH FLORIDA EYE CENTER / MAHER M. FANOUS, MD

B. Patient Name: **C. Identification Number:**

Advanced Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.refractions** below, you may have to pay.
Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare not to pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
REFRACTIONS AND CONTACT LENS EXAMS ARE NOT COVERED BY MEDICAL INSURANCE AND IS THE PATIENT'S RESPONSIBILITY	**NON-COVERED SERVICE**	$48.00 FOR A GLASSES PRESCRIPTION

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. refractions** listed above. **NOTE:** If you choose Option 1 or 2, we may help you use any other insurance that you might have, but Medicare cannot require us to do this.

G. Options: **Check only one box. We cannot choose a box for you.**

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following directions on the MSN. If medicare does pay, you will refund any payments I made to you, less copays or deductibles.

☐ **OPTION 2.** I want the **D.**_____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**_____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

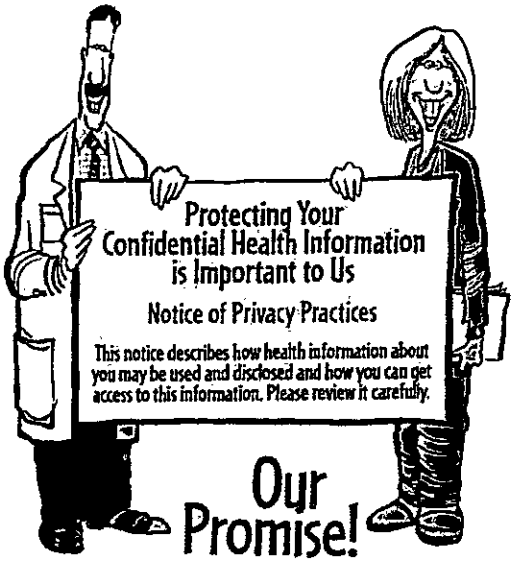
H. Additional Information:

**** Refractions are done in order to obtain a prescription for corrective lenses by request. Contact lens exams are $90 and patient responsibility.

This notice gives our opinion, not an official Medicare decision. If you have any other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also received a copy.

I. Signature:	J. Date:

CMS does not discriminate in its program and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.



Dear Patient:

This notice is not meant to alarm you. Quite the opposite! It is our desire to communicate to you that we are taking seriously Federal law (HIPAA–Health Insurance Portability and Accountability Act) enacted to protect the confidentiality of your health information. We never want you to delay treatment because you are afraid your personal health history might be unnecessarily made available to others outside our office.

Why do you have a privacy policy? Very good question!

The Federal government legally enforces the importance of the privacy of health information largely in response to the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers but also with the Internet, phone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we follow to protect your health information when we use it.

We want you to know about these policies and procedures which we developed to make sure your health information will not be shared with anyone who does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your HEALTH INFORMATION only for the purposes of providing your treatment, obtaining payment, conducting healthcare operations, and as otherwise described in this notice.

How your HEALTH INFORMATION may be used To Provide Treatment

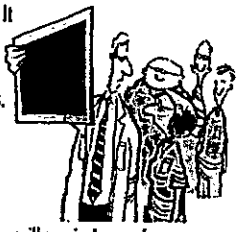
We will use your HEALTH INFORMATION within our office to provide you with care. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care. In addition, we may share your health information with pharmacies or other healthcare personnel providing you treatment.

To Obtain Payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.

To Conduct Health Care Operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.



In Patient Reminders

Because we believe regular care is very important to your health, we will remind you of a scheduled appointment or that it is time for you to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family. These communications are an important part of our philosophy of partnering with our patients to be sure they receive the best care. They may include postcards, folding postcards, letters, telephone reminders or electronic reminders such as email (unless you tell us that you do not want to receive these reminders).

To Business Associates

We have contracted with one or more third parties (referred to as a business associate) to use and disclose your health information to perform services for us, such as billing services. We will obtain each business associate's written agreement to safeguard your health information.

NOTICE OF PRIVACY PRACTICES

Federal law generally permits us to make certain uses or disclosures of health information without your permission. Federal law also requires us to list in the Notice each of these categories of uses or disclosures. The listing is below.

As Required By Law

We may use or disclose your health information as required by any statute, regulation, court order or other mandate enforceable in a court of law.

Abuse or Neglect

We may disclose your health information to the responsible government agency if (a) the Privacy Official reasonably believes that you are a victim of abuse, neglect, or domestic violence, and (b) we are required or permitted by law to make the disclosure. We will promptly inform you that such a disclosure has been made unless the Privacy Official determines that informing you would not be in your best interest.

Public Health and National Security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical device.

For Law Enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

Family, Friends and Caregivers

We may share your health information with those you tell us will be helping you with your treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our best judgment when sharing your health information only when it will be important to those participating in providing your care.

Workers' Compensation Purposes

We may disclose your health information as required or permitted by State or Federal workers' compensation laws.

Judicial and Administrative Proceedings

We may disclose your health information in an administrative or judicial proceeding in response to a subpoena or a request to produce documents. We will disclose your health information in these circumstances only if the requesting party first provides written documentation that the privacy of your health information will be protected.

Maher M. Fanous, M.D., FACS
6831 NW 11th PL., Ste. 1 • Gainesville, FL 32605 • (352) 331-7337
410 N. Main St., Ste. 6 • Chiefland, FL 32626 • (352) 493-2634

Incidental Uses and Disclosures

We may use or disclose your health information in a manner which is incidental to the uses and disclosures described in this Notice.

Health Oversight Activities

We may disclose your health information to a government agency responsible for overseeing the health care system or health-related government benefit program.

To Avert A Serious Threat To Health or Safety

We may use or disclose your health information to reduce a risk of serious and imminent harm to another person or to the public.

To The U.S. Department of Health and Human Services (HHS)

We may disclose your health information to HHS, the government agency responsible for overseeing compliance with federal privacy law and regulations regulating the privacy and security of health information.

For Research

We may use or disclose your health information for research, subject to conditions. "Research" means systemic investigation designed to contribute to generalized knowledge.

In Connection With Your Death Or Organ Donation

We may disclose your health information to a coroner for identification purposes, to a funeral director for funeral purposes, or to an organ procurement organization to facilitate transplantation of one of your organs.

If applicable State law does not permit the disclosure described above, we will comply with the stricter State law.

Authorization to Use or Disclose Health Information

We are required to obtain your written authorization in the following circumstances: (a) to use or disclose psychotherapy notes (except when needed for payment purposes or to defend against litigation filed by you); (b) to use your PHI for marketing purposes; (c) to sell your PHI; and (d) to use or disclose your PHI for any purpose not previously described in this Notice. We also will obtain your authorization before using or disclosing your PHI when required to do so by (a) state law, such as laws restricting the use or disclosure of genetic information or information concerning HIV status; or (b) other federal law, such as federal law protecting the confidentiality of substance abuse records. You may revoke that authorization in writing at any time.

PATIENT RIGHTS

You have the following rights related to your health information.

Restrictions

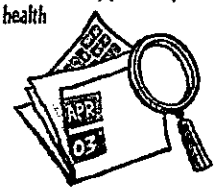
You have the right to request restrictions on the use or disclosure of your health information for treatment, payment, or healthcare operations in addition to the restrictions imposed by federal law. Our office is not required to agree to your request, unless (a) you request that we not disclose your PHI to a health insurance company, Medicare or Medicaid for payment or healthcare operations purposes; (b) you, or someone on your behalf, has paid us in full for the healthcare item or service to which the PHI pertains; and (c) we are not required by law to disclose to the insurer, Medicare, or Medicaid the PHI that is the subject of your request, but we will endeavor to honor reasonable requests. We generally are not required to agree to a requested restriction. Our office will honor your request that we not disclose your health information to a health plan for payment or healthcare operation purposes if the health information relates solely to a healthcare item or service for which you have paid us out-of-pocket in full.

Confidential Communications

You have the right to request that we communicate with you by alternative means or at an alternative location. You may, for example, request that we communicate your health information only privately with no other family members present or through mailed communications that are sealed. We will honor your reasonable requests for confidential communications.

Inspect and Copy Your Health Information

You have the right to read, review, and copy your health information, including your complete chart, x-rays and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable, cost-based fee to duplicate and assemble your copy. If there will be a charge, we will first contact you to determine whether you wish to modify or withdraw your request.



Amend Your Health Information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe the information to be changed and your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete. If we deny your request, we will provide you with a written explanation of the denial.

Accounting of Disclosures of Your Health Information

You have the right to ask us for a description of how and where your health information was disclosed. Our documentation procedures will enable us to provide information on health information disclosures that we are required to disclose to you. Please let us know in writing the time period for which you are interested. Thank you for limiting your request to no more than six years at a time. We will provide the first accounting during any 12-month period without charge. We may charge a reasonable, cost-based fee for each additional accounting during the same 12-month period. If there will be a charge, the Privacy Official will first contact you to determine whether you wish to modify or withdraw your request.

Request a Paper Copy of this Notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email a copy to you.

Receive Notice of a Security Breach

You have the right to receive notification of a breach of your unsecured health information.

Changes to the Notice

We are required by law to maintain the privacy of your health information and to provide to you or your personal representative with this Notice of our Privacy Practices. We are required to practice the policies and procedures described in this notice but we do reserve the right to change the terms of our Notice. If we change our privacy practices we will be sure all of our patients receive a copy of the revised Notice.

Complaints

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe your privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. We will not retaliate against you for submitting a complaint. Please let us know of your concerns or complaints in writing by submitting your complaint to our Privacy Officer.

Effective Date: 9/23/2013

Patient Acknowledgment

Patient Name(s):_____

Thank you very much for taking time to review how we are carefully using your health information. If you have any questions we want to hear from you. If not, we would appreciate very much your acknowledging your receipt of our policy by signing this form.

Patient Signature

Date _____/_____/_____

For additional information about the matters discussed in this notice, please contact our Privacy Officer.

ARBITRATION: THIS ARBITRATION AGREEMENT is made between North Florida Eye Center, P.A., their subsidiaries, affiliated professional, physicians, agents, employees, servants, or any of the foregoing, referred to hereinafter as "Doctor" and _____, referred to hereinafter as the "Patient". It is the intention of the parties to this Arbitration Agreement to bind not only themselves, but their heirs, personal representatives, guardians and any persons deriving claims through or in helf of the patient.

It is understood by the patient that he or she or not required to use North Florida Eye Center, P.A. or any Doctor and that there are numerous other physicians located near Patient who are qualified to provide care to Patient.

In the event of any controversy or dispute, which might arise between Doctor and Patient, regardless of whether the dispute concerns the medical care rendered, including any negligence claim relating to the diagnoses, treatment, or care of the Patient, or payment of surgical fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by Arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statutes. Other than what may be in conflict with the Arbitration Agreement, the laws of the State of Florida shall apply to any dispute between Doctor and Patient. The Florida Rules of Civil Procedure shall apply for discovery purposes only. Prior to commencing any action under the Arbitration Agreement, Patient must comply with the pre-suit notice and investigation requirements of Chapter 766, Florida Statutes. Any arbitration under this Arbitration Agreement must be commenced by the filing of any application within the applicable statute of limitation for the controversy or dispute at issue.

This arbitration shall be in lieu and instead of any trial by Judge or Jury. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. All arbitrators shall be selected from the following counties: Alachua, Clay, Duval, Nassau, St. Johns and Volusia. The Panel of Arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties and may be enforced by a court of law if necessary. Arbitration shall be conducted in Alachua county, Florida. In the event that either party to this Arbitration Agreement refuses to go forward with arbitration the party compelling arbitration reserves the right to proceed with arbitration, including the appointment of the arbitrator and hearings to resolve the dispute, despite the refusal to participate or the absence of the opposing party. The arbitrator shall render a binding decision without the participation of the party opposing arbitration or despite his or her absence at the arbitration hearing.

Except for legal reporting requirements, all arbitration proceedings and outcome under the Arbitration Agreement will be confidential and private. The parties shall be required to attend non-binding mediation in Alachua county, florida prior to arbitration.

The Patient understands that the Patient has a constitutional right under Article 1, Section 21 of the Florida Constitution of Access to Courts as follows: "The courts shall be open to every person for redress or any injury, and injustice shall be administered without sale, denial, or delay." The Patient understands and acknowledges the signing the Arbitration Agreement waives this constitutional right.

Should any sentence(s) of this Arbitration Agreement be declared unenforceable or in conflict with the law, sentence(s) shall be severed and the validity of the remaining parts and provisions shall not be affected by such holding.

The Patients has had an opportunity to read this Arbitration Agreement, or to have it read to him or her if necessary. The Patient understands English or has had the Arbitration Agreement translated for him or her by _____. The Patient has had the opportunity to ask questions about this Arbitration agreement. The Patient understands this Arbitration Agreement and has no unanswered questions.

The Patient has not been coerced or compelled to sign this Arbitration Agreement, and does so of his or her own free will. The Patient may consult with any attorney before signing this Arbitration Agreement.

BY SIGNING THE ARBITRATION AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature:_____Date:_____

Parent, Guardian or Legal Representative Signature:_____

Witness Signature:_____

Physician Signature:_____