

Welcome to our practice. Our first priority is you, **our patient**.

Eric R. Jamrich, M.D., John R. Barker, M.D., Chad J. Prusmack, M.D. and David Whatmore, PA-C specialize in the care of people with spinal disorders. Our primary office is located in Lone Tree, Colorado. We also see patients in Aurora, Colorado. We are enclosing a map for your convenience.

Enclosed are forms you will need to complete and bring with you to your appointment. These forms will become an important part of your medical record in our office and will greatly aid your physician in your health care.

Please bring all x-rays, MRI scans, CT scans or myelograms, and all previous medical records that pertain to your spine, as these will assist the doctor in performing a more complete exam.

**Your doctor must have the original x-ray films. Reports only will not be sufficient.**

Any records brought or sent to our office will become part of your permanent file and will be the property of our office. If you need copies of these records, please copy them prior to releasing them to us.

We will also need to make a copy of your insurance card, so please bring that with you.

Your appointment is scheduled on \_\_\_\_\_ at \_\_\_\_\_  
at the office indicated below.

**We will call you the day before to confirm your appointment. If you do not receive a call, please call our receptionists at 303-225-8120 to confirm your appointment.**

- Our Lone Tree office is located adjacent to Sky Ridge Medical Center in the Aspen Building. The address is 10103 RidgeGate Parkway, Suite 306, Lone Tree 80124
- Our Aurora office is located on Potomac Street across from The Medical Center of Aurora. The address is 1550 South Potomac Street, Suite 250, Aurora 80112
- Our Yosemite Street office is located in the Lone Tree Medical Plaza. The address is 9695 South Yosemite Street, Suite 385, Lone Tree 80124

## Financial Arrangements and Insurance

We are committed to providing you with the best possible care. If you have health insurance, we will help you receive your maximum allowable benefits. In order to achieve this, we need your assistance and understanding of our payment policy. Please always bring your current insurance card with you to all appointments. **We will collect your co-payment at the time of service. If you cannot pay your co-pay at the time of service, your appointment will need to be rescheduled.**

We participate with Medicare. We accept Medicare assignment and will bill Medicare for you. If you have supplemental insurance please bring that information with you to your appointment. You may be responsible for a portion of your charges such as Medicare deductible and co-insurance.

If you belong to an insurance which requires a referral from your primary care physician, please bring the referral with you to your appointment. **We must have a current referral before you can be seen. If you do not bring a current referral with you to your appointment, your appointment will have to be rescheduled.**

If you are being treated for a work-related injury, injuries occurring from an automobile accident, or a third party liability (for example, injured on the property of another person), we must have approval from your adjuster prior to seeing you. We will also need the following information: name of your insurance carrier, their address and phone number, your adjuster's name, your claim number and the date of your injury/accident.

If your claim is denied by workmen's compensation, auto insurance or third party liability, you will be responsible for the entire bill for services. **If the automobile insurance fails to pay 100 percent of the billed charges, you will be held responsible for any amount the insurance does not cover.**

Returned checks and balances older than 30 days are subject to additional collection fees. Charges may also be made for broken appointments and appointments cancelled without 24 hours advance notice.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50% or 80%) of "U.C.R." which is defined as "usual, customary and reasonable" fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies.

This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.

3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

**DISABILITY FORMS** - Our charge for filling out disability forms is \$20.00 per form. We will be happy to fill out 3 disability forms for you, at no charge, following surgery. All charges for completing disability forms must be paid in advance.

If you have any questions about the above information or are uncertain regarding your insurance coverage, PLEASE don't hesitate to ask us. We are here to help you.

I have read and understand the financial policy of Eric R. Jamrich, M.D., John R. Barker, M.D. and Chad J. Prusmack, M.D. and agree to abide by the policy as stated.

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Signature of Patient or Person with Authority to Sign for Patient

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Date

## NARCOTIC PAIN MEDICATION CONTRACT

Patient Name (please print): \_\_\_\_\_

Physician Name: \_\_\_\_\_

The purpose of this agreement is to prevent a misunderstanding about how narcotic prescriptions (medicines) are distributed by the physician to the patient in this office. This document will help both the patient and the doctor comply with the law regarding controlled pharmaceuticals.

Use of narcotic pain medication can produce dangerous side effects and potentially cause addiction if used for extended periods of time. Narcotic pain medications are used in this office for treatment of acute or short-term pain such as the pain experienced after an injury. The amount of narcotics taken for any condition will be limited in order to prevent the body from building up a tolerance to the medications.

It is important to remember that other techniques may be used in place of narcotics for symptom control such as ice/heat, massage, deep breathing and relaxation techniques, and over-the-counter medications such as Extra Strength Tylenol, etc. You should check with your physician or his medical assistant prior to starting any over-the-counter medications.

After 90 days alternative sources will be recommended by the physician (return to primary care doctor, pain management, physiatrist evaluation, etc.).

If any side effects from the prescriptions occur, the patient should notify the medical assistant at the Rocky Mountain Spine Clinic at 303-225-8120. Medication refill requests must be called in before 4:00 PM Monday-Thursday and before 12:00 noon Friday. Prescription refills will not be issued after these hours or on the weekends by the on-call physician. Allow 48 hours for processing refill requests.

Medication will be provided post surgery up to 90 days.

This office will not permanently take over medications if a patient is enrolled in a pain management program.

If you are receiving pain medications from multiple doctors, we will discontinue prescribing pain medications for you and dismiss you from our practice.

(continued)

## NARCOTIC PAIN MEDICATION CONTRACT

I will use any and all prescription medications that are issued to me in accordance with the specific dosing regimen, without deviation, escalation or significant disparity from my provider's directions. Violation of this agreement shall constitute grounds for termination of the patient/provider relationship and subsequent discharge from our practice immediately.

I will not use any illegal substances, including marijuana, cocaine, etc., while under this agreement.

I will not trade with or sell my medicines to anyone.

I will not attempt to obtain any controlled medications, including opioid pain medication, controlled stimulants or any anti-anxiety medicines from any other physician without consent of my prescribing physician.

I will safeguard my medicines from loss or theft. Lost or stolen medicines WILL NOT be replaced.

I will turn in all unused medicine if a prescription is changed.

I authorize the doctor and my pharmacy to cooperate fully with any city, state or Federal law enforcement agency including the State Board of Pharmacy, State Board of Medical Examiners and the Drug Enforcement Administration (DEA) in the investigation of any possible misuse, sale or other diversion of my pain medicine.

I authorize my doctor to provide a copy of this agreement to my pharmacy if requested. I agree to waive any applicable right of privacy or confidentiality with respect to these authorizations.

Patient's signature indicates that the patient understands and agrees to this policy.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**ROCKY MOUNTAIN SPINE CLINIC, P.C.**  
Eric R. Jamrich, M.D.      John R. Barker, M.D.      Chad J. Prusmack, M.D.

NAME \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last First Middle Initial

NICKNAME \_\_\_\_\_ EMAIL Address \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

Gender  Male  Female      Marital Status  Single  Married  Widowed  Divorced

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employment Status  Full-Time  Part-Time  Retired  On Leave  Other

In case of emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

**REFERRING PHYSICIAN / COMPLETE NAME AND ADDRESS:**

\_\_\_\_\_

**PCP (if different from Referring Physician) COMPLETE NAME AND ADDRESS**

\_\_\_\_\_

**INSURANCE INFORMATION ~ We will need a copy of your insurance card(s).**

**Primary Insurance**      Address (Street/City/State)      Employer

\_\_\_\_\_

Group # \_\_\_\_\_ ID # \_\_\_\_\_ Policy Holder  Self  Spouse  Parent/Guardian

**Secondary Insurance**      Address (Street/City/State)      Employer

\_\_\_\_\_

Group # \_\_\_\_\_ ID # \_\_\_\_\_ Policy Holder  Self  Spouse  Parent/Guardian

**INSURED RESPONSIBLE PARTY INFORMATION – If other than self**

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ SSN \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Employer \_\_\_\_\_

**ACCIDENT INFORMATION**

Is this a  Work Comp or  Motor Vehicle Accident?  Yes  No      If YES, on what date did the injury occur? \_\_\_\_\_

Work Comp / Motor Vehicle Claim Number \_\_\_\_\_

Adjuster's Name \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

I authorize that payment of any insurance benefits for health care services be made directly to Rocky Mountain Spine Clinic, P.C.      **NOTE: If patient is a minor under the age of 18 years, these forms must be signed by parent or legal guardian. They cannot be signed by a minor.**

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date

**ROCKY MOUNTAIN SPINE CLINIC, P.C.**

NAME: \_\_\_\_\_

What symptoms are you having? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long ago did your symptoms begin? \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

Do your symptoms limit you? \_\_\_\_\_

Do you have pain? If so, where? \_\_\_\_\_

Is the pain constant, or does it come and go? \_\_\_\_\_

Does the pain radiate into your arms or legs? \_\_\_\_\_

Is the pain worse at night? \_\_\_\_\_

Do you have any weakness or numbness in arms or legs? \_\_\_\_\_

Have you lost control of bowel or bladder function? \_\_\_\_\_

How long can you sit? \_\_\_\_\_ stand? \_\_\_\_\_

How far can you walk? \_\_\_\_\_

What, if anything, makes the pain better? \_\_\_\_\_

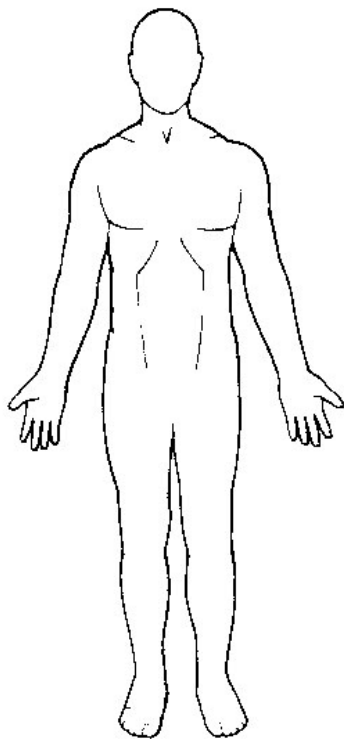
What makes your pain worse? \_\_\_\_\_

Using the symbols below, please draw your pain on the diagrams below:

FRONT

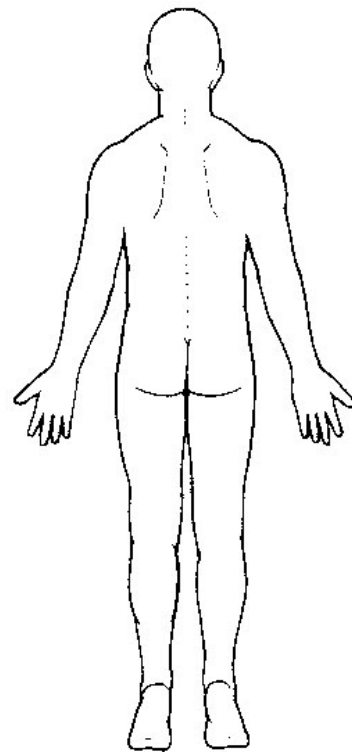
BACK

Right



Left

Left



Right

Stabbing Pain  
/////

Burning Pain  
00000

Aching Pain  
xxxxx

Pins & Needles  
++++

Numbness  
-----

Circle your pain level on a scale of 1 to 10, with 10 being unbearable or the worst imaginable pain.  
(no pain) 1 2 3 4 5 6 7 8 9 10 (extreme pain)

**ROCKY MOUNTAIN SPINE CLINIC, P.C.**

NAME: \_\_\_\_\_

Tell us about any previous treatments and/or tests you have had.

Who first treated you for this problem? \_\_\_\_\_

What treatments did you have? \_\_\_\_\_

\_\_\_\_\_

Did this include any surgery on your neck or back? If so, what and when: \_\_\_\_\_

\_\_\_\_\_

Have you had physical therapy? \_\_\_\_\_ If so, did it help? \_\_\_\_\_

Explain: \_\_\_\_\_

Do you do any special exercises for your neck or back? \_\_\_\_\_

Have you had any of the following tests regarding your back or neck within the last year?

- X-rays       MRI       CT Scan       EMG/nerve conduction studies

Have you had any injections for your problem? \_\_\_\_\_ If so, please describe: \_\_\_\_\_

\_\_\_\_\_

What other concerns do you have, if any?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What do you hope we can accomplish today?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ROCKY MOUNTAIN SPINE CLINIC, PC.**

HEALTH HISTORY FORM

NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Today's Date \_\_\_\_\_

**PAST MEDICAL HISTORY**

List all current medical problems:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List all medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

**DRUG ALLERGIES:**

**REACTION:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you recently experienced fever/chills, weight gain, weight loss, chest pain or shortness of breath? (circle)

**PAST SURGICAL HISTORY** ~ Please list all surgeries you have had, the year, and any complications.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had any problems with anesthesia? Yes No If yes, explain: \_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY**

Do your parents, grandparents, siblings or your children have any of the following? If yes, please explain:

Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Heart conditions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	_____

**SOCIAL HISTORY**

Do you live alone? Yes No  
Do you have children? Yes No # \_\_\_\_\_  
Do you exercise? Yes No How often? Daily Weekly Rarely Never

What types of exercises do you do? \_\_\_\_\_

Do you currently smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How many packs per day _____ for how long _____
Have you quit smoking?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When did you quit: _____
Do you chew tobacco?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How much: _____
Do you drink alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	How much / how often: _____
History of substance abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____

\_\_\_\_\_

Rocky Mountain Spine Clinic, P.C.

NAME: \_\_\_\_\_

REVIEW OF SYSTEMS

Are you currently having or have you had problems with:

Describe all YES responses

Eyes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Ears, Nose, Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Lungs/Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Digestion/Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bowel movements	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bladder problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Heart problems / Chest pain (including rheumatic fever)	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Bleeding problems / Blood clots	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Balance problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Numbness / Tingling	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Blackouts / Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Psychological problems / Depression	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
AIDS / Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Arthritis / Rheumatoid	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Polio	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
Other	Explain	_____ _____

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_

Date: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_



## NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

**Rocky Mountain Spine Clinic, P.C. is required to maintain the privacy of your health information and to provide you with a notice of its legal duties and privacy practices. Rocky Mountain Spine Clinic will not use or disclose your health information except as described in this Notice. This Notice applies to all of the medical records generated by Rocky Mountain Spine Clinic as well as records we receive from other providers.**

### **USES AND DISCLOSURES REQUIRING YOUR CONSENT:**

With your consent, Rocky Mountain Spine Clinic may use and disclose your health information for the following purposes:

#### *Treatment:*

Rocky Mountain Spine Clinic may use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your attending physician, consulting physician(s), nurses, technicians, medical students and other health care providers who have a legitimate need for such information in your care and treatment. Different departments may share health information about you in order to coordinate specific services, such as prescriptions, lab work and x-rays. Rocky Mountain Spine Clinic also may disclose your health information to people outside Rocky Mountain Spine Clinic, such as family members, clergy and others used to provide services that are part of your care. Other ways we may use or disclose your health information for purposes related to treatment are:

- Treatment Alternatives - To tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- Appointment Reminders - To contact you as a reminder that you have an appointment for treatment or medical care at Rocky Mountain Spine Clinic.

#### *Payment:*

Rocky Mountain Spine Clinic may release health information about you for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. The information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record which are necessary for payment of your account. For example, a bill sent to a third party payer may include information that identifies you, your diagnosis, and the procedures and supplies used. We may also provide payment information to other care providers who have been involved in your care, e.g., an ambulance company.

#### *Routine Healthcare Operations:*

Rocky Mountain Spine Clinic may use and disclose your health information during routine healthcare operations including quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing or credentialing activities of Rocky Mountain Spine Clinic, medical research and educational purposes. Rocky Mountain Spine Clinic may engage outside companies to carry out certain aspects of routine healthcare operations. These entities are called the "business associates" of Rocky Mountain Spine Clinic. Rocky Mountain Spine Clinic may need to disclose your health information to the business associates to allow them to perform their duties. The business associates will, in turn, use and disclose your health information as they conduct business on behalf of Rocky Mountain Spine Clinic. Examples of business associates include, but are not limited to, a copy service used by Rocky Mountain Spine Clinic to copy medical records, consultants, accountants, lawyers, medical transcriptionists and third-party billing companies. Rocky Mountain Spine Clinic requires the business associates to protect the confidentiality of your health information.

**USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION:**

Rocky Mountain Spine Clinic may not disclose your health information to persons outside of Rocky Mountain Spine Clinic for purposes other than treatment, payment or healthcare operations without your authorization. In addition, Rocky Mountain Spine Clinic may not use or disclose psychotherapy notes written by your mental health provider, if any, without your authorization, even for treatment, payment or healthcare operations. You have the right to revoke any authorization you have previously given by submitting a written statement of revocation to Rocky Mountain Spine Clinic.

**RIGHT TO RECEIVE A COPY OF THIS NOTICE:**

You have the right to receive a paper copy of this Notice upon request, if this Notice has been provided to you electronically.

**RIGHT TO REVOKE CONSENT TO AUTHORIZATION:**

You have the right to revoke your consent or authorization to use or disclose your health information, except to the extent that action has already been taken in reliance on your consent and authorization.

**FOR MORE INFORMATION REGARDING HOW TO EXERCISE THESE RIGHTS:**

If you have questions or would like more information regarding any of the rights listed above, please call 303-225-8120.

**IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED:**

If you believe that your rights have been violated, you may file a complaint with Rocky Mountain Spine Clinic or with the Secretary of the Department of Health and Human Services. To file a complaint with Rocky Mountain Spine Clinic, please contact Rocky Mountain Spine Clinic at 303-225-8120. All complaints must be submitted in writing. There will be no retaliation for filing a complaint.

**CHANGES TO THIS NOTICE:**

Rocky Mountain Spine Clinic will abide by the terms of the Notice currently in effect. Rocky Mountain Spine Clinic reserves the right to change the terms of this Notice at any time. Any new notice provisions will be effective for all protected health information that it maintains. Rocky Mountain Spine Clinic will mail any revised Notice to the address indicated on the Patient Information forms or such other address you may provide to us from time to time.

**CONSENT TO COMMUNICATE MEDICAL RESULTS:**

OKAY to leave message/results at home:       Yes       No      Phone #: \_\_\_\_\_  
OKAY to leave message/results at work :       Yes       No      Phone #: \_\_\_\_\_  
OKAY to leave message/results on cell :       Yes       No      Phone #: \_\_\_\_\_

Persons with whom Rocky Mountain Spine Clinic may **discuss** my medical condition, test results, billing issues and/or schedule appointments are named below:      SPOUSE       Yes       No

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

**PATIENT'S PRINTED NAME:** \_\_\_\_\_

**PATIENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**NOTICE EFFECTIVE DATE:** The effective date of this Notice is April 15, 2008

## **NEW PATIENT CHECKLIST**

**Please use this checklist to ensure that you have all the necessary paperwork and records for your first visit.**

**If you have any questions, please give our office a call at 303-225-8120.**

- Previous MRI, CT scans, discograms and x-rays pertaining to complaint**
- Medical records and imaging reports from referring physician pertaining to complaint**
- New patient paperwork completed**
- Insurance card(s)**
- Insurance referral (if necessary)**
- Name, address and telephone number of referring physician**
- Insurance co-payment**

**PHYSICIAN-PATIENT ARBITRATION AGREEMENT**

**Article 1: Agreement to Arbitrate:** It is understood that any claim of medical malpractice, including any claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered or omitted, will be determined by submission to binding arbitration in accordance with the provisions of part 2 of article 22 of this title, and not by a lawsuit or resort to court process except as Colorado law provides for judicial review of arbitration proceedings. The patient has the right to seek legal counsel concerning this agreement, and has the right to rescind this agreement by written notice to the physician within ninety days after the agreement has been signed and executed by both parties unless said agreement was signed in contemplation of the patient being hospitalized, in which case the agreement may be rescinded by written notice to the physician within ninety days after release or discharge from the hospital or other health care institution. Both parties to this agreement, by entering into it, have agreed to the use of binding arbitration in lieu of having any such dispute decided in a court of law before a jury.

**Article 2: All Claims Must Be Arbitrated:** It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, 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.

Filing by Physician 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 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 by U.S. mail, postage prepaid, to all parties, describing the claim against Physician, the amount of damages sought, and the names, addresses and telephone numbers of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Colorado revised Statute 13-64-403 and the Federal Arbitration Act (9 U.S.C. §§ 1-4). The parties shall bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

**Article 4: Severability Provision:** In the event any provision(s) of this Agreement is declared void and/or unenforceable, such provision(s) shall be deemed severed therefrom and the remainder of the Agreement enforced in accordance with California law.

I understand that I have the right to receive a copy of this agreement. By my signature below, I acknowledge that I have received a copy.

**NOTE: BY SIGNING THIS AGREEMENT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION RATHER THAN BY A JURY OR COURT TRIAL.**

**YOU HAVE THE RIGHT TO SEEK LEGAL COUNSEL AND YOU HAVE THE RIGHT TO RESCIND THIS AGREEMENT WITHIN NINETY DAYS FROM THE DATE OF SIGNATURE BY BOTH PARTIES UNLESS THE AGREEMENT WAS SIGNED IN CONTEMPLATION OF HOSPITALIZATION IN WHICH CASE YOU HAVE NINETY DAYS AFTER DISCHARGE OR RELEASE FROM THE HOSPITAL TO RESCIND THE AGREEMENT.**

**NO HEATHCARE PROVIDER SHALL WITHHOLD THE PROVISION OF EMERGENCY MEDICAL SERVICES TO ANY PERSON BECAUSE OF THAT PERSON'S FAILURE OR REFUSAL TO SIGN AN AGREEMENT CONTAINING A PROVISION FOR BINDING ARBITRATION OF ANY DISPUTE ARISING AS TO PROFESSIONAL NEGLIGENCE OF THE PROVIDER.**

**NO HEALTHCARE PROVIDER SHALL REFUSE TO PROVIDE MEDICAL CARE SERVICES TO ANY PATIENT SOLELY BECAUSE SUCH PATIENT REFUSED TO SIGN AN AGREEMENT OR EXERCISED THE NINETY-DAY RIGHT OF RESCISSION.**

By: \_\_\_\_\_  
Physician's or Duly (Date)  
Authorized Representative Signature

By: \_\_\_\_\_  
Patient's Signature (Date)

\_\_\_\_\_  
Print Patient's Name

By \_\_\_\_\_  
Print or Stamp Name of Physician,  
Medical Group or Association Name

By: \_\_\_\_\_  
Patient's Representative's Signature (if applicable) (Date)

By: \_\_\_\_\_  
Signature of Translator (if applicable) (Date)

\_\_\_\_\_  
Print Name and Relationship to Patient

\_\_\_\_\_  
Print Name of Translator