API

South Florida ENT Associates, P.A.

PLEASE PRINT PATIENT'S COMPLETE LEGAL NAME

HAVE YOU REGISTERED ON OUR PATIENT PORTAL? Y / N **If not, please go to www.sfenta.com and Click on the Portal Link.**

Patient Name: ______________________________ **Social Security Number:** ________ - ________ - ________

Date of Birth: _______ / _______ / ________ **Home Tel:** (_____) ____________________ **Cell:** (_____) ______________________

Address: ____ **APT /UNIT:** ______________________

City: ________________________________ **State:** _______________ **Zip:** _______________

Please circle or fill in for the below section.

Sex: Male Female **Marital Status:** Single Married Widowed Divorced **Language:** English Spanish ____________

Race: White Black Hispanic Asian ____________ **Ethnicity:** Hispanic/Latino or Non-Hispanic/Non-Latino

Email: ____ **Consent to release Medication Hx**: Yes No

Visit Summary Provided Via? Portal Printed Decline **Appt. Reminder's Via?** Portal Text Cell Home Work Email Decline

PHARMACY NAME: ____ **PHONE:** (_____) ______________________

Pri Care Prov: ______________________________ **Phone:** (_____) ________________ **Fax:** (_____) ________________

Referring Phy: ______________________________ **Phone:** (_____) ________________ **Fax:** (_____) ________________

Employer: ______________________________ Phone: (_____) ________________ Occupation: ____________________

Spouse Name: ________________________ **Spouse DOB**: _____ / _____ / _______ **Spouse's Phone:** (_____) ________________

****

EMERGENCY CONTACT/RELATIONSHIP ____

PHONE NUMBER: (_____) ________________________ ALTERNATE NUMBER: (_____) ________________________

Would you like to designate a personal representative which grants your physician permission to discuss your personal health information (PHI) with your spouse or other family member? **(CIRCLE) YES NO**

NAME OF FAMILY MEMBER____________________________________ **RELATIONSHIP**______________________

Do you give permission to our physicians to leave messages on your answering machine/voicemail regarding your Personal Health Information (i.e. test results, etc.)? **(CIRCLE) YES NO**

IF YES, WHAT PHONE NUMBER? (_____) ________________________

HEALTH INSURANCE

***A photocopy of these assignments shall be valid as the original**

***PRIMARY INSURANCE:** ______________________________ POLICY# ______________________ GRP# ____________

INSURED'S NAME: ______________________________ INSURED'S DOB: ________ / ________ / ________

INSURED'S SS#: _________ - _________ - _________ RELATIONSHIP TO PT: ________________________

***SECONDARY INSURANCE**: ______________________________ POLICY# ______________________ GRP# ____________

INSURED'S NAME: ______________________________ INSURED'S DOB: ________ / ________ / ________

INSURED'S SS#: _________ - _________ - _________ RELATIONSHIP TO PT: ___________________________

NOTICE TO PATIENTS: Provider will look solely to the contracted insurance company for compensation of covered services rendered to covered persons with the exception of any copayments, coinsurance, deductibles, and/or non-covered services required under the health care agreements in your plan benefit summary.

I declare that all information presented at date of service is complete and accurate. In the event that insurance is inaccurate or incomplete the patient will be responsible for all charges incurred.

AUTHORIZATION & ASSIGNMENT OF BENEFITS

I authorize South Florida ENT Associates, P.A. to release any information to my insurance company. I authorize direct payment of medical/surgical benefits to South Florida ENT Associates, P.A. I understand that I am financially responsible to the Doctor for all charges, for any balance or fee not covered in the event that I have no insurance or my insurance is rejected. I further understand that I will be responsible for any and all costs incurred in the attempt to collect this debt.

SIGNATURE: ____ **DATE**: ____________________

MEDICAL HISTORY

Patient Name: ______________________________ Birthdate: ____ /_____ /_____ Age: ________

SEX: ☐M ☐F If female, are you pregnant? ☐Y ☐N Home #: _________________ Cell #: _________________

Chief Complaint/Reason For Visit: ____

Past Medical History/Health Conditions (Circle any Positives):

HEAD-SINUSES: FACIAL PAIN / HEADACHES / CONGESTION / HEAD OR FACIAL TRAUMA / SINUSITIS HISTORY OF SINUS SURGERY	NONE ☐
EARS-HEARING: PAIN / HEARING LOSS / RINGING IN THE EARS / PRESSURE / LOSS OF BALANCE / ITCHING / DRAINING / INFECTIONS / MASTOIDITIS / EAR WAX	NONE ☐
NOSE: CONGESTION / BLEEDING / SNEEZING / RUNNY NOSE / LOSS OF SMELL / PRESSURE / ITCHING / POST NASAL DRAINAGE	NONE ☐
MOUTH: DENTAL PROBLEM / DRY MOUTH / BAD BREATH / COLD SORES / ULCERATIONS / PAROTITIS / BLEEDING	NONE ☐
THROAT: SORE / HOARSENESS / LOSS OF TASTE / BAD TASTE / WHITE SPOTS / LESIONS / SNORING / TONSILLITIS	NONE ☐
RESPIRATORY: SHORTNESS OF BREATH / COUGH / WHEEZING / COUGHING UP BLOOD / ***ASTHMA*** / PNEUMONIA / BRONCHITIS	NONE ☐
GI: DIFFICULTY SWALLOWING / HEARTBURN / ***REFLUX*** / DIARRHEA / NAUSEA / VOMITING / GASTRITIS / HIATAL HERNIA	NONE ☐
NEUROLOGICAL: HEADACHES / PASSING OUT / DIZZINESS / NUMBNESS / ***STROKE*** / SEIZURES / TREMORS	NONE ☐
CARDIOVASCULAR: ***HYPERTENSION*** / ***MVP*** / HIGH CHOLESTEROL / ***PAST HEART ATTACKS*** / PACEMAKER	NONE ☐
GU: PROSTATE / KIDNEY STONE / DIALYSIS / CONGENITAL PROBLEMS / GOUT / INFECTIONS	NONE ☐
CONSTITUTIONAL SYMPTOMS: FATIGUE / FEVER / CHILLS / NIGHT SWEATS / WEIGHT LOSS OR GAIN / FAINTING	NONE ☐
EYES: DOUBLE VISION / ITCHING / VISION LOSS / PAIN / BURNING / TEARING / DRY EYES / GLASSES / ***GLAUCOMA***	NONE ☐
SKIN: RASH / ITCHING / LESIONS / HIVES / HISTORY OF SKIN CANCER	NONE ☐
MUSCULOSKELETAL: JOINT PAIN / ARTHRITIS / JAW PAIN / MUSCULAR DYSTROPHY / FRACTURES / GOUT / OSTEOPOROSIS / LUPUS	NONE ☐
PSYCHIATRIC: ANXIETY / SLEEP DISORDER- SNORING OR APNEA / MEMORY LOSS / DRUG ADDICTION / DEPRESSION	NONE ☐
ENDOCRINE: ***DIABETES*** / OBESITY / HAIR LOSS / ***THYROID DISEASE*** / PARATHYROID DISEASE / PITUITARY DISEASE / LUPUS	NONE ☐
HEMATOLOGIC-LYMPHATIC: NECK MASSES / BRUISING / BLEEDING / ANEMIA / IMMUNE PROBLEMS / PVT PULMONARY EMBOLISM	NONE ☐
ANY OTHER MEDICAL CONDITIONS:	

Past Surgical History: ☐Y ☐N If yes, please list the procedures and dates: ______________________________

____

Family History of Medical Problems: ☐Y ☐N If yes, please list and indicate family member: __________________

____

Are you currently using **tobacco** products? ☐Y ☐N If yes, quantity smoked per day: ____________________

If you quit, how often did you smoke before (per day)? ________________ For how long? ___________

Do you drink **alcohol**? ☐Y ☐N If yes, amount: ________________ How often: _________________

Do you currently have or have you in the past had a problem with **substance abuse** ? ☐Y ☐N

Please list all **allergies** below(including medication, environmental, and/or food allergies): ☐ No Allergies

____

List all **medications** you are currently taking (including all over the counter medications and vitamins): ☐ None

____

Patient Signature: ____ Date: __________________

(If patient is a minor, please indicate the person completing the Medical History and the relationship to patient)

Revised 10/2011

Designation of Personal Representative

As required by the Health Information Portability and Accountability Act of 1996, you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

Patient Name: ____ Date: ______/____/_______
(Last) (First) (MI)

Address: ____

Telephone: ____________________________________ Date of Birth_________/_______/_________

I request the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of my protected health information:

Name: _______________________________________

Address: _______________________________________

Telephone: _______________________________________

What relationship is this person to you? ____

I authorize the above person(s) to have the same rights to obtain my medical history.

_________________________________ _________________________________
Patient Signature Date

I understand that I may revoke this designation at any time by signing the revocation section of my copy of this form and returning it to **South Florida ENT Associates, P.A.** I further understand that any such revocation does not apply if that person or person's authorized use or disclosure of my protected health information have already taken action on my behalf.

I hereby revoke this designation of a personal representative.

_________________________________ _________________________________
Patient's Signature Date

TO OUR PATIENTS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

South Florida ENT Associates, P.A. is dedicated to protecting your medical information. We are required by law to maintain the privacy of protected health information and to provide you with this Notice of our legal duties and privacy practices with respect to protected health information.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED:

We will use your medical information as part of rendering patient care. For example, your medical information may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered, and by administrative personnel reviewing the quality of the care you received.

We may also use and /or disclose your information in accordance with federal and state laws for the following purposes:

Appointment Reminders:
We may contact you to provide appointment reminders

Treatment Information:
We may use health information about you to provide you with medical treatment and services. We may disclose health information and demographic information about you to doctors, nurses, technicians, medical students, interns or other personnel who are involved in taking care of you during your visit with us.

Payment:
We may use and disclose health information about you so the treatment and services you receive at South Florida ENT Associates, P.A. may be billed to and payment collected from you, an insurance company, or a third party. This may also include the disclosure of health information to obtain prior authorization for treatment and procedures from you insurance plan.

Family and Friends:
We may disclose your health information to individuals, such as family members and friends, who are involved in your care, or who help pay for your care. We may make such disclosures when: (a) we have your verbal agreement to do so; (b) we make such disclosures and you do not object; (c) we can infer from the circumstances that you would not object to such disclosures. For example, if family members are in the exam room with you, we will assume that you agree to our disclosure of your information in their presence.

We also may disclose your health information to family members or friends in instances when you are unable to agree or object to such disclosures, provided that we feel it is in your best interest to make such disclosures and the disclosures relate to that family member or friend's involvement in your care. For example, if you present to our office with an emergency medical condition, we may share information with the family member or friend that comes with you to our office. We also may share your health information with a family member or friend who calls us to request a prescription refill on your behalf.

Health Related Products or Services:
We may notify you of health related products, treatment alternatives, or other services that may be of interest to you.

Business Associations:
We may disclose your health information to a business associate with whom we contract to provide services on our behalf. To protect your health information, we require our business associates to appropriately safeguard the health information of our patients.

Research:
We may use or disclose your medical information for certain research purposes if an Institutional Review Board or a privacy board has altered or waived individual authorization, the review is preparatory to research or the research is on only decedent's information.

SPECIAL SITUATIONS THAT DO NOT REQUIRE YOUR AUTHORIZATION:

The following disclosures of your health information are permitted bylaw without any oral or written permission from you.

Disclosure to Department of Health and Human Services.
We may disclose medical information when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.

Disaster Relief.
We may disclose your medical information to a public or private entity, such as the American Red Cross, for the purpose of coordinating with that entity to assist in disaster relief efforts.

Health Oversight Activities.
We may use or disclose your medical information for public health activities, including the reporting of disease, injury, vital events and the conduct of public health surveillance, investigation and / or intervention. We may also disclose your medical information to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions, administrative and/or legal proceedings.

Abuse or Neglect.
We may disclose your medical information when it concerns abuse, neglect or violence to you in accordance with federal and state law.

Legal Proceedings.
We may disclose your medical information in the course of certain judicial or administrative proceedings.

Law Enforcement.
We may disclose your medical information for law enforcement purposes or other specialized governmental functions.

Coroners, Medical Examiners and Funeral Directors.
We may disclose your medical information to a coroner, medical examiner or a funeral director.

Organ Donation.
If you are an organ donor, we may disclose your medical information to an organ donation and procurement organization.

Public Safety.
We may use or disclose you medical information to prevent or lessen a serious threat to the health or safety of another person or to the public.

Worker's Compensation.
We may disclose your medical information as authorized by laws relating to workers' compensation or similar programs.

AUTHORIZATIONS:
We will not use or disclose your medical information for any other purpose without your written authorization. Once given, you may revoke your authorization in writing at any time. To request a Revocation of Authorization form, you may contact:

South Florida ENT Associates, P.A.
Compliance Manager
14750 NW 77th Court, Suite 200
Miami Lakes, FL 33016
305-558-3724

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION:
You have the following rights with respect to your medical information:

- You may ask us to restrict certain uses and disclosures of your medical information. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your medical information. This right is subject to certain specific exceptions, and you may be charged a reasonable fee for any copies of your records.
- You may ask us to amend your medical information. We may deny your request for certain specific reasons. If we deny your request, we will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting disclosure of your medical information made by South Florida ENT Associates, P.A. during the last six years(or following August 1st, 2009), except for disclosures for treatment, payment or healthcare operations, disclosures which you authorized and certain other specific disclosure types.
- You may request a paper copy of this Notice of Privacy Practices for Protected Health Information.
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us, please contact:

South Florida ENT Associates, P.A.
Compliance Manager
14750 NW 77th Court, Suite 200
Miami Lakes, FL 33016
305-558-3724

THIS NOTICE IS EFFECTIVE AS OF August1st, 2009.

REVISIONS OF NOTICE OF PRIVACY PRACTICES.
We reserve the right to change the terms of this Notice, making any revisions applicable to all the protected health information we maintain. If we revise the terms of this Notice, we will post a revised notice at South Florida ENT Associates, P.A. and will make paper copies of the revised Notice of Privacy Practices available upon request.

Patient Acknowledgement of Receipt of the Notice of Privacy Practices
and
Consent to Use and Disclose Health Information

I acknowledge that I was provided with a copy of the South Florida ENT Associates, P.A.'s Notice of Privacy Practices, describing how my health information may be used or disclosed under the federal law. Provided that South Florida ENT Associates, P.A. continues to its good faith effort to comply with the requirements of the Federal privacy law, I hereby consent to the use and disclosure of my Health Information for the purposes and the activities permitted under the federal privacy law.

I understand that I should read the Notice of Privacy Practices carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy by calling the South Florida ENT Associates, P.A Corporate office at (305) 558-3724.

I acknowledge that I have received a copy of the South Florida ENT Associates, P.A. Notice of Privacy Practices.

_______________________________________ _______________________

Patient Name Date

____

Signature of Patient

_______________________________________ _______________________

Patient Legal Representative (if applicable) Date

____

Signature of Legal Representative

FOR PHYSICIAN'S OFFICE USE ONLY

____

Office Staff Member Obtaining Signature

<u>Reason Signature and Date were not obtained</u>

☐ **Individual Refused to Sign**

☐ **Communication barriers prohibited obtaining the acknowledgement**

☐ **An emergency situation prevented us from obtaining acknowledgement**

☐ **Other (Please specify)** ____

South Florida EM Associates, P.A.

Corporate Office: 14750 NW 77th Court, Suite 200
Miami Lakes, Florida 33016
Phone: (305) 558-3724

BY SIGNING THIS AGREEMENT YOU ARE WAIVING YOUR RIGHT TO A JURY TRIAL AND YOU ARE AGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE

ARBITRATION AGREEMENT FOR CLAIMS ARISING OUT OF OR RELATED TO MEDICAL CARE

1. AGREEMENT TO ARBITRATE CLAIMS REGARDING FUTURE CARE & TREATMENT. The client agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the services of the undersigned provider of services, including any partners, agents, or employees of the provider shall be submitted to binding arbitration.

2. AGREEMENT TO ARBITRATE CLAIMS REGARDING PAST CARE & TREATMENT. The client further agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the services provided by the undersigned provider or the provider's agents or employees, shall be submitted to binding arbitration.

3. WAIVER OF RIGHT TO JURY TRIAL. Both parties to this Agreement, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

4. ALL CLAIMS MUST BE ARBITRATED BY ALL CLAIMANTS. All claims based upon the same occurrence, incident, or care shall be arbitrated in one proceeding. It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or services, including the patient, the patient's estate, any spouse or heirs of the patient, and any children of the patient, whether born or unborn, at the time of the occurrence giving rise to the 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. By signing this Agreement, the parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action.

5. ARBITRATION PROCEDURES. If either party contends that the injuries claimed and/or issues arose out of the rendering of medical care, the parties agree to recognize that the provisions of Florida Statute Section 766 governing medical malpractice claims shall apply to the parties and/or claimants in all respects except that unless at the conclusion of pre-suit there is no mutual agreement to arbitrate under Florida Statute 766.106 or 766.207, the parties and/or the claimants shall resolve any claim through arbitration pursuant this Agreement. Within fifteen (15) days after parties to this Agreement have given written notice to the other of a demand for arbitration of said disputed controversy, the parties to the dispute or controversy shall each appoint an arbitrator and give notice of such appointment to the other. Within a reasonable time after such notices have been given, the two arbitrators so selected shall select a neutral arbitrator and give notice of the selection therefore to the parties. The arbitrator shall hold a hearing within a reasonable time from the date of the notice of selection of a neutral arbitrator. The parties agree that the arbitration proceeds are private, not public, and the privacy of the parties and of the arbitrator shall be preserved. If the parties proceed to arbitration pursuant to Florida Statute Section 766, as indicated above, then the arbitration proceeds shall be in accordance with that statutory section. Otherwise, these arbitration proceedings apply.

6. ARBITRATION EXPENSES. Expenses of the arbitration shall be shared equally by the parties to this Agreement.

7. APPLICABLE LAW. Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes, Section 682.01 *et seq*. In conducting the arbitration under Florida Statutes, Section 682.01 *et seq.*, all substantive provisions of Florida law governing medical malpractice claims, including **but not limited to** caps on damages, Florida's Wrongful Death Act, the standard of care for medical providers, and the statute of limitations set forth in Florida Statute Section 95.11(4)(b) shall apply. **Expert witness testimony will be required to support any allegations of a deviation in the standard of care. Said expert testimony will be governed by the Florida Rules of Evidence, Florida Evidence Code, and Florida Statutes Chapter 766.**

____________ (Patient Initials)

South Florida ENT Associates, P.A.

Corporate Office: 14750 NW 77th Court, Suite 200
Miami Lakes, Florida 33016
Phone: (305) 558-3724

8. EFFECT OR REFUSAL TO PROCEED WITH ARBITRATION. In the event that any party to this Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of this Arbitration Agreement or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this Agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite that party's absence at the arbitration hearing.

9. SEVERABILITY. If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision **and the parties still want to arbitrate any claims arising out of or related to medical care.**

10. ACKNOWLEDGMENTS BY PATIENTS. The client by signing this Agreement, also acknowledges that he or she has been informed that:

    a. NO DURESS. The Agreement may not be submitted to a client for approval when the client's condition prevents the client from making a rational decision whether or not to agree;

    b. AGREEMENT BASED UPON OWN FREE WILL. The decision whether or not to sign the Agreement is solely a matter for the client's determination without any influence by SOUTH FLORIDA ENT ASSOCIATES, P.A. and/or its agents or employees;

    c. RECEIPT OF COPY OF AGREEMENT. I have received a copy of this Agreement;

    d. BINDING ARBITRATION AND EFFECT ON RIGHT OF APPEAL. Binding arbitration means that the parties give up their right to go to court to assert or defend a claim covered by this Agreement. The resolution of claims covered by this Agreement will be determined by a neutral panel of arbitrators and not a judge or jury. Each party is entitled a fair hearing, but the arbitration procedures are simpler and more limited than rules applicable in court. Arbitration decisions are as enforceable as any court order. The decision of an arbitration panel is final and there will generally be no right to appeal an adverse decision.

____ ______________________,20______

Patient (Sign and Print)

____ ______________________,20______

Parent or Guardian if patient is a minor (Sign & Print)

By:____ ______________________,20______

SOUTH FLORIDA ENT ASSOCIATES, P.A.

Corporate Office: 14750 NW 77th Court, Suite 200
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Phone: (305) 558-3724

ARBITRATION EXPLANATION

Many of our patients have questioned why South Florida ENT Associates has begun requiring our patients to sign an arbitration agreement. Many are concerned that this means they are giving up the right to sue and also their right to compensation for any situation in which they might have a legitimate complaint against the doctor or his/her office. This is in fact not the case and not our intent.

Lawsuits are the most common method of resolving disputes in this country. Unfortunately, the process of reaching a resolution is an extremely long, complicated and often painful process for all of those involved. Most suits drag on for years before a jury ever reaches a verdict, which than also delays any required compensation. The extended time period creates added expense for both sides and reduces the potential recovery for the patient.

Arbitration is a much more efficient process; the arbitrators are chosen by both sides and are professionals who are trained to help arrive at a more timely conclusion. The process will also be much less disruptive to the life of both the patient and doctor and less expensive. It is for these reasons that we have chosen to use arbitration as our method of resolving disputes.

As always, we will strive to provide quality medical care and service to our patients, and we hope that the arbitration system will rarely if ever be needed by our patients.

What is Arbitration?

- Arbitration is the process of resolving disputes in front of a panel of neutral arbitrators.

Am I giving up my right to sue?

- No, Arbitration takes the place of and avoids a lengthy jury trial. This document simply states that you must to go through the arbitration process, in order to find a neutral resolution.

Why are we doing this?

- Traditionally, medical malpractice suits have been resolved through litigation and a process that is time consuming, expensive and stressful for both sides. The high financial and emotional costs of litigation have given rise to binding arbitration, which is an alternative method for resolving disputes. The Arbitration process has proven to be faster and less costly to both parties involved.

What happens if I do not sign?

- If you are an existing patient, in the middle of treatment and refuse to sign the arbitration agreement, after the treatment for the current problem has completed you will be provided with a 30 day notice to find another ENT Physician.
- If you are a new patient or an existing patient that has not been seen for a while and is not in current treatment, you will not be seen.

Arbitration is not new and has been used by physicians since 1920, with the ever increasing costs, arbitration has become more popular and a viable alternative to resolving disputes in the courts.