Ocean Medical

FAMILY & URGENT CARE
1106 S. Pacific Coast Highway
Redondo Beach, CA 90277-4902
Phone: 310-316-1661 Fax: 310-316-1846

[OTE: THE APPROPRIATE AUTHORIZATIONS MUST BE SIGNED TO EXPEDITE THE FILING O YOUR INSURANCE CLAIM.

[ ] AUTHORIZATION AND AGREEMENT: By my signature below, I hereby authorize and direct my insurance carrier to pay directly to this provider of medical services any benefits due me under my insurance plan. I agree t pay the balance of charges not paid under my plan. I also hereby authorize this provider to use and disclose any o my personal medical information for treatment and payment (including to my insurance company). Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and other collection expenses. IF I AM UNINSURED, I understand I am fully responsible for all charges.

Patient Signature: _____ Date: _____

[ ] **AUTHORIZATION AND CONSENT FOR MEDICAL AND SURGICAL TREATMENT:** By my signature below, I hereby authorize Ocean Medical to furnish the necessary medical or surgical treatment, or procedures, including diagnostic x-ray and laboratory procedures, anesthesia, drugs and supplies as may be ordered by the attending physician(s), his assistants or designees. I am aware that the practice of medicine and surgery is not an exact science, that I have been explained the risks associated with the treatment/procedures to be performed, and I acknowledge that no guarantees have been made to me as to the result of treatment or diagnostic procedures conducted at Ocean Medical.

Patient Signature: _____ Date: _____

[ ] MEDICARE B SIGNATURE AUTHORIZATION: By my signature below, I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare & Medicaid Services or it's intermediaries or carriers, or to the billing agent of Ocean Medical any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits be made to the holder of this assignment on my behalf. I understand that I am responsible for any deductible and coinsurance.

Patient Signature: _____ Date: _____

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it,, are giving up thei constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement 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 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 mothers' 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 th 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 o the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, 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 Code of Civil Procedure Sec. 1280-1295 and the Federal Arbitration Act (9 U.S.C. Sec. 1-4). The parties sha bear their own costs, fees and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by Physician not only after the date it signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to Physician within 30 days of signature and if not revoked will govern all medical services received by the patient.

Article 6: 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.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OF COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

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

By: OCEAN MEDICAL FAMILY & URGENT CARE

By: _____
Signature of Translator (if applicable) (Date)

_____
Print Name of Translator

By: _____
Patient's Signature (Date)

_____
Print Patient's Name

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

_____
Print Name and Relationship to Patient

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