



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

Appointment Reminders Via: Home Cell Text Email Visit Summary Provided Via: Portal Printed Decline

Email: How did you hear about us:

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? ()

IS THIS VISIT RELATED TO AUTO ACCIDENT (CIRCLE) YES NO WORKER'S COMPENSATION (CIRCLE) YES NO

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:



PAST MEDICAL HISTORY

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

SEX: M F If female, are you pregnant? Y N Height: _____ Weight: _____

Primary Language Spoken: _____ Home #: _____ Cell #: _____

Chief Complaint/Reason For Visit: _____ Referring Doctor/PCP: _____

If you are 65 years of age or older, have you had the Pneumococcal Polysaccharide Vaccine (PPV)? _____

If so, please indicate the date when you received the vaccine: _____

Past Medical History (please check yes or no):

RESPIRATORY:	ASTHMA	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	SLEEP APNEA	YES <input type="checkbox"/>	NO <input type="checkbox"/>
GI:	REFLUX	YES <input type="checkbox"/>	NO <input type="checkbox"/>
NEUROLOGICAL:	STROKE	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	SEIZURES	YES <input type="checkbox"/>	NO <input type="checkbox"/>
CARDIOVASCULAR:	HYPERTENSION	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	MVP	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	PAST HEART ATTACKS	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	PACEMAKER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
EYES:	GLAUCOMA	YES <input type="checkbox"/>	NO <input type="checkbox"/>
SKIN:	HISTORY OF SKIN CANCER	YES <input type="checkbox"/>	NO <input type="checkbox"/>
ENDOCRINE:	DIABETES	YES <input type="checkbox"/>	NO <input type="checkbox"/>
	THYROID DISEASE	YES <input type="checkbox"/>	NO <input type="checkbox"/>

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/Guardian Signature: _____ Date: _____

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

Relationship to Patient: _____ Name of Guardian: _____



**SOUTH FLORIDA
ENT ASSOCIATES**

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





NOTICE OF PRIVACY PRACTICES

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

South Florida ENT is committed to protecting your personal health information. We strongly encourage you to contact our office first if you have any issues or a question arises in regards to your personal information being used by South Florida ENT.

Effective Date: June 1, 2013

This Notice was revised on May 16, 2013

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer: Stacey Citrin

Mailing Address: 14750 NW 77th Court, Suite 200, Miami Lakes, FL 33016

Telephone: (305)558-3724

Fax: (786) 662-3555

Email: scitrin@southfloridaent.com

About This Notice

We are required by law to maintain the privacy of Protected Health Information and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations – regarding the privacy of your Protected Health Information, and this Notice also explains your rights and our obligations. We are required to abide by the terms of the current version of this Notice.

What is Protected Health Information?

“Protected Health Information” is information that individually identifies you and that we create or get from you or from another health care provider, health plan, your employer, or a health care clearinghouse and that relates to (1) your past, present, or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present, or future payment for your health care.

How We May Use and Disclose Your Protected Health Information

We may use and disclose your Protected Health Information in the following circumstances:

- **For Treatment.** We may use or disclose your Protected Health Information to give you medical treatment or services and to manage and coordinate your medical care. For example, your Protected Health Information may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
- **For Payment.** We may use and disclose your Protected Health Information so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment.
- **For Health Care Operations.** We may use and disclose Protected Health Information for our health care operations. For example, we may use your Protected Health Information to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.
- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services.** We may use and disclose Protected Health Information to contact you to remind you that you have an appointment for medical care, or to contact you

to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

- **Minors.** We may disclose the Protected Health Information of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law. *(Optional, only included if applicable.)*
- **Research.** We may use and disclose your Protected Health Information for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your Protected Health Information. Even without that special approval, we may permit researchers to look at Protected Health Information to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any Protected Health Information. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.
- **As Required by Law.** We will disclose Protected Health Information about you when required to do so by international, federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose Protected Health Information when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates.** We may disclose Protected Health Information to our business associates who perform functions on our behalf or provide us with services if the Protected Health Information is necessary for those functions or services. For example, we may use another company to do our billing, or to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your Protected Health Information.
- **Organ and Tissue Donation.** If you are an organ or tissue donor, we may use or disclose your Protected Health Information to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may disclose Protected Health Information as required by military command authorities. We also may disclose Protected Health Information to the appropriate foreign military authority if you are a member of a foreign military.
- **Workers' Compensation.** We may use or disclose Protected Health Information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose Protected Health Information for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Abuse, Neglect, or Domestic Violence.** We may disclose Protected Health Information to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- **Health Oversight Activities.** We may disclose Protected Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Data Breach Notification Purposes.** We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose Protected Health Information in response to a court or administrative order. We also may disclose Protected Health Information in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your Protected Health Information to defend ourselves in the event of a lawsuit.
- **Law Enforcement.** We may disclose Protected Health Information, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security.** If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your Protected Health Information to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors.** We may disclose Protected Health Information to a coroner, medical examiner, or funeral director so that they can carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose Protected Health Information to the correctional institution or law enforcement official if the disclosure is necessary

(1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out

- **Individuals Involved in Your Care or Payment for Your Care.** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Disaster Relief.** We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- **Fundraising Activities.** We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (*Optional*) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

Your Written Authorization is Required for Other Uses and Disclosures

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and
2. Disclosures that constitute a sale of your Protected Health Information.

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Your Rights Regarding Your Protected Health Information

You have the following rights, subject to certain limitations, regarding your Protected Health Information:

- **Right to Inspect and Copy.** You have the right to inspect and copy Protected Health Information that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Right to a Summary or Explanation.** We can also provide you with a summary of your Protected Health Information, rather than the entire record, or we can provide you with an explanation of the Protected Health Information which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
- **Right to an Electronic Copy of Electronic Medical Records.** If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.
- **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your unsecured Protected Health Information.
- **Right to Request Amendments.** If you feel that the Protected Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **Right to an Accounting of Disclosures.** You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your Protected Health Information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice. It excludes disclosures we may have made to you, for

a resident directory, to family members or friends involved in your care, or for notification purposes. The right to receive this information is subject to certain exceptions, restrictions and limitations. Additionally, limitations are different for electronic health records. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the Protected Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Protected Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. To request a restriction on who may have access to your Protected Health Information, you must submit a written request to the Privacy Officer. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to your request, unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we do agree to the requested restriction, we may not use or disclose your Protected Health Information in violation of that restriction unless it is needed to provide emergency treatment.
- **Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.
- **Right to Request Confidential Communications.** You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To exercise your right to inspect and copy your Protected Health Information, you may also contact your physician directly. To get a paper copy of this Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for Protected Health Information we already have as well as for any Protected Health Information we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

You may file a complaint with us or with the Secretary of the United States Department of Health and Human Services if you believe your privacy rights have been violated.

To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

To file a complaint with the Secretary, mail it to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775) or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information. There will be no retaliation against you for filing a complaint.

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.



**SOUTH FLORIDA
ENT ASSOCIATES**

**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

Reason Signature and Date were not obtained

- Individual Refused to Sign**
- Communication barriers prohibited obtaining the acknowledgement**
- An emergency situation prevented us from obtaining acknowledgement**
- Other (Please specify) _____**





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



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)

_____,20_____
Patient (Print)

_____,20_____
Parent or Guardian if patient is a minor (Sign)

_____,20_____
Parent or Guardian if patient is a minor (Print)

By: _____,20_____
SOUTH FLORIDA ENT ASSOCIATES, P.A.



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 then 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 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.