THE SPORTS CLINIC ORTHOPAEDIC MEDICAL ASSOCIATES, INC.

PATIENT REGISTRATION FORM

DATE: _____

PATIENT NAME: _____ AGE: _____ BIRTHDATE: _____

EMAIL: _____ CELL PHONE: ( )_____ _____

MALE FEMALE ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ PHONE ( ) _____

SS#: _____ DRIVER LICENSE _____ Work Phone ( ) _____

EMERGENCY CONTACT PERSON: _____ PHONE: ( ) _____

YOUR EMPLOYER:_____Work PHONE: ( ) _____
EMPLOYER ADDRESS: _____
CITY: _____ STATE: _____ ZIP CODE: _____

RESPONSIBLE PARTY IF MINOR INFORMATION

NAME _____ RELATIONHIP_____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE: ( )_____ DATE OF BIRTH: _____ SOCIAL SECURITY _____
EMPLOYER _____ WORK PHONE ( ) _____
WORK ADDRESS: _____ CITY _____ STATE _____ ZIP _____

PLEASE SEE THE RECEPTIONIST IF THIS IS A WORK RELATED INJURY OR MOTOR VEHICLE ACCIDENT
DO YOU HAVE INSURANCE: YES NO PLEASE SHOW INSURANCE CARD TO RECEPTIONIST

Subscriber _____ Date of Birth _____Group/Policy/Claim _____
Carrier _____ Member ID Number _____ _____
Address _____ Do you have a co-pay? YES NO Amount _____
Phone for benefits _____ Authorization Numbers _____
Secondary Insurance Information: Carrier _____Policy/Group _____
Address: _____
Subscriber's Name _____ Date of Birth _____
Subscribers ID Number _____ Social Security Number _____

AREA TO BE EXAMINED _____ DATE OF INJURY/ ONSET: _____

WHO REFERRED YOU TO THE SPORTS CLINIC: FRIEND ___ PHYSICIAN ___THERAPIST _____ OTHER_____
NAME OF REFERRING PARTY _____ PHONE NUMBER ( ) _____
ADDRESS: _____ CITY _____ STATE _____ ZIP _____
CITY: _____ STATE: _____ ZIP: _____

The Sports Clinic as a courtesy to our patients will bill your primary insurance company. Authorizations and pre-certifications are not a guarantee of payment. Co-pays and un-met deductibles are due at the time of service. You are financially responsible for all charges regardless of insurance coverage. Fee information is available (request).

Signature _____ Date _____

MEDICAL HEALTH QUESTIONNAIRE

NAME_____AGE_____DATE OF BIRTH_____

MALE____FEMALE_____WEIGHT_____HEIGHT_____RIGHT OR LEFT HANDED (**please circle)**

NAME OF INTERNIST/PRIMARY PHYSICIAN_____

PRIOR SIGNIFICANT MEDICAL ILLNESSES:

Diabetes	.No	Yes	Heart Disease	..No	Yes
Stroke	.No	Yes	Tuberculosis	No	Yes
Cancer	.No	Yes	Hepatitis	..No	Yes
Rheumatic Fever	.No	Yes	Other serious diseases_____		

OPERATIONS:

Have you had any surgery	No	Yes	Cataract	..No	Yes
Tonsils	..No	Yes	Hysterectomy	.No	Yes
Hernia	...No	Yes	Other	..No	Yes(please list)

Other surgeries:_____

MEDICATIONS CURRENTLY TAKING:

Prescription drugs:

Name:_____Dose_____

Name:_____Dose_____

Name_____Dose_____

Over the counter drugs:

Name:_____Dose_____

Name;_____Dose_____

Name:_____Dose_____

Other drugs taken within past 6 months (circle one)			**Dosage**
Heart Medication	Yes	No	_____
Anticoagulant .	...Yes	No	_____
Blood pressure medication .	Yes	No	_____
Tranquilizers	..Yes	No	_____
Diuretics	..Yes	No	_____
Sleeping medications	..Yes	No	_____
Cortisone	Yes	No	_____
Anti-inflammatory drugs	Yes	No	_____

ALLERGIES AND SENSITIVITIES

Penicillin or other antibiotics .	.Yes	No
Codeine .	..Yes	No
Sulfa	Yes	No
Aspirin	Yes	No
Iodine	..Yes	No
Any foods such as milk, eggs, chocolate	Yes	No

Any other drugs (please list)_____

SOCIAL HISTORY:

SINGLE _____ MARRIED _____ SEPARATED _____ DIVORCED _____ WIDOWED _____

ALCOHOLIC BEVERAGES: NEVER _____ RARELY _____Frequency _____

TOBACCO: CIGARETTES _____ PACKS PER DAY CIGARS _____ PIPE _____

OCCUPATION: _____

RETIRED: YES _____ NO _____

FAMILY HISTORY:

FATHER: IF LIVING AGE____ IF DECEASED AGE _____ HEALTH ISSUES _____

MOTHER: IF LIVING AGE ____ IF DECEASED AGE _____ HEALTH ISSUES _____

BROTHER/SISTER: AGES _____ HEALTH ISSUES _____

HAS ANY BLOOD RELATIVE BEEN DIAGNOSED:

(PLEASE CIRCLE BELOW)

CANCER

TUBERCULOSIS

DIABETES

HEART DISEASE

HIGH BLOOD PRESSURE

STROKE

SEIZURES

BLEEDING TENDENCY

GOUT

OTHER SERIOUS ILLNESS: _____

MEDICAL HISTORY 3

REVIEW OF SYSTEMS

(PLEASE CIRCLE YOUR POSITIVE RESPONSES)

GENERAL: RECENT WEIGHT CHANGE

CANCER TYPE _____

SKIN: SKIN DISEASE _____

EAR-NOSE-THROAT; EYE DISEASE SINUS DISEASE EASY NOSEBLEEDS

IMPAIRED HEARING DIZZINESS

NECK: STIFFNESS THYROID DISEASE ENLARGED GLANDS

LUNGS: ASTHMA SHORTNESS OF BREATH PNUEMNOIA

CARDIAC: CHEST PAINS HEART ATTACK HIGH BLOOD PRESSURE

GASTROINTESTINAL ULCERS GALLBLADDER DISEASE LIVER DISEASE

HEPATITIS HEMORRHOIDS ABNORMAL RECTAL BLEEDING

GENITOURINARY LOSS OF URINE CONTROL FREQUENCY OF URINATION BURNING

BLOOD IN URINE KIDNEY DISEASE

GYNECOLOGICAL SPECIFIC PROBLEMS _____

MUSCULOSKELETAL PRIOR FRACTURES _____

PRIOR SKELETAL INJURIES _____

UROLOGIC PROSTATE HYPERTROPHY URINARY RETENTION

HEMATOLOGIC BLOOD DISEASES EXCESSIVE BLEEDING WITH SURGERY

OTHER CONDITIONS _____

Dear Shoulder Patient:

We would appreciate if you could complete the enclosed questionnaire and provide it at your initial appointment. We appreciate your time in completing this form. Please circle the appropriate response **number** in each section.

PAIN

Present all the time, unbearable, strong medications frequently	1
Present all of the time, bearable, strong medication occasionally	2
None or little at rest, present during light activity, aspirin like meds frequently	4
Present during heavy or particular activity only, aspirin like meds occasionally	6
Occasional and slight	8
None	10

FUNCTION

Unable to use the limb	1
Only light activities possible	2
Able to do light housework, and most activities of daily living	4
Most housework, shopping, driving possible, able to fix hair, dress, do brassiere	6
Slight restriction only, able to work about shoulder level	8
Normal activities	10

QUESTIONNAIRE CONTINUED (page 2)

Patient Self-Evaluation: Instability Questionnaire

Does your shoulder feel unstable (as if it is going to dislocate)?	YES NO **Circle one**
How unstable is your shoulder (mark line)? 0 10 Very stable Very Unstable	

Patient Self-Evaluation: Activities of Daily Living Questionnaire

Circle the number in the box that indicates your ability to do the following activities:
0=unable to do, 1=very difficult to do; 2=somewhat difficult, 3= not difficult

ACTIVITY	RIGHT ARM	LEFT ARM
1. Put on a coat	0 1 2 3	0 1 2 3
2. Sleep on your painful or affected side	0 1 2 3	0 1 2 3
3. Wash back or do up bra in back	0 1 2 3	0 1 2 3
4. Manage toileting	0 1 2 3	0 1 2 3
5. Comb hair	0 1 2 3	0 1 2 3
6. Reach a high shelf	0 1 2 3	0 1 2 3
7. Lift 10 lb. above the shoulder	0 1 2 3	0 1 2 3
8. Throw a ball overhead	0 1 2 3	0 1 2 3
9. Do usual work-list:	0 1 2 3	0 1 2 3

We appreciate your time in completing this questionnaire. At the end of the year, we will be mailing you the same questionnaire to complete. Thank you again for your time.

OFFICE FINANCIAL POLICY

The Sports Clinic Orthopeadic Medical Associates, Inc is committed to providing you with the best care possible. Your clear understanding of the financial policy agreement is important to our professional relationship. We require a signature to document that you have read and understand these policies. If you have any questions please do not hesitate to ask a member of our staff.

PAYMENT

Payment is expected at the time of service. This includes co-insurance and/or deductible for participating insurance companies. **A $10 processing fee will be added to your bill if the co-payment is not made at time of service for the additional time to process and bill your co-payment.** We accept cash, checks, Visa, Master Card and AMEX. There is a service charge of $50 for any returned checks.

Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling future appointments.

Patients are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or contractual agreement.

INSURANCE

It is the patient's responsibility to provide us with current insurance information and to present an active insurance card at each visit. If the insurance company you designate is incorrect, you will be responsible for the charges, or you may choose to pay a $10 refiling fee and we will submit the bill to the correct insurance.

It is your responsibility to understand your benefit plan with regard to covered & non-covered services. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. If we participate with your insurance company all services performed will be submitted as a courtesy to your insurance. Pre-authorization does not guarantee payment of a service by the insurance company.

We **do not** accept third party insurance, or liens for payment of services.

PATIENT BILLING

Patient balances are billed immediately on receipt of your insurance plans explanation of benefits. Your remittance is due within 30 days of your receipt of the bill. You will be charged a $10 fee for every 30 days there after, that the bill is not paid; after 90 days the account may be forwarded to a collection agency.

MISSED APPOINTMENTS/LATE CANCELLATION

Broken appointments represent a cost to us, to you, and to other patients that could have been seen in the time set aside for you. We reserve the right to charge you for any missed appointments or appointments that are not cancelled with a 24 hours notice.

THE FINANCIAL AGREEMENT

We must emphasize that our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly you responsibility from THE DATE SERVICES ARE RENDERED. Charges not paid by your insurance within 90 days, will become your responsibility.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY THE SPORTS CLINIC ORTHOPAEDIC MEDICAL ASSOCIATES, INC.

PATIENTS NAME (PLEASE PRINT) _____.

RESPONSIBLE PARTY SIGNATURE _____.

RELATIONSHIP TO PATIENT _____ **DATE** _____.

THE SPORTS CLINC ORTHOPEDIC MEDICAL ASSOCIATES, INC.

OFFICE POLICIES SIGN-IN SHEET

1. FAILED APPOINTMENT CHARGE: We reserve the right to charge for each failed appointment not cancelled at least 24 hours before the scheduled appointment time.

THIS CHARGE IS NOT COVERED BY YOUR INSURANCE

2. FORMS COMPLETION CHARGE: All forms requiring completion, excluding disabled parking form, but including forms such as state disability forms, assisted living forms, insurance benefit forms, FMLA forms, leave of absence forms, health assessment forms, time off work forms specific to employers will be charged at $35 for up to two pages.

THIS CHARGE IS NOT COVERED BY YOUR INSURANCE

3 DICTATED LETTERS: Letters prepared for third parties excluding attorneys, (such as insurance companies, or employers) will be charged at $35 per page. All medical legal letters arranged between this office (Lynne) and your attorney will be charged on a case by case basis.

THIS CHARGE IS NOT COVERED BY YOUR INSURANCE

4. RETURNED CHECK CHARGE: All accounts with checks returned by the bank unpaid will be charged $50 per check.

THIS CHARGE IS NOT COVERED BY YOUR INSURANCE

5. CO-PAYMENTS ARE REQUIRED AT THE TIME OF VISIT: This is a contractual obligation between you and your insurance company. Failure to make co-payments can lead to denial of insurance payments. We accept cash, credit cards (AMEX, MasterCard, Visa) and checks.

THIS CHARGE IS NOT COVERED BY YOUR INSURANCE

6. COPY OF MEDICAL RECORDS: There is a charge for copying your medical records and transferring them to another physician. The charge is $35.00 and includes postage.

THIS CHARGE IS NOT COVERED BY YOUR INSURANCE

By signing this document, I acknowledge and agree to the above office policies.

Patient Name _____ DATE _____

Patient Signature: _____

Address: _____

Phone: _____ Email: _____

- Inspections and Copies: the right to inspect and obtain copies of the medical information that may be used to make decisions about you, including medical records, billing records, but not including psychotherapy notes. In order to inspect or obtain records, you must submit the request in writing to the address on the back of the brochure.

- Amendment: the right to ask us to amend your medical information if you believe it is incorrect or incomplete, and you may request and amendment for as long as the information is kept by or for our organization. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request and the reason for your request in writing to the address in the back of this brochure. Also, we may deny the request if you ask us to amend information that is accurate and complete; not part of the information kept by or for our organization; not part of the information which you are permitted to inspect and copy; not created by our organization, unless the individual or entity that created the information is not available to amend the information.

- Accounting of Disclosures: the right to request an accounting of disclosures made of your medical information to entities whom you do not have an established relationship with. In order to obtain an accounting, you must submit your request in writing to the address on the back of this brochure. All requests may not be longer than 6 years and may not include dates prior to October 16, 2002. The first request in a 12 month period is free of charge. You will be charged for any additional lists requested in a 12 month period.

- Right to File a Complaint: If you believe your rights have been violate, you may file a complaint with our organization or with the Secretary of the Department of Health and Human Services. You will not be penalized for filing the complaint. All complaints must be submitted in writing at the address listed below.

- Right to Provide an Authorization of Other uses and Disclosures: our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or are not permitted by applicable law. Any authorization you provide to us regarding the use and disclosure if your medical information may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your medical information for the reasons described in the authorization. Of course, we will not be able to take back any disclosures that we have already made with your permission.

- Right to a Paper Copy of This Notice: you are entitled to receive a paper copy of this notice of privacy practices. You will be asked to sign an acknowledgment proving receipt of this Notice of Privacy Practices.

The Sports Clinic Orthopaedic Medical

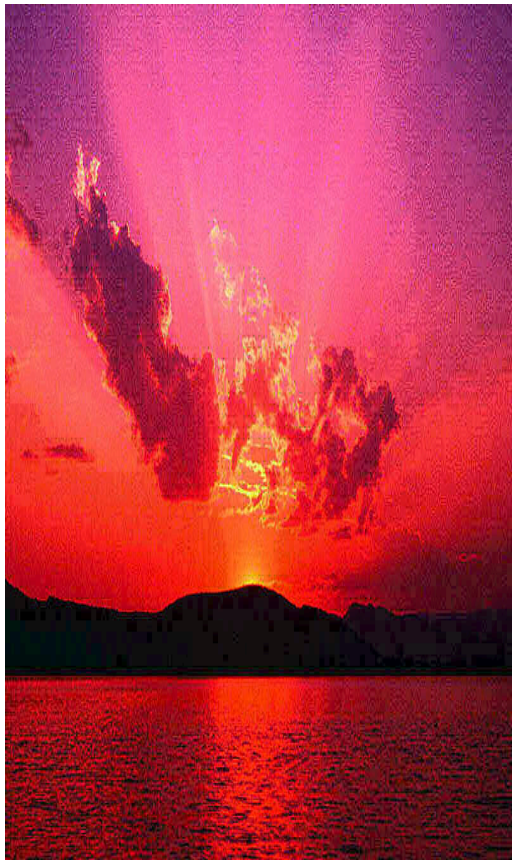
Associates, Inc.

23961 Calle de Magdalena, Suite 229

Laguna Hills, CA 92653

HIPAA

PATIENT PRIVACY RIGHTS NOTIFICATION



HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following describe the different ways in which we may use and disclose your medical information.

1. Treatment: in order to treat you and may disclose information to others who assist with your care or treatment.

2. Payment:: in order to bill and collect payment for services you receive from us. We may use and disclose information to obtain payment from third parties that may be responsible for such costs such as family members. We may use your medical information in order to bill you directly for services and items.

3. Health Care Operations: to operate our business to ensure you receive quality care and to assure our organization is well run.

4. Appointment Reminders: to remind you that you have an appointment at the daytime number you provide us with.

5. Treatment Alternatives: to inform you of treatment alternatives and/or health related benefits and services that may be of interest to you.

6. Fundraising: in order to contact you as part of fund raising activity. We may disclose your information to a business associate or to a foundation related to our organization to raise money for our organization. Name and address only will be used.

7. Marketing: to make a marketing communication to you that occurs in a fact-to-face encounter with you; concerns products or services of nominal value; or concerns our health-related products or services, or those of another party, provided that we tell you that we are the party communicating with you, and tell you if we have received, or will receive, directly or indirectly, any money or other remuneration for making the communication to you.

8. Required By Law: when required by applicable law regarding crime or criminal conduct; warrant, summons, subpoena or legal process. If served with a legal subpoena for records (contains a release of records signed by you or verbal authorization obtained from you or your attorney of record or proof of service from the requesting party) we must honor the request.

9. Public Health Activities: to control disease, injury, or disability; maintain vital records such as birth or death; report child abuse or neglect; exposure to communicable disease; drug reactions or FDA warnings; recalled devices or medications. To notify appropriate government agencies and authorities regarding the potential abuse or neglect of an adult patient including domestic abuse if the patient agrees or we are required or authorized by law to do so. Under limited circumstances, to your employer for related workplace injury or illness or medical surveillance.

10. Coroners, Medical Examiners, and Funeral Directors: as needed to carry out their duties required by law.

11. Organ and Tissue Donation: to organizations that handle organ and tissue procurement, banking or transplantation.

12. Research: subject to special approval process, information may be used on research projects or studies. The information will not leave our premises.

13. Serious Threats to Health Or Safety: to reduce or prevent a serious threat to your health and safety or that of another individual or the public. We will only disclose to persons or organizations able to help prevent the threat.

14. Specialized Government Functions: if you are a member of U.S. or foreign military forces (including veterans) and if required by appropriate military command authorities; or to federal officials for intelligence and national security.

15. Workers Compensation: our organization will release your medical information for workers' compensation and similar programs to all parties as required by state and federal law.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

You have the following rights regarding the medical information that we maintain about you. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when necessary to treat you. In order to request a restriction in our use or disclosure of your medical information , you must make your request in writing to the address on the back of this brochure.

- Requesting Restrictions: the right to request a restriction in our use or disclosure of your medical information for treatment, payment or health care operations. You have the right to limit our disclosure to individuals involved in your care or the payment for your care such as family members and friends.

- Confidential Communications: the right to request our organization communicate with you about your health and related issues in a particular manner or certain locations without stating a reason for your request.

THE SPORTS CLINIC
ORTHOPEDIC MEDICAL ASSOCIATES, INC.
23961 Calle de la Magdalena #229 Laguna Hills, CA 92653
949-581-7001

PRIVACY RIGHTS NOTIFICATION AND ACKNOWLEDGEMENT

I hereby acknowledge that I have received the notice of Privacy Practices ((Patient Privacy Rights Notification)

Signature: _____

Print Name: _____

Date: _____

Secure Phone Option:

Is there a telephone number on which personal health information can be left on your message recording in the event that you are not available when we call? YES NO

IF yes, what is the number: _____ _____
Initials

**This acknowledgement reflects the proposed modifications to s164.520 of the Privacy Standards as set forth by the Department of Health and Human Services at 67 Fed. Reg.14814 (March 27, 2002). It applies to health care providers with direct treatment relationships. This acknowledgement or some other form of acknowledgment (i.e. initials) must be on a cover sheet accompanied by the disclosure log, kept in a separate, visible place in the patient record, apart from the Medical PHI.

ASSIGNMENT OF BENEFITS

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare benefits, private insurance, and any other health plan to:

The Sports Clinic Orthopaedic Medical Associates, Inc.

23961 Calle de la Magdalena #229

Laguna Hills, CA 92653

This assignment will remain in effect until revoked in writing by myself. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I hereby authorize said assignee to release all information necessary to secure payment.

SIGNED: _____

Printed Name: _____

DATE: _____

THE SPORTS CLINIC
ORTHOPAEDIC MEDICAL ASSOCIATES, INC.

Wesley M. Nottage, MD
Orthopaedic Surgery

A MESSAGE TO MY PATIENTS ABOUT ARBITRATION

The attached contract is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be presented. You still can call witness and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. This is because the time to conduct an arbitration hearing is far less than for a jury trial. Further, both parties are spared some of the rigors of trial and the publicity which may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

REORDER # 04-1029

The Sports Clinic's office policy is to have all patients being seen by the physicians to read, understand, and agree to the arbitration agreement. This copy is for your review only, and the final document will have to be signed in the office upon registration.

If you are unable to agree to and sign the arbitration agreement, please call our office at 949-581-7001 Monday to Thursday 9-5 PM to cancel your appointment.

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 their constitutional rights 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 bind all parties whose claims may arise out of or relate to treatment or service provided by the physician 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.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing 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 the 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 to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Sections 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrators a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05; however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days of signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services

_____
Patient's or Patient Representative's Initials

If any provision of this arbitration 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.

I understand that I have the right to receive a copy of this arbitration 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 OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

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

_____
Print or Stamp Name of Physician, Medical Group, or Association Name

THE SPORTS CLINIC
ORTHOPAEDIC MEDICAL ASSOCIATES, INC.
AND ITS AFFILIATED PHYSICIANS

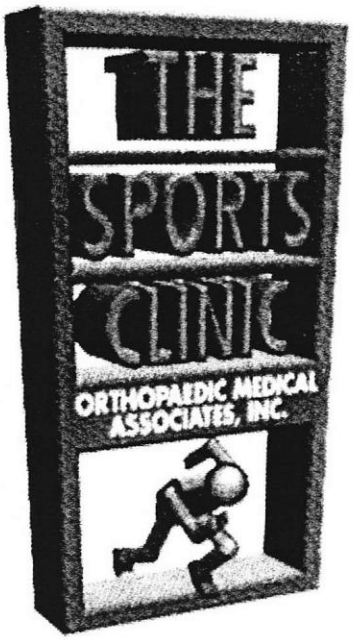
By: _____ _____
Patient's or Patient Representative's Signature (Date)

By: _____
Print Patient's Name

_____
(If Representative, Print Name and Relationship to Patient)

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

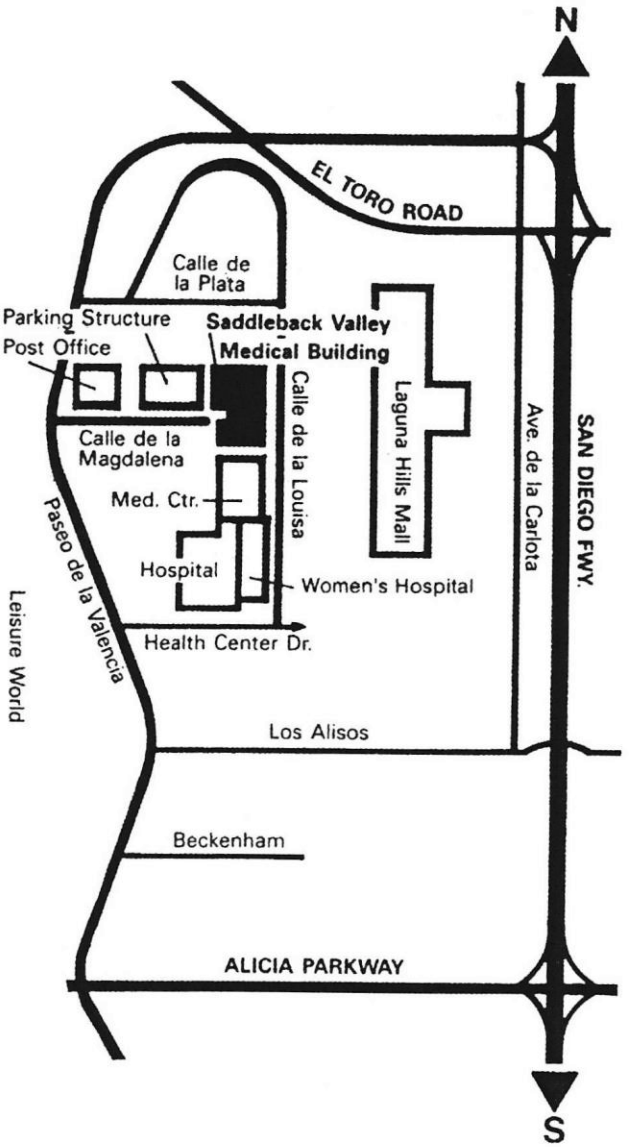
(2-08)



PLEASE BRING ALL X-RAYS, MRI'S AND REPORTS CONCERNING THIS APPOINTMENT. IF YOU RECEIVED FORMS IN THE MAIL, PLEASE COMPLETE THEM AND BRING THEM WITH YOU.

FROM CENTRAL AND NORTH ORANGE COUNTY

Take the 5 or 405 freeway south and exit at El Toro Road. Go straight through the signal, you are on Paseo de Valencia. Cross over El Toro Road and take the second left on Magdalena. You can park in the parking structure at the end of the cul de sac on the left hand side, but there is a fee. We do not validate parking.
Enter the Saddleback Valley Medical Center Building and take the elevator to the second floor. Exit the elevator and turn **left** to Suite 229.



FROM SOUTH ORANGE COUNTY

Take the 5 freeway north, exit El Toro Road. Turn left at the signal. Turn left on Paseo de Valencia. Turn left on Calle de la Magdalena. You can park in the parking structure on the left side, but there is a fee. WE DO NOT VALIDATE. Enter the Saddleback Valley Medical Center building and take the elevator to the second floor. Exit the elevator and turn **left** to Suite 229.

THE SPORTS CLINIC
Orthopaedic Medical Associates, Inc.
23961 Calle de la Magdalena
Suite 229
Laguna Hills, California 92653
Phone: 949/581-7001
Fax: 949/581-8410

Diplomate, American Board of Orthopaedic Surgery
Fellow, American Academy of Orthopaedic Surgeons
Fellow, American College of Surgeons
Associate Clinical Professor,
University of California at Irvine
Member:
Arthroscopy Association of North America
International Arthroscopy Association
American Academy of Orthopaedic Surgeons
American College of Sports Medicine

REORDER # 04-10297