

CHART # _____

FOR OFFICE USE ONLY

Staff/Doctor Check List

- Pt Checked In By _____ (staff name)
- Pt Signed All Forms
- Photo Taken
- Copy of License
- Insurance Card
- Insurance Card Entered
- Breakdown Completed
- HMO List Checked
- Insurance Checked/Verified
- Pt Seen By Dr. _____

- Treatment Plan Presented _____ (staff name)
- Pt Checked Out By _____ (staff name)
- Co-Pay Collected by _____ (staff name)

Completed by Front Desk Staff

- Was Casey Watched
 - Yes
 - No
- Was Referred Made to endo., o.s., perio, Dr. Hunt (circle)
- Were Proper Codes given by Dr. _____
 - Yes
 - No
- Other information regarding visit today _____

CHART # _____

Reason for Visit: _____

PATIENT INFORMATION

DATE: _____

Patient Name: _____

PERSON RESPONSIBLE FOR ACCOUNT:
Check Box if Self and continue to page C3

Home Address: _____

If Other continue below:

City: _____

State: _____ Zip: _____

Name: _____

Home Phone #: _____

Address: _____

Cell Phone #: _____

City: _____

Work Phone #: _____

State: _____ Zip: _____

Email Address: _____

Social Security #: _____

*This will **only** be used for apt confirmations!*

Home Phone #: _____

Sex: Male [] Female []

Cell Phone #: _____

Marital Status: (circle)
Married Divorced
Separated Single

Work Phone #: _____

Sex: Male [] Female []

Social Security #: _____

Marital Status: (circle)

Date of Birth: _____

Married Divorced
Separated Single

Full Time Student: Yes [] No []

Date of Birth: _____

Driver's License #: _____

In case of Emergency notify: (name and #)

(Relationship to patient: _____)

CHART # _____

**DENTAL INSURANCE
INFORMATION**

Insurance Company Name: _____

Insurance Company Address:

Group #: _____

ID#: _____

Local #: _____

Insurance Company Phone #:

Insured's Name: _____

Date of Birth: _____

Insured's Employer: _____

Employer's Address:

Work Phone #: _____

Home Phone #: _____

Sex: Male [] Female []

Marital Status: (circle)

Married Divorced

Separated Single

CHART # _____ **MEDICAL AND DENTAL HISTORY**

It is important that we know your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out the questionnaire.

ARE YOU PREGNANT?	YES	NO
How LONG SINCE you have seen a dentist? _____		
Last COMPLETE Dental Exam: (Date) _____		
Last FULL MOUTH X-RAY (machine that rotates around head): (Date) _____		
	YES	NO
Are you having problems now?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth SENSITIVE to (check all that apply) [] hot [] cold [] sweets [] pressure	<input type="checkbox"/>	<input type="checkbox"/>
Do you have problems with teeth/fillings breaking?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums BLEED or feel TENDER or IRRITATED?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any PERIODONTAL (gum) treatments?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have (check all that apply) [] LOOSE, [] TIPPED, [] SHIFTING TEETH?.....	<input type="checkbox"/>	<input type="checkbox"/>
Are you aware if GRINDING or CLENCHING your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have HEADACHES, EARACHES, or NECK PAINS?	<input type="checkbox"/>	<input type="checkbox"/>
Are you unhappy with the APPEARANCE of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have DISCOLORED teeth that bother you?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like to know more about PERMANENT REPLACEMENTS?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear DENTURES? (partials or full)	<input type="checkbox"/>	<input type="checkbox"/>
Are you UNHAPPY with your dentures?	<input type="checkbox"/>	<input type="checkbox"/>
Are you APPREHENSIVE about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had BAD dental experiences in the past?	<input type="checkbox"/>	<input type="checkbox"/>

CHART # _____ **MEDICAL AND DENTAL HISTORY continued**

CIRCLE any of the following which you have had or have it present

Bleeding Problems/Hemophilia
 Circulatory Problems
 High or Low Blood Pressure
 Stroke
 Heart Attack
 Kidney Disease/Transplants
 Cancer or Tumor
 Radiation Treatments
 Asthma
 Blood Transfusions
 Sickle Cell Disease
 Cortisone Medication
 Psychiatric Therapy
 Osteoporosis
 Diabetes/Excess Sugar
 Joint Replacement

Headaches
 Dizziness
 Blurred Vision
 Ringing Ears
 Anemia
 Fainting Spells
 Shortness of Breath
 Painful or Swollen Joints
 Skin Disease
 Thyroid Disease
 History of Substance Abuse
 Alcohol Abuse
 Drug Abuse
 Chronic Diarrhea
 Unexplained Weight Loss
 Swollen Lymph Glands

Tiredness/Lethargy
 Unhealed Mouth Sores
 Bruise Easily
 Emphysema
 Hay Fever
 Sinus Trouble
 Glaucoma
 Mitral Valve Prolapse
 (Barlow's Syndrome)

Artificial Heart Valve
 Pacemaker/Defibrillator
 Heart Surgery
 Prosthetic Cardiac Heart Valve
 Congenital Heart Disease
 Previous Heart Infection
 Heart Transplant

Biosphosphonates
 Alendronate
 Clodronate
 Etidronate
 Ibandronate
 Pamidronate
 Risedronate
 Tiludronate
 Zoledronic-Acid

Fosomax-oral
 Ostac, Bonefos- IV and Oral
 Didronel-IV and Oral
 Boniva- Oral
 Aredia- IV
 Actonel- Oral
 Skelid- Oral
 Zometa- IV

ALLERGIES or BAD REACTIONS TO

Aspirin
 Codeine
 Demerol
 Erythromycin
 Tylenol or Tylenol #3
 Local Anesthetic

Nitrous Oxide
 Percodan
 Valium
 Penicillin
 Sulfa Drugs
 Tetracycline

Latex Sensitivity
 Fosmex Biophospytes
 Other:

Have you ever taken Prescription Diet Drugs alone or with other weight loss medications?

Fen-phen
 Redux

CHART # _____ **MEDICAL AND DENTAL HISTORY *continued***

CIRCLE all that apply

INFECTIOUS DISEASES OR EXPOSURE TO SOMEONE WITH:

- | | |
|-------------------------|------------------|
| Hepatitis A (infection) | AIDS/HIV |
| Hepatitis B (serum) | Herpes I/II |
| Hepatitis C | Venereal Disease |
| Rheumatic Fever | Mononucleosis |
| Scarlet Fever | Measles |
| Epstein-Barr Virus | Mumps |
| Chicken Pox | Tuberculosis |

Surgery:

- Artificial Heart Valve
- Pacemaker/Defibrillator
- Heart Surgery

- Tonsils
- Adenoids
- Cosmetic

Joint Replacement
Other: _____

- | | | |
|--|-----|----|
| Do you have any CURRENT HEALTH PROBLEMS? | YES | NO |
| Are you under any CURRENT PHYSICIAN'S CARE NOW?
IF yes, for what? _____ | YES | NO |
| Are you currently taking any MEDICATIONS?
IF yes, what? _____ | YES | NO |
| Have you been HOSPITALIZED RECENTLY?
IF yes, for what? _____ | YES | NO |
| Are there any Physical or Mental Handicaps?
IF yes, what? _____ | YES | NO |

Current Physician's Name: _____

Address: _____

Phone #: _____

*** Insurance Companies will only allow replacements for crowns, bridges and dentures after 5 or 10 years.
How old are your crowns, bridges or dentures? Date of Placement: _____

I have read over and answered to the best of my knowledge all medical and dental history questions so that my dentist may be able to approach my dental care and treatment in a safe and client-centered manner.

Signature _____ Date _____

I hereby grant authority to:

DOCTORS BATZ and WEINER and/or associates to administer any treatment; or to administer such anesthesia; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

**Signature _____ Date _____
(Patient or Legal Guardian)**

Relationship to Patient: _____

Authorization must be signed by the patient or the nearest relative in the case of a minor or when the patient is physically or mentally incompetent.

DRS. BATZ & WEINER

Chart # _____

Our office is pleased to accept your insurance assignment. After verification of coverage we will file your claim forms and assist you in every way we can.

However, it must be fully understood that the contract is between YOU and your insurance company and YOU are fully responsible for any amount not paid by your insurance company.

Our office does NOT guarantee that your insurance company will pay. We will make every attempt, at the beginning of your dental care, to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill. We will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, And therefore, are covered up to the maximum allowance determined by each carrier. You are responsible for any balance not covered by your insurance company.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. You are also responsible for any and amounts over your yearly contract allowance.

I authorize the release of all information pertaining to all claims if requested by my insurance, company. I authorize all insurance payments to Drs. Batz & Weiner Lake Dental. A photostat copy of this authorization shall be considered with the same force and effect as the original.

I authorize Drs. Batz & Weiner as my advocate to my insurance company or the Maryland Health Insurance Administration regarding any appeals of contestments.

Should an insurance payment inadvertently be sent to me, I will endorse it and return it to the office of Drs. Batz & Weiner immediately.

I understand that my dentist may recommend a dental service to aid in diagnosis, therapy or screening purposes that may not be covered under the guidelines of my insurance plan. I agree to be fully responsible for payment of services provided by my dentist. I also understand that it is my responsibility to obtain from my general dentist pertinent specialist referrals and authorizations if required under the guidelines of my insurance plan at or before the time of service. I agree to be fully responsible for claims denied by my insurance plan for lack of referrals and/or prior authorization.

I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. To the extent permitted under applicable law. I authorize release of any information relating to this claim. I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

I agree to pay all reasonable collection fees should Drs. Batz & Weiner need to use an outside collection agency to collect on this account. Returned checks and balances older than 30 days may be subject to additional collection fees and interest charges of 1-1/1/2% per month. The undersigned will be responsible for all costs incurred in the collection of any past due account including attorneys fees. Charges may also be made for broken appointments and appointment cancellations.

A 48 hour notice of cancellation is required. There may be a charge for a broken or cancelled appointment.

I understand and agree with all of the above. Please sign your name below and we will accept your assignment.

Signature of patient/guardian _____ date _____

DR. BATZ & WEINER

INSURANCE BENEFIT POLICY

As a service to you, our office will be happy to process your insurance and accept assignment of benefits, it is important that you understand our office regarding this matter.

1. It is your responsibility to make sure we receive full payment from your insurance company. If your insurance terminates or changes you will be responsible for any unpaid balance;
2. If payment is NOT received from your carrier within 90 days from any claim we submit on your behalf, you will held responsible for full payment;
3. We will submit only one time. IF FOR ANY REASON we do not receive payment, it is YOUR responsibility to work things out with your insurance carrier;
4. We STRONGLY recommend that you take a proactive stance with your insurance carrier to make sure all payments are made to our office in a timely manner.

Signature of Responsible party

date

Chart Number

BATZ & WEINER LAKE DENTAL Chart # _____

The Department of Health & Human Services has established a “Privacy Rule” to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients’ consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purpose of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name _____ Signature _____ Date _____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that all our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule”. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, or VISA/MASTERCARD, AMERICAN EXPRESS, and DISCOVER.

Regarding Insurance

Our office is pleased to accept your insurance assignment. After verification of coverage we will file your claim forms and assist you in every way we can. However, it must be fully understood that the contract is between YOU and your insurance company and YOU are fully responsible for any amount not paid by your insurance company. Our office does NOT guarantee that your insurance company will pay. We will make every attempt, at the beginning of your dental care, to receive verification of your policy and what it covers. However, if for some reason your insurance claim is denied, you are responsible for the full amount of your bill. We will NOT enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. I authorize the release of all information pertaining to all claims if requested by my insurance company. A photostat copy of this authorization shall be considered with the same force and effect as the original. I authorize Drs. Batz & Weiner as my advocate to my insurance company or the Maryland Health Insurance Administration regarding any appeals of contestments. Should an insurance payment inadvertently be sent to me, I will endorse it and return it to the office of Drs. Batz & Weiner immediately.

Regarding Insurance Plans where we are a participating provider. All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa, Mastercard, or payment by cash or check at time of service has been verified.

Missed appointments

Unless canceled, at least 48 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments.

Interest

We reserve the right to charge interest in the amount of 1.5% as provided by state law. We also reserve the right to charge this interest percentage retroactive to the initial date of appointment.

Refunds

Most insurance companies allow claims submitted up to 1 year from date of service. Refunds will be reviewed up to 1 year from last insurance payment received.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns. I have read the Financial Policy. I understand and agree to this Financial Policy:

X _____ Date _____
Signature of Patient or Responsible Party

X _____ Date _____
Signature of Co-Responsible Party

DRS. BATZ & WEINER LAKE DENTAL
8363 CHERRY LANE
LAUREL, MD 20707

Chart # _____

The office of Drs. Batz & Weiner is a digital office. The originals will be scanned into the computer and shredded.

The scanned copies have the same legal rights as the original paper copies.

Patient name/social security number

Date

For office use only

Chart number

Doctor treatment notes:

PHYSICIAN PATIENT BINDING ARBITRATION AGREEMENT

I, _____ (hereinafter “Patient”) hereby enter voluntarily into the following binding arbitration agreement (hereinafter “Agreement”) with _____ (hereinafter “Physician”).

I. Consent to Arbitration: Except as provided in Section VIII (Exclusions), the parties hereby agree that any and all disputes arising between Patient and Physician including, but not limited to, claims for breach of contract, medical and/or dental care, informed consent (or lack thereof), assault, battery, fraud, misrepresentation, intentional infliction of emotional distress, violations of the Maryland Consumer Protection Action, loss of consortium, wrongful death and/or survivorship, among others, shall be submitted to binding arbitration as provided under the terms of this Agreement, regardless of when or where the cause of action(s) arose. By entering into this Agreement, both Patient and Physician hereby understand that they are foregoing their constitutional and statutory right to have such disputes resolved in a court of law and/or before a jury of their peers.

II. Binding Nature of Arbitration: It is the intent of the parties that this Agreement shall bind them, as well as their agents, servants, heirs, successors, spouses, children, employers, partners and/or assigns, to the terms set forth herein. In the case of a pregnant mother, the term “Patient” shall mean both the mother and her expected child / children.

III. Arbitration Procedures: The parties incorporate herein by reference the terms of the 2006 Maryland Uniform Arbitration Act (‘MAN’), Maryland Code, Courts and Judicial Proceedings Article, §~ 3-201, *et seq.* as governing the binding arbitration required by this Agreement, subject to the following terms, which are in addition to and/or supersede the provisions of the MAA where inconsistent:

(A) Any party wishing to initiate binding arbitration under the terms of this Agreement shall serve written notice to the other party consistent with Rule 1-121 of the Maryland Rules of Civil Procedure (2006).

(B) Within sixty (60) days after receiving written notice as required by Section III.A of this Agreement, the parties shall confer and select a single arbitrator to resolve their dispute(s).

(1) In the event that the parties cannot reach an agreement, each party shall appoint an individual to serve as an arbitrator (hereinafter “party arbitrator”). Said individuals must have prior alternative dispute resolution experience, either as an arbitrator or mediator, and be listed as an “approved” arbitrator/mediator by either a court of law or an appropriate third party entity such as, but not limited to, the American Arbitration Association. Once selected, the party arbitrators shall confer and select a third arbitrator (hereinafter “neutral arbitrator”) within thirty (30) days. At least one arbitrator shall be a member of the Maryland Bar, in good standing with the Maryland Court of Appeals, and have a minimum of eight (8) years experience practicing law in the State of Maryland. In addition, at least one member of the arbitration panel shall be a physician, licensed in the State of Maryland, with at least eight (8) years experience in the field of dentistry and/or medicine at issue in the dispute.

(C) The parties agree and hereby incorporate by reference the Certificate of Qualified Expert requirements as set forth in the Maryland Code, Court & Judicial Proceedings Article, Sections 3-2A-

02 and 3-2A-04 (2006). Failure to comply with these provisions shall subject the parties to the same mandatory and/or discretionary remedies as if suit was filed in the Health Claims Arbitration Dispute Resolution Office and/or a court of law. Any dispute regarding the Certificate requirements shall be decided by the arbitrator or, if a panel of arbitrators are appointed under Section 111.(B)(1), the attorney member of the arbitration panel and subject to judicial review in the Circuit Court for Montgomery County.

(D) The parties agree and hereby incorporate by reference the Maryland Rules of Civil Procedure governing discovery, acknowledging that each party shall have the right to engage in discovery, if desired, consistent with those Rules prior to any binding arbitration proceeding under this Agreement. Any disputes regarding discovery shall be decided by the arbitrator or, if a panel of arbitrators are appointed under Section III.(B)(1), the attorney member of the arbitration panel.

(E) At any formal arbitration proceeding from which a binding decision shall be made, the Maryland Rules of Evidence shall be applicable and enforced by the arbitrator or, if a panel of arbitrators are appointed under Section III.(B)(1), the attorney member of the arbitration panel. In addition, Maryland substantive law regarding the issues in controversy shall apply.

(F) Notwithstanding the provisions of the MAA, if a panel of arbitrators are appointed under Section III.(B)(1), any decision reached by the arbitration panel must be by the unanimous consent of the arbitrators.

IV. Fees / Expenses: Each party shall share equally the fee of the arbitrator or, if a panel of arbitrators are appointed under Section III.(B)(I), pay the fees of their own selected party arbitrator, and shall share equally the fees of the neutral arbitrator. Each party shall be responsible for their own expenses and/or expert witness fees.

V. Consent to Additional Parties: To the extent that a third party would be a proper party to a dispute between Patient and Physician in a court of law, the parties to this Agreement hereby consent to the joinder and intervention of said third party(ies), provided said third party(ies) consent and adopt the terms of this Agreement.

VI. Statute of Limitations: A dispute by either Patient or Physician shall be waived and forever barred if written notice of a demand for binding arbitration in accordance with this Agreement is not made within three (3) years of the date the underlying injury was discovered. Notwithstanding this provision, in no event will either party have a claim for damages if notice of a demand for binding arbitration is not made within five (5) years of the date that the underlying treatment and/or services were rendered.

VII. Cap on Damages: Any decision rendered under the terms of this Agreement shall be subject to the applicable statutory cap on non-economic damages as set forth in Maryland Code, Courts & Judicial Proceedings Article, Sections 3-2A-09 (2006) and 11-108 (2006). Furthermore, Physician shall maintain an insurance policy covering allegations of professional malpractice with minimum limits of one million dollars per incident. Patient hereby agrees to limit his / her recovery for claims covered by this Agreement to the applicable limits of the Physician's coverage. In no event shall any arbitrator have the authority to award punitive damages and/or attorneys fees under this Agreement, as such damages are hereby expressly waived by the parties.

VIII. Exclusions: To the extent a dispute arises between the parties in which the amount in

controversy is within the small claims jurisdiction of the District Court for Montgomery County, Maryland, the terms of this Agreement shall apply and the parties are free to seek legal recourse in the District Court. For the purpose of this exclusion, insofar as it applies to a collections action by the Physician, the “amount in controversy” shall be the balance due to Physician, exclusive of the additional costs, fees and/or interest entitled to Physician in the event of a judgment entered by the District Court. The filing of a small claims action by any party shall have no effect, and will not be construed as a waiver of the terms of this Agreement, as to any other dispute between the parties.

IX. Confidentiality: The parties hereby agree that any arbitration proceeding pursuant to this Agreement, as well as any decision, payment and/or resolution involving a dispute subject to this Agreement, shall be confidential and not disclosed to any third person and/or party except as is required by law.

X. Applicable Laws, Severability & Venue: The parties hereby acknowledge that this Agreement is a binding legal contract entered into between the parties and governed by the laws of the State of Maryland. In the event that any of the terms of this Agreement are deemed to be invalid and/or contrary to Maryland law, said terms shall be severable from the Agreement with the remaining terms given their full force and effect. To the extent that further legal action is necessary to resolve a dispute between the parties, the parties hereby agree and acknowledge that Montgomery County Maryland shall be the proper venue for said action.

XI. Right to Rescind: Either party has the right to rescind this agreement within ten (10) business days by providing written notice in accordance with Rule 1-121 of the Maryland Rules of Civil Procedure (2006).

This Agreement, which totals four (4) pages, contains all terms agreed upon between Patient or Patient’s Legal Guardian and Physician with respect to binding arbitration. By signing below, Patient acknowledges having had the opportunity to review this Agreement in its entirety, ask questions, have it reviewed by independent counsel of the Patient’s own choosing (if desired) and consents to the terms as set forth above.

Patient Name

D.D.S and/or
Authorized Representative

Patient or Authorized Representative Signature

Date: