PATIENT INFORMATION

Doctor _____

Date _____ Account No. _____

Patient's Name Last	First	Middle Initial	Social Security No.

Street Address	City and State	Zip Code

P.O. Box	City and State	Zip Code

Home Phone No.	Cell Phone No.	E-mail Address
( )	( )	

Date of Birth	Age	Sex	Marital Status S M D W	Who referred you?

Patient's Employer	Occupation	Business Phone
		( )

Employer's Street Address	City	State	Zip Code

Spouse's Name	Spouse's Employer	Employer's Street Address City State Zip Code

Spouse's Occupation	Spouse's Date of Birth	Spouse's Cell Phone No.	Spouse's Social Security No.
		( )	

In Case of Emergency Contact (Not living with you)	Relationship	Contact's Home Phone	Contact's Cell Phone
		( )	( )

Contact's Street Address	City State Zip Code

Primary Care Provider	Referring Provider (if different from Primary Care Provider)

IF THE PATIENT IS A MINOR OR STUDENT

Mother's Name	Street Address, City, State, and Zip Code	Home Phone No.
		( )

Mother's Employer	Occupation	Cell Phone	Business Phone No.
			( )

Employer's Street Address, City, State and Zip	Social Security No.

Father's Name	Street Address, City, State, and Zip Code	Home Phone No.
		( )

Father's Employer	Occupation	Cell Phone	Business Phone No.
			( )

Employer's Street Address, City, State and Zip	Social Security No.

INSURANCE INFORMATION

Primary Group Insurance Company Name and Address	Name of Policy Holder

Policy Number	Group Name	Group Number

Medicaid Number	State	Medicare Number

Secondary Group Insurance Company Name and Address

Insured Date of Birth	Name of Policy Holder	

Policy Number	Group Name	Group Number

CLINIC – PHYSICIAN – PATIENT ARBITRATION AGREEMENT

_____("Patient"), engages Gastrointestinal Associates and Endoscopy Center or employee thereof, and each Physician that renders medical care and services to perform services in conjunction with Patient's medical care. For and in partial consideration of the rendition of any and all present and future medical care and services, Patient agrees that in the event of any dispute, claim or controversy arising out of or relating to the performance of medical services, including but not limited to, patient fees, informed consent, negligence or medical malpractice, between Patient (whether a minor or an adult) or the heirs-at-law or personal representative of Patient, as the case may be, and the Gastrointestinal Associates and Endoscopy Center and each Physician individually, where the claim or the amount in controversy exceeds $5,000, such dispute or controversy shall be submitted to JAMS (Judicial Arbitration and Mediation Services, Inc.), or it successor, on an arbitration form for final and binding arbitration. All claims for unliquidated damages shall be deemed claims for in excess of $5,000.

Either party may initiate arbitration of any matter subject to arbitration by filing a written demand for arbitration at any time. Patient shall be entitled to an in-person hearing in his or her county in accordance with the Federal Arbitration Act. The arbitration shall be administered by JAMS pursuant to its Comprehensive Arbitration Rules and Procedures and Minimum Standards of Procedural Fairness, and all parties agree to be bound by the arbitrator's decision. Any decision by the arbitrator(s) shall be accompanied by a reasoned opinion. Judgment may be entered on the arbitrator's award, if any, by any court having jurisdiction of the subject matter.

All parties agree that their relationship affects interstate commerce and that this Agreement shall be governed by the Federal Arbitration Act, and, if not, by Mississippi law. The party requesting arbitration shall bear all costs of the arbitration, except the Patient is not required to pay any more than $125.00, with Gastrointestinal Associates and Endoscopy Center bearing the other arbitration costs.

This Agreement may be rescinded by written notice by either party within fifteen (15) days of signature. However, any claim or dispute related to medical services rendered after execution of this Agreement and prior to the date of such written notice of rescission shall be subject to the terms of this Agreement. Written notice of such rescission may be given by a guardian or conservator of Patient if Patient is a minor or incapacitated. If any portion of this Agreement is found unenforceable, that portion shall be stricken and the remainder of this Agreement fully enforced. If a court rules that the dispute must be litigated and not arbitrated, Patient agrees the suit will be heard in the county where services are rendered.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY CLAIM OF NEGLIGENCE OR MEDICAL MALPRACTICE DECIDED BY NEUTRAL BINDING ARBITRATION AND YOU ARE GIVING UP YOUR STATUTORY AND CONSTITUTIONAL RIGHT TO A JURY OR COURT TRIAL.

If a parent or guardian has signed on behalf of their minor child or ward, such parent or guardian hereby attests that he or she has full legal authority to execute this Arbitration Agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless the Clinic from any claim, demand or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

A photo static or electronic copy of this authorization shall be considered as effective and as valid as the original.

SIGNATURE OF PATIENT/GUARDIAN

By: _____ Date: _____

For Office Use Only

Witness Signature: _____ Date: _____