ClearAll

PATIENT INFORMATION

Doctor None

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	Who referred you?
		Other	Other	

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
	Spouse		

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

The undersigned Patient ("Patient") hereby engages GI Alliance (formally known as Texas Digestive Disease Consultants, PLLC), together with any subsidiary and any associated Physicians, PA's NP's, Member(s) or employee(s) thereof (hereinafter collectively referred to as "Clinic"), together with each person that renders medical care or performs 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 or allied health 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(s) of Patient, as the case may be, and the Clinic, or any subsidiary and any associated Physicians, PA's, NP's, Member(s) or employee(s), where the claim or the amount in controversy exceeds $5,000, such dispute or controversy shall be submitted to JAMS, or its successor, on an arbitration form for final and binding arbitration. This Agreement further applies to any claim that derives or arises from injuries or damages to the patient which is asserted against the Clinic or any of its subsidiaries, Physicians, Members or employees, including loss of consortium or wrongful death. 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 arbitration at a location in the Jackson metropolitan area pursuant to 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 Clinic bearing the other arbitration costs. Each side will pay its own attorney's fees and litigation costs.

The arbitration proceedings or any award or judgment arising therefrom shall be confidential. Should the award need to be filed with a court for confirmation or enforcement purposes, the award shall be filed under seal and will remain under seal unless not satisfied within twenty (20) days of the later of the filing of the Motion to Confirm the Award or the conclusion of any appeal which may be taken by agreement of the parties pursuant to JAMS Optional Arbitration Appeal Procedure, if applicable.

If you are not willing to submit to binding arbitration, the Clinic may perform the services or refer you to another health care provider capable of rendering the medical care or services which you require (although Clinic and Physician assume no responsibility for the quality of care or service rendered by any other health care provider). **Please inform a Clinic representative immediately if you do not agree to binding arbitration and desire such referral.**

This Agreement, which specifically applies to any care provided after execution of the 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 prior to the date of such written notice of rescission shall be subject to the terms of this Agreement or any subsequent agreement that may be executed. This Agreement shall stay in full force and effect until rescinded. 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 Circuit Court of Rankin County, Mississippi.

This Agreement is binding upon the undersigned's spouse, heirs, administrators, executors, personal representatives, successors, and assigns and the undersigned's spouse (if any) acknowledges this. A photostatic or electronic copy of this authorization shall be considered as effective and as valid as the original.

NOTICE: BY SIGNING THIS AGREEMENT, 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.

This the _____ day of Blank , 20_____.

GI ALLIANCE (formally known as Texas Digestive Disease Consultants, PLLC)
and any subsidiary and any associated Physicians, PA's, NP's, Member(s) or employee(s)

_____
Patient

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 Agreement on behalf of said child or ward. Furthermore, said parent or guardian hereby agrees to indemnify and hold harmless the Clinic, the Members, and their employees and Physicians from any claim, demand or loss which may occur in the event said parent or guardian does not, in fact, have such legal authority.

By:_____
Parent or Guardian