The Vein Clinic (of Santa Barbara) (of Imperial Valley)

CONDITION OF SERVICES

1. Voluntary Arbitration: ARTICLE 1. It is understood that any dispute as to medical malpractice, that is as to whether any medical service 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 right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
Initials:__________
2. Consent to Treatment: The patient identified below consents to the procedures which may be performed while under the care of his/her physician, which may include but are not limited to medical and surgical treatment or procedures, or anesthesia under the general and special instructions of the patient's physician or surgeon.
3. Medicare Patient's Assignment of Benefits and Release of Information: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges of the physician for his/her services. I understand I am responsible for any remaining balances.
4. **Consent to Photography/Videotaping:** The Vein Clinic is permitted to take pictures of the medical or surgical progress involving the patient and use same for scientific, educational or research purposes. The patient consents to routine photography related to patient care.
5. Personal Valuables: It is understood and agreed that Vein Clinic and physicians shall not be liable for the loss or damage to any money, jewelry, documents, fur garments, dentures, hearing aids, eyeglasses, prosthetics or other articles of unusual value and small size and shall not be liable for loss or damage to any other personal property.
6. Financial Obligation: I understand that I am responsible to the Vein Clinic for all charges incurred by me and not paid by third party benefits. In the event that said bill, or any part thereof, is deemed delinquent by the practice, I understand that I will be responsible for collection of expenses as well as reasonable attorney's fees and court costs if a suit is instituted. All delinquent accounts shall bear interest at the maximum rate allowed by law.
7. Release of Information: The Vein Clinic physicians will obtain the patient's consent and authorization to release protected health information concerning the patient, in accordance with HIPPA regulations, except in those circumstances when it is permitted by law to release information.
8. Canceling Appointments: I understand that if I am unable to keep my scheduled appointment time, failure to notify the Vein Clinic staff 24-hours before my scheduled appointment will result in a **$100.00 cancellation fee.**
APPOINTMENTS THAT REQUIRE AN HOUR OF PHYSICIAN-TIME (INCLUDING BUT NOT LIMITED TO: ENDOVENOUS LASER AND PHLEBECTOMY) MUST BE CANCELLED WITH 48 HOURS NOTICE. FAILURE TO DO SO WILL RESULT IN $150 CANCELLATION FEE.
Initials:__________
9. Severability: If any terms or conditions of this agreement are held by a court of law to be invalid or unenforceable, then this agreement, including all of the remaining terms and conditions, will remain in full force and effect as if such invalid or unenforceable term or condition had never been included.
Initials:__________
10. REFUNDS: ANY REFUND DUE WILL BE PAID OVER 3 (THREE) EQUAL MONTHLY PAYMENTS.

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.

Patient Name (PRINT)	Patient Signature	Date
Witness Name (PRINT)	Witness Signature	Date
Translator Name (and relationship to patient)	Translator Signature	Date