NOTICE OF PRIVACY PRACTICES
ACKNOWLEGEMENT AND CONSENT FORM

I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA),** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as the business aspects of running the practice on a daily basis.

I have received, read, and understand your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice Of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____

Signature:_____

Relationship to Patient: _____

Date:_____

Witness:_____

Orange Coast Oral & Maxillofacial Surgery
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DOCTOR - PATIENT ARBITRATION AGREEMENT

1. It is understood that any dispute as to medical and dental malpractice, that is as to whether any medical and dental 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 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.

2. I voluntarily agree to submit to arbitration any and all claims involving persons bound by this agreement, as set forth herein, whether those claims are brought in tort, contract, for punitive damages or otherwise. This includes, but is not limited to, suits for personal injury, breach of contract, actions to collect debts, or any kind of civil action.

3. I understand that this agreement binds me, my non-signing spouse, my heirs, or personal representatives on one hand and the Undersigned Doctor (collectively defined as: Ron An Vuong D.D.S., M.D., An Vuong D.D.S., M.D., An Vuong INC, Dieu Pham D.D.S., M.D., dba "doing business as" Orange Coast Oral & Maxillofacial Surgery, and dba Orange Coast OMFS) and his, her or their corporation, limited liability company or partnership, if any, and his, her or their employees, agents, partners, officers, directors, members, shareholders, contractors, heirs, assigns, or personal representatives, and any substitute doctor on the other hand. I also consent to the intervention or joinder in the arbitration proceeding of all parties relevant to a full and complete settlement of any dispute arbitrated under this agreement.

4. I agree to accept medical and dental services from the Undersigned Doctor and to pay therefore. I UNDERSTAND THAT IF I DO NOT SIGN THIS AGREEMENT, THE UNDERSIGNED DOCTOR WILL NOT PROVIDE ME WITH ANY SERVICES. IF I DO SIGN THIS AGREEMENT, BUT CHANGE MY MIND WITHIN 30 DAYS OF TODAY, I MAY REVOKE THIS AGREEMENT BY GIVING WRITTEN NOTICE TO THE UNDERSIGNED DOCTOR WITHIN THAT TIME STATING THAT I WANT TO WITHDRAW FROM THIS ARBITRATION AGREEMENT. If I timely revoke this arbitration agreement, the Undersigned Doctor will cease providing me any services, other than emergency services or those services necessary to avoid abandonment. After those 30 days, this agreement may be changed or revoked only be written revocation signed by both parties.

5. I acknowledge that I have been given adequate time to read, ask questions concerning, and understanding the terms of this agreement. I acknowledge that I have been advised to seek independent legal advise before entering into this agreement and have been given adequate time to do so.

6. This agreement is retroactive and governs all past and future services the Undersigned Doctor has previously or may later perform for me.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE AN ISSUE OF MEDICAL / DENTAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT.

I CERTIFY THAT I SPEAK, READ AND WRITE ENGLISH.

IF NOT, I CERTIFY THAT THIS CONTRACT HAS BEEN EXPLAINED TO ME THOROUGHLY IN MY NATIVE LANGUAGE (VIETNAMESE / SPANISH / OTHER: _____).

Patient's Signature: _____ Date: _____

Print Patient's Name: _____

If the patient is a minor or an incompetent person: I, _____, as parent of or legal guardian of or responsible person authorized by the parent of the patient, and responsible for the patient, have read and understood the above arbitration agreement, including the first article and the NOTICE. I have discussed this agreement and its terms with the patient in order that he or she may know of and understand it to the limit of his or her ability. On behalf of the patient, I agree to bind him or her to the above arbitration agreement. If the patient continues to be unable to exercise his or her rights for thirty (30) days from the date of this agreement, then my decision or the decision of his or her parent or legal guardian whether or not to revoke this agreement shall bind the patient. I understand that the decision to revoke this agreement, whether made by me or by the patient's parent or legal guardian, shall be made by written notification thereof to the Undersigned Doctor within thirty (30) days.

Patient's Parent or Legal Guardian's Signature: _____ Date: _____

Print Parent or Legal Guardian's Name: _____

Address: _____ Home Phone: _____

_____ Business Phone: _____

Doctor's Signature: _____ Date: _____