KRISTINA MCLEAN, MD
MARYBETH LEWIS-BOARDMAN, MD
ALANA MCGEE, MD
GISELLE TORRES, MD
DEBRA ORTIZ, MD
TIFFANY KNIGHTLY, DNP

Women's Care Florida

The Women's Centre for Excellence

2400 HOOKS ST.
CLERMONT, FL 34711
PH: 352-241-6460
FAX: 352-241-6461

Consult Form

Name: _____ DOB: ___/___/_____

Current Address: _____

Phone: _____ Alt. Phone: _____

Current Medications: _____

Allergies: _____

- Are you or could you be pregnant? ☐ No ☐ Yes ☐ Actively Trying
- Do you have a history of any sexually transmitted infections? ☐ No ☐ Yes: _____
- Do you have a history of Keloid scaring? ☐ No ☐ Yes
- Have you taken Accutane or any Anticoagulants in the last 6 months? ☐ No ☐ Yes
- Have you had sun exposure, used tanning creams or tanning beds in the last 4-6 weeks? ☐ No ☐ Yes

Skin Evaluation

Your Skin type is: ☐ Dry ☐ Normal/Combination ☐ Oily ☐ Acne

What skin care products do you currently use?

Cleansers: _____ Toners: _____

Moisturizers: _____ Sunscreens: _____

Masks/Scrubs: _____ Make-Up: _____

Other: _____

What are your main concerns: ***(Please check all that apply)***

☐ Acne ☐ Uneven Skin Tone ☐ Preventing Skin Cancers ☐ Sun Damage ☐ Large Pores ☐ Loose Skin

☐ Scars ☐ Wrinkles ☐ Insufficient Lashes ☐ Age Spots ☐ Dark Eye Circles ☐ Lip Lines ☐ Cellulite

Please check all of the procedures that interest you:

☐ Chemical Treatments ☐ Botox/Xeomin ☐ Photo Rejuvination ☐ Hair Removal ☐ Vibraderm

☐ Microneedling ☐PRP Therapy ☐ Venus Legacy ☐ Facial Waxing

☐ Facial Vein Treatments ☐ Cosmetic Fillers ☐ Fractional Laser ☐ SculpSure Fat Removal

Emergency Contact: _____ Phone #: _____

Who may we talk to regarding your appointments? _____

PLEASE READ BE AWARE OF THE FOLLOWING STATEMENT BEFORE SIGNING.

I understand that under Florida State Law **ALL** prescription products are **non-refundable**. This includes, but is not limited to: Obagi Products, Products containing Hydroquinone, Retin A or Metronidazole & Latisse.

Please email me information about Medspa updates and sales to: _____

X **Patient Signature:** _____ Date: _____

Women's Care Florida
Exceptional Women's Care for Every Patient, Every Time

NEW PATIENT REGISTRATION FORM

Acct#:_____

Today's Date_____
Social Security #_____ **Email**_____

Last Name_____ **First**Name_____ MI____

Nickname/Maiden Name_____

Address_____
Apt/Unit #_____

City_____ State_____ Zip_____

Home Phone (_____)_____ Work Phone (_____)_____ **Cell Phone** (_____)_____

Age_____ Date of Birth_____/_____/_____ Marital Status: ☐Single ☐Married ☐Divorced ☐Other

Gender: ☐F ☐M

Race: **(Optional)** ☐Black ☐White ☐Asian ☐Hispanic ☐Other

Employer _____

Occupation_____

How did you hear about us? : ☐Personal Reference_____
☐Physician_____ ☐Internet ☐Yellow Pages ☐Newspaper/ Magazine/ Television
☐Other _____

EMERGENCY CONTACT

Name_____ Relationship_____

Home Phone (_____)_____ Work Phone (_____)_____Cell Phone (_____)_____

INSURANCE INFORMATION

Primary Insurance Company Name_____
Phone # (_____)_____
Insured Name (if other than self) _____
Relationship_____

Social Security # _____
Date of Birth_____/_____/_____

Policy/Member #_____
Group #_____

Employer Providing Insurance_____

Secondary Insurance Company Name_____
Phone # (_____)_____

Insured Name (if other than self) _____ Relationship_____

Social Security # _____
Date of Birth_____/_____/_____

Policy/Member #_____
Group #_____

Employer Providing Insurance_____

PRIMARY CARE PHYSICIAN

Name_____ Phone # _____

PHARMACY

Name_____ Phone #_____

PHI DISCLOSURE

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below the name(s) of the individual(s) you authorize our office to discuss your care with. Your PHI will be disclosed to the individual(s) listed below unless you notify us otherwise in writing.

_____ _____

_____ _____

Please specify anything that you do NOT want to be released:

_____

I understand this authorization extends to all or any part of my medical record, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol /drug abuse and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on the authorization. I understand that my PHI used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my PHI may no longer be protected by law. **Parents/Guardians: Minor patients may consent to certain services and limit access to certain protected health information such as care related to pregnancy, birth control, STIs/STDs, and HIV under state law.**

INSURANCE AUTHORIZATION, RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize Women's Care Florida to furnish and/or release any information necessary to insurance carriers concerning my illness and treatments, and I hereby assign to the physician(s) all payments for medical services rendered to myself or my dependents. It may be used to process my insurance claim acquired in the course of my examination or treatment, to allow a photocopy of my signature to be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Women's Care Florida on behalf of myself and/or my dependents, and I understand by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I further understand that fees are due and payable on the date services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) including Medicare, Medigap, private insurance and any other health/medical plan to issue payment directly to Women's Care Florida, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand I am responsible for any amount not covered by insurance, regardless of insurance coverage.

CONSENT TO TREAT

The purpose of medical care is to facilitate the treatment of disease, injury and disability. Medical services are provided through examination, testing and use of procedures to the aid of diagnosis or treatment of a medical condition or conditions. I request and authorize Women's Care Florida to provide me with medical services as described above. I agree to cooperate fully and to participate in all medical procedures and to comply with the plan of medical care/services that is established.

I acknowledge I have received a copy of the Women's Care Florida "Notice of Privacy Practices". I have read and understand all of the above and agree to comply.

Date_____ **Signature**_____

Responsible Party Signature (required if patient is under 18):

_____

To be completed by office staff, if applicable:

On this date the patient presented for treatment and was provided with a copy of the practice's Notice of Privacy Practices. Although a good faith effort was made to obtain a written acknowledgement of receipt of Notice of Privacy Practices, one was not obtained because:

____ Patient refused to sign.

____ Patient was unable to sign or initial because: _____

_____

Responsible Party – Adult present signing consent to treat

Relationship to Patient_____

Last Name_____

First Name_____ MI_____

Social Security # _____ Date of Birth____/____/____

Gender ☐F ☐M

Address_____

Apt/Unit #_____

City_____ State_____ Zip_____

Home Phone (_____)_____ Work Phone (_____)_____

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MaryBeth Lewis-Boardman, MD
Alana McGee, MD
Debra Ortiz, MD
Giselle Torres, MD
Tiffany Knightly, DNP

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We thank you for choosing The Medspa at The Women's Centre for Excellence with your aesthetic Medspa needs. Our mission is to provide you with the highest level of professional care, and one important aspect in providing optimal care is having an understanding of our policies and your financial responsibilities. Our office requires that all clients read and sign the Authorization and Consent for Treatment Form, acknowledging full understanding of our policies prior to receiving any aesthetic/medical services.

First Visit

If this is your first visit with us, please arrive 15 minutes prior to your appointment to allow ample check-in time, as we do have intake and client consent forms for each of our separate procedures. Upon request, we are able to email forms to you to save on time. Patients coming in for injectable services and consults with Dr. McLean, Dr. Lewis or Dr. McGee are subject to a **$50 consultation fee**. This fee will be applied towards any purchase made that day only.

Client Responsibility

Client is responsible for the payment of their services rendered. Payment is expected at the time of service for all charges toward current visit, as well as any previous balances (ex: late, no-show fees). We accept cash, check, Visa, Master Card, Discover, American Express and Care Credit. There is a $30 fee on all returned checks.

Late Policy

We ask that clients please arrive 10-15 minutes early so that we may start your service on time. A late arrival may reduce your appointment time out of respect to the clients scheduled after you. We will make every effort to accommodate your full appointment, but this is not always possible based on our schedule. Lateness beyond 15 minutes, your appointment **WILL** be cancelled, and you will be responsible for the **$25 No Show Fee**.

Cancellations / Rescheduling Policy

The most valuable thing that you can give someone is your time, and we fully believe that everyone's time should be respected. That being said, we ask that you please give us a 24 hour notice of a need to cancel or reschedule your appointment (48 hours for groups of two or more), so that we are able to readjust our schedule accordingly.
A failure to do so will result in the following:

-**Late Cancellations** –Those attempting to cancel within less than 24 hours of appointment time will be charged a $25 Late Cancellation fee.

-**"No-shows"**- Clients who are not present for their appointment will be considered a No-show, and charged a $25 No Show Fee per half hour of booked appointment. No show fees must be payed prior to receiving any future service.

- Repeated No-Shows / Cancellations - Clients who have received 3 No-shows and/or Late Cancellations will be required to pay a $25 deposit per half hour to book any future appointments along with any past due balances, this fee will be deducted from the cost of that day's service. If you are coming for a prepaid service you may also choose to forfeit one of your prepaid treatments in lieu of this fee. A continued history of no-shows may result in a dismissal from The Medspa at The Women's Centre for Excellence. Consultation visits that are repeatedly cancelled will count towards the patient's no-show record and may result in refusal to schedule future appointments. In accordance with state guidelines, a patient may be discharged from the practice following three (3) no-shows in a one-year period (365 Days)

Changes in Scheduled Service

Sometimes clients ask to change their service after arriving at The Medspa, and while most times we are able to accommodate this change, occasionally we are unable to do so given the amount of time scheduled and change in set up (ex: Deciding to get Microneedling which lasts an hour or more vs. a chemical peel which takes 20 minutes). So that we are able to give you the best treatment possible, we ask that you please call 24 hours in advance to discuss any changes to that you would like to make to your scheduled service.

Product Refund Policy

All of our Skincare products are Physician grade products and are non-refundable. By Florida State Law (F.S. 465.005, 64 B 16-28.118) prescription grade products are not able to be returned for ANY reason. This includes, but is not limited to, any product containing 4% Hydroquinone (which can be found in some Obagi & Glytone), Tretinoin or Retin-A, Metronidazole, Latisse or any of our vitamin and supplements.

PREPAID PACKAGED SERVICES

All packages must be started within 3 months up purchase date and used within 18 months of the purchase date. Any treatments not performed within the 18 months will be forfeited, unless you can provide a doctors not as to why you need an extension of this time. (Ex. Pregnancy, prolonged medical treatment of a medication that is contraindicated to your treatment with a doctor's note, etc.) In the event you are no longer able to receive a prepaid treatment, you may gift remaining treatments to a friend or relative or we will calculate what you would have paid individually for the treatments you have already received and deduct that from what you paid for that package. The difference is what you would receive as a refund since you will no longer be getting the package deal.

AGE REQUIREMENT AND CHILDREN

We love teaching children and teens about starting with the right skin care at a young age, so we do allow them to enjoy certain spa treatments with the following conditions: Children under 16 must be accompanied by an adult and all children under the age of 18 must have a parent or guardian give signed consent acknowledging that they understand the treatment and give full consent. And while this is a family-friendly practice, we do like to maintain a peaceful and safe atmosphere, especially when we have multiple clients visiting with us. It is the adult's responsibility to monitor the behavior of their child/children and assist us in keeping this a calm environment.

SPECIAL CONDITIONS

Certain treatments may not be advisable for all clients, so please be sure to inform us of any medical conditions, pregnancy, or special requests when you book your appointment.

We understand that there may be conditions outside of your control that require you to miss an appointment or may cause you to be late (ex. Wake up to a sick child, get a flat tire, etc.) In such case we appreciate a call ASAP so we may reuse that time with another client instead of waiting for someone who is not coming We can then rebook your appointment and we may waive one $25 last minute cancellation fee at the discretion of the office. This can only be done once.

I, _____, understand, agree to the above policies and understand neglecting to adhere to these policies may result in extra fees being placed on my account that must be paid before any future services may be performed.

Patient Signature: _____ Date: _____

Witness Signature: _____

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Medical History

1. Do you have any current or chronic medical illness we should know about?

   _____

2. Are you currently under a doctor's care? If so, why?

   _____

3. Do you take or use any medications, herbal or natural supplements, or topical on a regular daily basis?

   _____

4. Do you have any allergies to medications, foods, latex or other substances?

   _____

5. Have you ever had any surgeries?

   _____

6. Are you or could you be pregnant?

   _____

7. Do you have a history of Herpes Type 1 or 2 in the area being treated? (Cold Sores)

   _____

8. Have you taken any Accutane or Anticoagulants in the last 6 months?

   _____

9. Do you have permanent make-up, implants or tattoos?

   _____

10. Have you had unprotected sun exposure, used tanning creams or in tanning beds in the last 4-6 weeks?

    _____

Signature: _____ Date: _____

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Confidentiality Questionnaire

1. Please list the family members and/or other person(s), if any, whom we may inform about your general medical condition and diagnosis (including treatments, payment and healthcare options.)

   _____
   _____
   _____

2. Please list family members and/or significant others if any, whom we may inform about your medical condition **ONLY IN CASE OF EMERGENCY**.

   _____
   _____
   _____

3. Please print the address where you would like your correspondence sent from our office, if other than your home address: _____
   _____

4. Please indicate if you want all correspondence from our office to be sent in a sealed envelope marked **"CONFIDENTIAL."** **Yes** _____ **No** _____

5. Please print the telephone number where you wish to receive calls regarding your appointments, lab and test results or health care information if other than your home phone: (_____)_____-_____

6. May we leave a message on your answering machine regarding your appointments, lab and test results or other health care information? **Yes** _____ **No** _____

(Please be aware that a cell phone is not a secure and/or private line.)

_____ _____
Patient's Printed Name **Signature of Patient or Guardian**

_____ _____
Date **Witness**

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Patient Name: _____ Date: _____

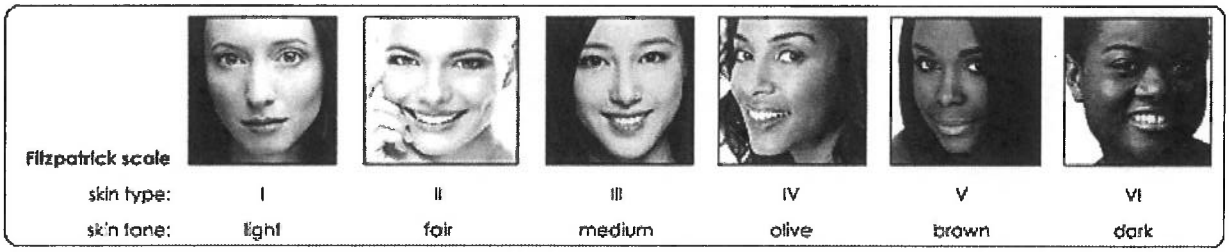
Fitspatrick Scale Questionnaire

Score	Questions	0	1	2	3	4
	What is your eye color?	Light Blue, Gray or Green	Blue, Gray or Green	Blue	Dark Brown	Brown/ Black
	What is your natural hair color?	Red	Blonde	Chestnut, Dark Blonde	Dark Brown	Black
	What is your skin color on unexposed skin?	Reddish	Very Pale	Pale w/ Beige Tint	Light Brown	Dark Brown
	Do you have freckles on unexposed skin?	Many	Several	Few	Incidental	None
	What happens when you stay in the sun too long?	Blisters, Redness, Peeling	Burn followed by peeling	Burn sometimes then peel	Rarely Burn	Never Burn
	To what degree do you tan?	Hardly at all	Light color tan	Reasonably tan	Tan very easily	Dark brown tan
	Do you turn brown after several hours in the sun?	Hardly ever to not at all	Seldom	Sometimes	Often	Always
	How does your face respond to sun?	Very Sensitive	Sensitive	Normal	Very Resistant	Never had a problem
	When did you last expose your skin to the sun, tanning bed or sunless tanners?	More than 3 months ago	2-3 months ago	1-2 months ago	Less than 1 month ago	Less than 2 weeks ago
	Do you expose the area to be treated to the sun?	Never	Hardly ever	Sometimes	Often	Always

Total Skin Type

Score	Fitzpatrick Type	Ethnicity Examples
1-7	I	Celtic, Irish
8-16	II	Darker Caucasian
17-25	III	Lighter Mediterranean
26-30	IV	Dark Italian, Greek, Asian, Hispanic, Light Middle Eastern
>30	V or VI	Darker Middle Eastern, African American

Score: _____ Reviewed by: _____



WOMEN'S CARE FLORIDA

The Women's Centre for Excellence

& Medi-Spa

RETURN POLICY

By law, The Women's Centre for Excellence & Medi-Spa is unable to accept returns of any of our medical grade Products, i.e. Obagi, Latisse, Image, etc. or any vitamins/supplements.

I have read and understand this policy.

_____
Print Patient's Name

_____ _____
Patient's Signature Witness' Signature

_____
Date

Florida State Law does not allow the return of any prescription medications.
Florida Pharmacy State Citation
F.S. 465.005, 64 B 16-28.118

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Consent for Photography

Please carefully read over the following and choose one option. It is required that you agree to one of the following paragraphs to have any procedures done in our office. Thank you for your cooperation.

I, _____, herby authorize The Women's Centre for Excellence to take photographs of the work performed both before and after my treatment. I agree that these photographs will remain the property of The Women's Centre for Excellence. I further authorize The Women's Centre for Excellence to keep these photos in my chart to track my progress.

Initial: Agree: _____ Decline: _____

I hereby authorize The Women's Centre for Excellence to use the above mentioned pictures for in office before and after books seen by other patients and/or general use lectures for our staff.

Initial: Agree: _____ Decline: _____

I hereby authorize The Women's Centre for Excellence to use the above mentioned photographs for the purpose of advertisement. I am aware in such publication or use I will not be identified by name.

Initial: Agree: _____ Decline: _____

I am aware if at any point in time I no longer wish to give release for my photos for purposes other than for in office training purposes I am able to sign a new release with these changes that may be effective immediately.

Patient Signature: _____ Date: _____

Legal Guardian: _____

Witness Signature: _____ Date: _____

Women's Care Florida

Exceptional Women's Care for Every Patient. Every Time

BY SIGNING THIS AGREEMENT YOU ARE WAIVING YOUR RIGHT TO A JURY TRIAL AND YOU ARE AGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT

ARBITRATION AGREEMENT FOR CLAIMS ARISING OUT OF OR RELATED TO MEDICAL CARE AND TREATMENT

1. AGREEMENT TO ARBITRATE CLAIMS REGARDING FUTURE CARE & TREATMENT. The patient agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the diagnosis, treatment, or care of the patient by the undersigned provider of medical services, including any partners, agents, or employees of the provider of medical services, shall be submitted to binding arbitration.

2. AGREEMENT TO ARBITRATE CLAIMS REGARDING PAST CARE & TREATMENT. The patient further agrees that any controversy, including without limitation, claims for medical malpractice, personal injury, loss of consortium, or wrongful death, arising out of or in any way relating to the past diagnosis, treatment, or care of the patient by the undersigned provider of medical services or the provider's partners, agents or employees, shall be submitted to binding arbitration.

3. WAIVER OF RIGHT TO JURY TRIAL. BOTH PARTIES TO THIS AGREEMENT, BY ENTERING INTO IT, ARE GIVING UP THEIR CONSTIUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

4. ALL CLAIMS MUST BE ARBITRATED BY ALL CLAIMANTS. All claims based upon the same occurrence, incident, or care shall be arbitrated in one proceeding. It is the intention of the parties that this Agreement bind all parties whose claims may arise out of or relate to treatment or services provided by the provider of medical services, including the patient, the patient's estate, any spouse or heirs of the patient, and any children of the patient, whether born or unborn, at the time of the occurrence giving rise to the claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. By signing this Agreement, the parties consent to the participation in this arbitration of any person or entity that would otherwise be a proper additional party in a court action.

5. ARBITRATION PROCEDURES. The parties agree and recognize that the substantive provisions of Florida Statutes, Chapter 766, governing medical malpractice claims shall apply to the parties and/or claimant(s) in all respects, except that at the conclusion of the pre-suit screening period and provided there is no mutual agreement to arbitrate under Florida Statutes, 766.106 or 766.207, et seq. (which remain available if elected by the parties), the parties and/or

claimant(s) shall resolve any claim through arbitration pursuant to this Agreement. Within thirty (30) days after a party to this Agreement has given written notice to the other of a demand for arbitration of said dispute or controversy under this Agreement, the parties to the dispute or controversy shall each appoint an independent arbitrator who is a member of the American Health Lawyers Association and give notice of such appointment to the other. Within a reasonable time after such notices have been given the two arbitrators so selected shall select a neutral arbitrator, who shall be an administrative law judge furnished by the Florida Division of Administrative Hearings, and give notice of the selection thereof to the parties. The arbitrators shall hold a hearing within a reasonable time from the date of notice of selection of the neutral arbitrator. The parties agree that the arbitration proceedings are private, not public, and the privacy of the parties and of the arbitration proceedings shall be preserved.

6. NICA. Nothing in this Agreement shall be construed as a waiver of any law related to Florida's Birth-Related Neurological Injury Compensation Plan (Florida Statutes 766.301 - 766.316, hereinafter the "Plan"). If a request to submit a claim to the Plan is made by any party to this Agreement, all arbitration proceedings shall be stayed until it is determined whether the claim filed with the Plan is compensable. In accordance with the Plan, claims for "birth-related neurological injury", as defined by the Plan, shall be the exclusive remedy except that a civil action shall not be foreclosed and shall be submitted to binding arbitration in accordance with this Agreement where there is clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety or property, provided that such suit is filed prior to and in lieu of payment of an award under the Plan and provided that such suit shall be filed before the award of the Division of Administrative Hearings becomes conclusive and binding.

7. ARBITRATION EXPENSES. Each party shall bear the cost of her/its own attorneys' fees, the costs of presenting her/its case, and her/its arbitrator. Any cost associated with the neutral arbitrator shall be shared equally by the parties, to the extent not provided by the State Department of Administrative Hearings. Other costs of the arbitration (e.g. of securing a location for the arbitration, court reporter, etc.) shall be paid by Women's Care Florida, LLC.

8. APPLICABLE LAW. Except as herein provided, the arbitration shall be conducted and governed by the provisions of the Florida Arbitration Code, Florida Statutes, Section 682.01 et seq. In conducting the arbitration under Florida Statutes, Section 682.01 et seq., all substantive provisions of Florida law governing medical malpractice claims and damages related thereto, including but not limited to, Florida's Wrongful Death Act, the standard of care for medical providers, the applicable statute of limitations and the application of collateral sources and setoffs shall be applied. Except as otherwise provided by law, interest shall only accrue after an award by the arbitration panel. Post-decision interest shall be computed in a manner consistent with other civil claims. The provisions of Fla. Stat. § 768.81 regarding comparative fault shall apply.

BY SIGNING THIS AGREEMENT YOU ARE WAIVING YOUR RIGHT TO A JURY TRIAL AND YOU ARE AGREEING TO ARBITRATE ALL CLAIMS ARISING OUT OF OR RELATED TO YOUR MEDICAL CARE AND TREATMENT

9. EFFECT OF REFUSAL TO PROCEED WITH ARBITRATION. In the event that any party to this Agreement refuses to go forward with arbitration, the party compelling arbitration reserves the right to proceed with arbitration, the appointment of an arbitrator, and hearings to resolve the dispute, despite the refusal to participate or absence of the opposing party. Submission of any dispute under this agreement to arbitration may only be avoided by a valid court order, indicating that the dispute is beyond the scope of this Agreement or contains an illegal aspect precluding the resolution of the dispute by arbitration. Any party to this Agreement who refuses to go forward with arbitration hereby acknowledges that the arbitrator will go forward with the arbitration hearing and render a binding decision without the participation of the party opposing arbitration or despite that party's absence at the arbitration hearing.

10. SEVERABILITY. If any provision of this Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

11. ACKNOWLEDGEMENTS BY PATIENT. The patient, by signing this Agreement, also acknowledges that he or she has been informed that:

    a. NO DURESS. The Agreement may not be submitted to a patient for approval when the patient's condition prevents the patient from making a rational decision whether or not to agree;

    b. AGREEMENT BASED UPON OWN FREE WILL. The decision whether or not to sign this Agreement is solely a matter for the patient's determination without any influence by the physician or hospital;

    c. BINDING ARBITRATION AND EFFECT ON RIGHT OF APPEAL. Binding arbitration means that the parties give up their right to go to court to assert or defend a claim covered by this Agreement. The resolution of claims covered by this Agreement will be determined by a neutral panel of arbitrators and not a judge or jury. Each party is entitled to a fair hearing, but the arbitration procedures are simpler and more limited than rules applicable in court. Arbitration decisions are as enforceable as any court order. The decision of an arbitration panel is final and there will generally be no right to appeal an adverse decision. However, any party may, within 15 days from a decision of an arbitration panel, file a written request for reconsideration. Any such request for reconsideration shall be based upon (i) a claim that the panel failed to properly apply the law or applicable rules of evidence or (ii) that the procedures specified in this Agreement or Fla. Stat. §§ 682.01, et seq. were not followed. A claim that the panel was incorrect as to the facts, or gave undue weight to certain evidence will not be a basis for a request for reconsideration.

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d. READ AGREEMENT, VIEWED VIDEO, AND UNDERSTOOD. I have read and understand the above Agreement and I have carefully viewed a video program that was presented to me that explained this Agreement to my satisfaction. I understand that I have the right to have my questions about arbitration or this Agreement answered and I do not have any unanswered questions. I execute this Agreement of my own free will and not under any duress.

e. SIGNATURE OF AGREEMENT. This Agreement shall be effective upon the patient's and/or the patient's representative's signature below. Upon such signature, this Agreement shall be deemed to be fully executed and binding upon all parties.

Ignacio Armas, M.D., President of Women's Care Florida, on behalf of Women's Care Florida, LLC, and as an agent of its physicians, partners, agents, and employees.

Patient:

Print name: Date

Patient Signature

Parent or Guardian [if patient is a minor]

Print name Date

Parent or Guardian Signature