**Christopher Unger, MD**

Senior Aviation Medical Examiner

301-332-5252

McLean, VA

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| Name of Patient |  |
| Time of Arrival |  |
| Time of Appointment |  |

Have there been any changes to your address or phone number? No \_\_\_\_\_ Yes \_\_\_\_\_

PLEASE MAKE THE DOCTOR AWARE IF YOU ARE PREGNANT OR ALLERGIC TO ANY MEDICINES.

PLEASE LET US KNOW IF YOU HAVE TRAVELED ABROAD IN THE LAST FEW MONTHS ESPECIALLY AFRICA.

Alternatives for payment for this service, that I have requested from Dr. Unger, have been explained to me.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have chosen to go out of my insurance coverage for this medical service for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I accept the costs that were explained to me prior to this service. I understand that out of Insurance medical services cannot be filed to my insurance plane or network. I am aware that this service may be available from another doctor, clinic or hospital who would file to insurance.

I have been given all necessary paperwork. I have no reason to request further billing statements. I have read the above and I understand its contents.

TYPE OF SERVICE COST

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s signature Witness signature

Date/Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADVANCE DIRECTIVE**

**FORUM SELECTION**

MY OPTION FOR MEDIATION, BINDING ARBITRATION, OR TRADITIONAL LEGAL RELIEF BY JURY

The following interactive agreement is between Christopher Unger, MD and myself. This document will introduce me to arbitration and mediation available in the Commonwealth of Virginia and any state or jurisdiction within the United States. This UNDERSTANDING pertains to any and all medical services, and procedures. In addition, it shall apply to accidents, injuries, and general office liability associated with Dr. Unger (and staff); now and in the future. This understanding applies to all issues or claims under discussion, and to consulting or affiliated doctors working with Dr. Unger. This advance directive is not revocable. [ ]

I. INFORMED AND EXPLAINED CONSENT:

**A**: Dr. Unger has explained to me, all possible risks and complications including: burns/lacerations, injury to dentition (teeth) and/or bones, sore throat, cancer, infection, bleeding and blood loss, blood clots, treatment failure, reaction to anesthetics, including nerve damage, rash, blood clots, gagging, hiccups, cardiac arrest, shock, heart rhythm problems, stress disorder, unforeseen complications, negative cosmetic outcome, scars/keloids, explosions of equipment, death or dismemberment and misplaced or lost documents. I understand that there is no guarantee that medical/surgical procedures will bring relief in all cases, and that results cannot be guaranteed.

**B**: All of my questions have been answered. I will notify Dr. Unger promptly of any change in my condition before and after my visit; and will keep my follow up appointment as scheduled.

II. SIXTY-DAY MEDIATION/BINDING ARBITRATION OR TRIAL BY JURY:

**A [ ] It is agreed by Dr. Unger and myself, that should good faith discussions not resolve a question or issue that arises from medical/surgical care, accidents, injuries, or general liability; then such claim shall be resolved exclusively by mediation AND ARBITRATION**

**B** [ ] Should that fail, by binding arbitration ***I waive trial by judge AND jury.*** Any insurance companies that insure Dr. Unger may be notified if mediation/arbitration is called for. I will bear the cost of mediation or binding arbitration, and the cost of my lawyer. If mediation/arbitration is found in my favor, the largest amount that I may receive will be $4,000.00. [ ]

Mediation/arbitration is understood to be concluded within sixty days from the date of service or procedure. The mediator and arbitrator may be chosen directly by me with Dr. Unger. The choice of mediator/arbitrator will be mutually agreeable between Dr. Unger, myself, my representatives, my heirs and assigns following the rules of the American Arbitration Association. This advance directive supersedes previous advance directives. [ ]

**Under Choice A and B. I understand that I may ask for all or part of $4,000.00 as payment in full.**

C [ ] Traditional legal process with judge and jury

III.

A. SPEEDY RESOLUTION: I may waive my right to mediation or an arbitration panel, or traditional litigation; and may instead, accept an option for a quick settlement, which will be understood to be compensation to me in full.

B. PRE EXISTING CONDITIONS: Any claim, shall be waived and forever barred, for any condition(s) that arose before this medical/surgical service/administrative service accident or injury in question.

C. CHOICE: I have spoken to (consulted with) my personal representative, or lawyer, before signing this agreement, which I do freely, knowingly and voluntarily. All of my questions have been answered to my satisfaction. I have read this memorandum thoroughly, and have had sufficient time to think it through. I have been given a copy of this memorandum for my records.

My reason for my choice is

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have read this document carefully on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. My level of education is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. My level of English is sufficient to the reading and comprehension of this document \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I am of sound mind \_\_\_\_\_\_\_\_\_\_\_.

If patient is a minor, (younger than 18 years of age): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or guardian (please print and sign your name, address, and phone number)

Witness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( name and address)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your lawyer (or personal representative) (name and address)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Christopher Pelham Unger, MD Date & Time

For myself, my family, my heirs and my representatives

Patient has received a copy of this form