PACIFIC
PAIN & WELLNESS GROUP

23150 Crenshaw Blvd.
Torrance, CA 90505
Tel: (310) 437-7399 Fax: (310) 437-7398
www.pacificpaingroup.com

REVIVEX HEALTHCARE, INC.,
PACIFIC MEDICAL & WELLNESS GROUP/PACIFIC PAIN & WELLNESS GROUP
MEDIATION & ARBITRATION AGREEMENT
(SEPARATE FROM CONSENT TO TREATMENT AGREEMENT)

This Agreement to Resolve Disputes by Mediation and/or Binding Arbitration ("Agreement") is made and entered into this day of _____ by and between **REVIVEX HEALTHCARE, INC., dba, PACIFIC MEDICAL & WELLNESS GROUP/PACIFIC PAIN & WELLNESS GROUP** ("PRACTICE") and _____ ("PATIENT"). Collectively known as the "Parties"; individually known as "Party". The Parties wish to work together to resolve any disputes in a timely fashion and in a manner that minimizes both of their legal costs. Therefore, in consideration of the mutual promises contained in this Agreement, PRACTICE and PATIENT hereby agree as follows:

1. **MEDIATION AND/OR BINDING ARBITRATION:** The parties agree that any and all disputes, claims or controversies arising out of or relating to patient care and treatment shall be settled by mediation and/or binding arbitration.

2. **NATURE OF CLAIMS**: Disputes, claims or controversies shall mean, but are not limited to, all claims based on breach of contract, negligence, medical malpractice, tort, breach of statutory duty, patient's rights, any departures from accepted standards of care, and all disputes regarding the interpretation of this Agreement, allegations of fraud in the inducement or requests for rescission of this Agreement. This includes claims against the PRACTICE, its employees, agents, officers, directors, any parent, subsidiary or affiliate of PRACTICE. All claims based in whole or in part on the same incident, transaction, or related course of care and services provided by the PRACTICE to PATIENT shall be arbitrated in one proceeding.

3. **NEUTRAL BODY:** The dispute shall be submitted to the American Health Lawyers Association ("AHLA") through its Alternative Dispute Resolution service. If the matter is not resolved through mediation, then it shall be submitted to the AHLA or its successor, for final and binding arbitration pursuant to the arbitration clause set forth below. If the AHLA process is no longer in existence at the time of the dispute, or AHLA is unwilling or unable to conduct the arbitration, then the parties shall mutually agree on an alternative organization to conduct the mediation or arbitration.

4. **MEDIATION:**
   a **FORM OF REOUEST**: Either party may commence mediation by providing to the other party a written request for mediation, setting forth the subject of the dispute, and the relief requested.
   b **COSTS OF MEDIATION AND/OR BINDING ARBITRATION:** The parties will cooperate with AHLA and with one another in selecting a mediator from the AHLA panel of neutrals and in scheduling the mediation proceedings. The parties agree that they will participate in the mediation in good faith and that they will share equally in its costs.
   c **MEDIATION & CONFIDENTIALITY:** All offers, promises, conduct and statements, whether oral or written, made in the course of the mediation by any of the parties, their agents, employees, experts and attorneys, and by the mediator or any AHLA neutral are confidential, privileged and inadmissible for any purpose, including impeachment, in any arbitration or other proceeding involving the parties, provided that evidence that is otherwise admissible or discoverable shall not be rendered inadmissible or nondiscoverable as a result of its use in the mediation.

5. **BINDING ARBITRATION:**
   a. **INITIATION:** Either Party may initiate arbitration with respect to the matters submitted to mediation by filing a written demand for arbitration to the other Party at any time following the initial mediation session or at any time following 45 days from the date of filing the written request for mediation, whichever occurs first

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("Earliest Initiation Date"). The mediation may continue after the commencement of arbitration if the Parties so desire.

b. **BINDING NATURE OF ARBITRATION:** The decision rendered by the arbitrator shall be final and binding, and judgment on the award, if any, shall be entered in accordance with applicable law in any court having jurisdiction thereof. The decision of the arbitrator shall be binding on all of the parties to the arbitration, and also on their successors and assigns, including the agents and employees of Practice, and all persons whose claim is derived through or on behalf of the Patient, including, but not limited to, that of any parent, spouse, child, guardian, executor, administrator, legal representative, or heir of the Patient.

c. **APPLICABLE LAW:** The arbitration shall follow the substantive law of the state wherein the hearing takes place. This shall include the provisions of statutory law dealing with arbitration, as they may exist at the time of the demand for arbitration insofar as the provisions are not in conflict with this agreement and specifically excepting therefrom sections of the statute dealing with discovery and requiring notice of hearing date by registered or certified mail. If for any reason there is a finding that the California Arbitration Act cannot be applied to this agreement, then the parties agree that they would like this agreement to be subject to the Federal Revised Uniform Arbitration Act.

d. **NOTICE:** Each party shall be deemed to have consented that any papers, notices or process necessary or proper for the initiation or continuation of an arbitration under this agreement.

e. **COSTS OF ARBITRATION.** All expenses of the arbitration shall be shared equally by the parties to this Agreement. Each party agrees to be responsible for their own attorney fees and costs, if any, incurred in relation to this Agreement.

6. **LEGAL REMEDY:** At no time prior to the Earliest Initiation Date shall either side initiate an arbitration or litigation related to this Agreement except to pursue a provisional remedy that is authorized by law.

7. **STATUTES OF LIMITATIONS:** All applicable statutes of limitation and defenses based upon the passage of time shall be tolled until 15 days after the Earliest Initiation Date. The parties will take such action, if any, required to effectuate such tolling.

8. **PATIENT ACKNOWLEDGMENT:** By signing this Agreement, the PATIENT acknowledges that he/she has been informed that:

   a This provision shall not limit in any way PATIENT's right to file formal or informal grievances with the State or Federal government;

   b Signing this Agreement is not a condition of care and treatment will be provided whether or not PATIENT signs this Agreement;

   c This Agreement may not even be submitted to PATIENT for approval when PATIENT's condition prevents him/her from making a rational decision whether to agree;

   d The decision whether to sign the Agreement is solely a matter for the PATIENT's determination without any influence;

   e ***The Agreement waives PATIENT's right to a trial in court and a trial bp a jury for any future legal claims PATIENT may have against the PRACTICE;*** and

   f He/she has the right to seek legal counsel regarding this Agreement.

9. **SEVERABILITY.** If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, in whole or in part, the remaining provisions, and partially invalid or unenforceable provisions, to the extent valid and enforceable, shall nevertheless be binding and valid and enforceable.

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IN WITNESS WHEREOF, the parties, intending to be legally bound, have signed this Agreement as of the date first above written

Idell Plascencia
Authorized Practice Representative

_____
Signature

If Patient is unable to sign this Agreement, then a legal representative of the resident may sign on his/her behalf. The person signing below certifies that he/she has the legal authority to enter into this Agreement on Resident's behalf with the Facility either through presentation of a valid Power of Attorney or a guardianship appointment.

LEGAL REPRESENTATIVE

_____
Legal Representative Signature

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CONTROLLED SUBSTANCES TREATMENT AGREEMENT

I, _____, understand and agree to follow the policies of Pacific Pain & Wellness Group (PPWG) as set forth below. I understand that PPWG is under no obligation to prescribe these medications for me. I also understand that there may be other, more reasonable treatment options available for my condition that my doctor may recommend instead of or in addition to the use of these medications.

DEFINITIONS OF OPIOIDS. BENZODIAZEPINES. STIMULANTS AND OTHER CONTROLLED SUBSTANCES

I understand the definitions of these medications to be:

1. **Opioid** - An opioid medication is a derivative of morphine or similar compound and thus has strong pain-relieving properties.
2. **Benzodiazepine** - A benzodiazepine is a sedative-hypnotic. Its primary role is for the treatment of anxiety.
3. **Other related drugs** - For the purposes of this agreement, "other related drugs" includes medications such as muscle relaxants (e.g., Soma), membrane stabilizers (e.g., Lyrica), and non-narcotic analgesics (e.g., Ultram). These medications may cause sedation, altered mental status, occasionally dangerous withdrawal effects when stopped abruptly, and may have medication interactions similar to or different from opioids or benzodiazepines.
4. **Stimulants** - Stimulants are used to manage symptoms, such as short attention span, impulsive behavior, and hyperactivity.
5. **Controlled Substance** - For the purposes of this agreement, a controlled substance will apply to medications as described above.

RISKS OF OPIOIDS BENZODIAZEPINES AND CONTROLLED SUBSTANCES

I understand that these medications have potential risks with the most significant being:

1. **Physical Dependence—**Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.
2. **Addiction—**Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.
3. **Overdose—**Taking too much of one or more medications may lead to respiratory arrest and death.
4. **Altered Mental Status—**These classes of medications may cause confusion, sedation, drowsiness, problems with coordination, and changes in thinking ability. This may make it unsafe for you to drive a motor vehicle, operate hazardous equipment and machinery, or perform dangerous activities. Other side effects may include but are not limited to, the following: nausea, constipation, unsteadiness, decreased appetite, difficulty urinating, depression, and loss of sexual drive with testicular atrophy (in males).

CONDITIONS OF AGREEMENT

1. I understand that Controlled Substances may be prescribed by my physician only if he determines that such treatment has a reasonable chance of improving my quality of life, ability to participate in work activities, and social activities.
2. I do not currently have problems with substance abuse (drugs and/or alcohol).

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3. I am not involved in the use, possession, diversion, or transport of illegally obtained controlled substances.
4. I agree to use these medications only as prescribed to me and will not take more of these medications than instructed. I agree to not allow other individuals to take my medication nor will I take medication prescribed to another person.
5. I understand the risk of controlled substances to unborn children and will notify PPWG if I am or become pregnant.
6. I will obtain controlled medications only from PPWG and not from any other source unless a true medical emergency exists. I will notify PPWG in advance of any anticipated acute needs (dental work or surgery).
7. I agree to accept generic brands of my controlled substances if available.
8. If it appears to my physician that the use of controlled substances is not providing a demonstrable therapeutic benefit such as improvement in daily function or improved ability to participate in the treatment program, if the controlled substances being prescribed are expected to be the mainstay of pain treatment when other medical options exist and are practical, or that addiction, rapid loss of effect, or significant side effects are developing, I agree to taper my medication as directed. If a substance abuse problem is suspected, I understand that I may be referred for evaluation and management of the problem.
9. I agree to keep my scheduled appointments and be prepared to provide a urine sample. Failure to provide a sample may result in withdrawal of treatment using controlled substances and possibly discharge from PPWG.
10. I agree to bring my medications to the office for random pill counts if requested by staff to assess compliance with treatments. Failure to provide medication for inspection may result in suspension of opioid treatment.
11. I agree to comply with my physicians' request for additional imaging studies, lab tests, diagnostic procedures (with separate
informed consent), and referrals to additional specialists as recommended by my physician.
12. I realize that is my responsibility to keep others and myself from harm, this includes the safety of my driving and the operation of machinery. If there is any question of impairment of my ability to safely perform any activity, I will not attempt to perform the activity until my ability to perform the activity has been evaluated or I have stopped the medication long enough for the side effects to resolve. This applies to all medications prescribed by PPWG.
13. I understand that strong medications, which may include opiates and other controlled substances may be prescribed for my treatment. I understand that there are potential risks and side effects with taking any medications, including the risks of addiction. Overdose of opiate medication may cause injury or death by stopping breathing. This may be reversed by emergency personnel if they know I have taken opiate pain killers. It is suggested that I wear a medical alert bracelet or necklace that contains this information. Other possible complications include, but are not limited to, constipation which could be severe enough to require medical treatment, difficulty with urination, fatigue, drowsiness, nausea, itching, stomach cramps, loss of appetite, confusion, sweating, flushing, depressed respiration, and reduced sexual function.

COMPLIANCE

1. I understand that phone calls after hours should be for issues such as post procedure, post-surgical complications, significant medication side effects and other urgent matters. For the true medical emergency, "911" should be called and/or emergency department treatment should be sought. For non-emergency matters the clinic should be called during normal business hours.
2. I understand that the main treatment goal is to improve my ability to function and/or to work and/or to reduce my symptoms. In consideration of that goal and the fact that I may be given potent medication to help me reach that goal, I agree to help myself by following better health habits. This may include exercise, weight control, and avoiding the use of nicotine. I must also comply with the treatment plan as prescribed by my doctor. I

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understand that through following a healthier lifestyle can I hope to have the most successful outcome to my treatment.

3. I agree to fully comply with all aspects of my treatment program, including behavioral, medicine and physical therapy. Failure to do so may lead to discontinuation of my medication and discontinuation from the pain program.
4. I agree to waive any applicable privilege or right to privacy or confidentiality with respect to the prescribing of my schedule II, III and IV medications and authorize the physicians, my pharmacy and insurers to cooperate fully with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion/inappropriate use of my pain medication. I authorize PPWG to provide a copy of this agreement to my pharmacy, other health care providers, insurance carrier and any emergency department upon request. I give my permission to allow sharing of medical history in regard to medication use with other health care agencies/facilities.
5. I have thoroughly read, understand and accept all of the above provisions. Any questions I had regarding this agreement have been answered to my satisfaction by the PPWG prescribing provider. I understand all the policies regarding the prescribing and use of opioids and other medications. I agree to comply with the PPWG medication management program. I also agree to random testing and detoxification if further indicated.
6. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substances prescribed by this physician/physician assistant or referrals for further specialty assessment.

REFILLS

1. Prescriptions will not be phoned in after hours, on weekends or holidays.
2. Timely request for refills of medications is solely the patient's responsibility. Refills will not be made as an "emergency". There is a 7-day minimal request to request medication/prescription refills
3. I agree that I will use my medication at a rate no greater than the prescribed rate unless it is discussed directly with a PPWG prescriber/physician.
4. The prescribing provider will be the only one to decide when and how the patient is to increase or decrease various pain medications. The patient is responsible for taking the medications as prescribed. No unauthorized increase in medications will be tolerated.
5. Changes in prescriptions/refills will be made only during scheduled appointments and not via phone, at night, on weekends or holidays. This policy will be strictly adhered to.
6. Renewals are contingent upon keeping scheduled appointments and following the PPWG prescription policy.
7. I agree that continued refill of medications may be contingent upon compliance with other chronic pain treatment modalities recommended by my doctor/physician assistant and with the program in general.
8. Refills will not be made if "I ran out early" or "I lost my prescription" or "spilled, damaged, misplaced, stolen medication". The patient is responsible for taking the medications in the dose prescribed and for keeping track of the amount remaining.
9. Medications will not be replaced if they are lost, misplaced, or destroyed, etc. If your medication has been stolen and you complete a police report regarding the theft, an exception may be made at the discretion of the PPWG prescriber/provider. However, there is a $50 fee for prescription replacement.
10. Prescriptions may be issued earlier if the physician or patient will be out of town when a refill is due. These prescriptions will contain instructions to the pharmacist regarding when prescription(s) is allowed to be refilled.

You are informed that you have the right and power to sign and be bound by this agreement, and that you have read, understand and accept all of its terms.

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Lack of strict adherence to any provision of this agreement by PPWG in no way invalidates any other provisions of this agreement.

I have read this agreement in its entirety or have had it read to me. I understand all of it. I have had a chance to have all of my questions regarding this treatment answered to my satisfaction. I am signing this form voluntarily; I give my consent for the treatment for my symptoms with controlled substances. I have also read and signed the comprehensive Controlled Substance Agreement as well and am aware of the many potential risks versus benefits.

Consequences for not following the treatment agreement are as follows:

> I understand that any violation of this agreement may pose a health risk to myself and others and may result in a discontinuation of treatment with controlled substances if deemed medically prudent. Violation of this agreement may result in dismissal from the care of Pacific Pain & Wellness Group as well as reporting any illegal activities to appropriate law enforcement agencies. All patients who demonstrate difficulties managing their controlled substance medications will be referred to an Addiction Psychiatrist and/or a Clinical Psychologist or Counselor for further evaluation.

I have read this document, understand it, have had all questions regarding risks and conditions of the agreement answered satisfactorily, and I agree to all of its elements.

Patient Signature: _____ Date: _____

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOUR HEALTH INFORMATION IS PRIVATE

Keeping your health information private is one of our most important responsibilities. We are committed to protecting your health information and following all laws regarding the use of your health information. The law says:

1. We must keep your health care information from others who do not need to know it.
2. You may ask that we not share certain health information (In some instances we may not be able to agree with your request.)

MAY I SEE MY HEALTH INFORMATION?

You may see your health information unless it is the private notes taken by a mental health provider or it is part of a legal case. Most of the time you may receive a copy if you ask. You may be charged an amount to cover copy costs. If you think some of the information is wrong, you may ask in writing that it be changed or that new information be added. You may ask that the changes or new information be sent to others who have received your health information from us. You may ask for a list of any places where health information has been sent, unless it was sent for treatment, payment, quality review, or to make sure we are following the laws protecting your privacy.

WHAT IF MY HEALTH INFORMATION NEEDS TO GO SOMEWHERE ELSE?

You may be asked to sign an authorization form allowing your health care information to go somewhere else if:

1. Your health care provider needs to send it to other places;
2. You want us to send it to another health care provider; or
3. You want it sent to another person for you.

The authorization form tells us what, where and to whom the information must be sent. Your authorization is good for six (6) months or until the date you put on the form. You can cancel or limit the amount of information sent at any time by letting us know in writing.

If you are less than 18 years old, your parents or guardians will receive your private health information, unless by law you are able to consent for your own health care treatment. If you are, then your private health information will not be shared with parents or guardians unless you sign an authorization form. You may also ask to have your health information sent to a different person that is helping you with your health care.

COULD MY HEALTH INFORMATION BE RELEASED WITHOUT MY AUTHORIZATION?

When private health information is released without authorization, it is normally used for Treatment, Payment or Operations (managing the business of a health care provider and reporting to agencies that oversee our business. such as state regulators). The release of health information for this purpose is not tracked and we are not accountable to you for it. Any other releases made without your authorization is tracked and accounted. We always report:

1. Contagious diseases, birth defects, and cancer
2. Reaction and problems with medicine
3. Victims of abuse, neglect or domestic violence
4. To the government agency that oversees our business
5. To prevent serious threat to your or others' health and safety

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6. Work-related injuries
7. Out of state offenders
8. As required by court order and/or subpoena
9. If you commit a crime on the premises

HOW CAN I FIND OUT IF MY HEATH INFORMATION HAS BEEN RELEASED WITHOUT MY AUTHORIZAI'ION?

To find out if your health information has been released without your authorization for purposes other than Treatment, Payment or Operations, contact your health care provider for a Request for Accounting Disclosures form. Simply fill out the form, attach a copy of your most recent picture ID, and return it to your health care provider.

MAY I HAVE A COPY OF THIS NOTICE?

This notice is yours. If we change anything in it, you will get a new notice. You can obtain additional copies of this notice by asking your health care provider.

QUESTIONS OR COMPLAINTS?

If you have questions about this notice or think that we have not protected your private health information and you wish to complain about it, please contact: Gelareh Solomon, Ph.D. at (424) 262-5026.

You can also complain to the Federal Government by writing to the:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201-0004

Or by calling the Office for Civil Rights at (800) 368-1019

By signing this form, you are acknowledging that you have received a copy of this notice (NOTICE OF USE OF PRIVATE HEALTH INFORMATION)

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (if necessary) Date

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OUR FINANCIAL POLICY

Thank you for choosing Pacific Pain and Wellness Group for your medical care. Our goal is to provide you with the highest quality of medical care and service. We feel it is helpful and important that you understand our billing process. We are happy to bill your insurance for any services provided at our offices. However, this is a courtesy service to you and you are responsible for any costs incurred during your course of treatment.

Each patient must complete the Patient Information Record which includes all demographic information including your insurance. We must have this information completed before you see the doctor on your first visit.

Methods of Payment:

CASH: Full payment is required at the time of service. You may choose to pay by check or cash, as well as a credit card (we accommodate Visa and MasterCard). We can arrange extended payments for patients if needed.

INSURANCE: We will bill your insurance carrier. We allow 60 days for your insurance to pay claims which have been submitted. Any unpaid balance or unpaid claims are your responsibility. We require payment of your co-payment and/or unpaid deductibles at the time of service. Delinquent accounts are subject to collection procedures and will be assessed a $50.00 special handling fee when collection procedures are initiated. *

HMO INSURANCE: If you are a member of a HMO, an insurance plan that requires prior authorization to see a specialist, you must contact your primary care physician for a referral to our office. This process is required for your initial office visit as well as follow-up visits, office procedures and surgeries. It may take two to three weeks to obtain the authorization from the health plan. Please schedule follow up visits with ample time to receive the authorization for the visit. We are required by most HMO health plans to collect any applicable co-payments and deductibles at the time of services. * *Should you require immediate care, you must contact your primary care physician to obtain an emergency or STAT referral.

MISSED APPOINTMENTS: We make every effort to schedule patients at a time that is convenient for them to see the doctor as quickly as possible. At times, there can be a wait to see the doctor, for nonurgent visits. If you are unable to keep a scheduled appointment, please notify our office as early as possible so that patients who are waiting to see the doctor may have the opportunity to be seen at their appointment time. Please help us to serve you and other patients better by keeping your scheduled appointments or by calling our office with a 24-hour advanced cancellation notice. If you fail to cancel your appointment within a 24-hour period on two occasions you will be billed a $50.00 "no-show" fee.

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PAYMENT POLICY

We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If you are not insured by an out-of-network plan we work with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles. All co-payments and deductibles must be paid before services are rendered. This arrangement is part of your contract with your insurance company. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. Please be aware that some of the services you receive may not be covered or not considered reasonable or necessary by your Insurance company. You will be liable to pay for these services.
4. Proof of insurance. All patients must complete our patient intake form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information at time of visit, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.
9. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. I have read and understand the payment policy and agree to abide by its guidelines:
10. I understand that I am allowing a maximum charge of $ 100 on MediWallet for my responsibility (deductible, co-insurance, balances, copays, or missed appointments).

_____ _____

Patient Signature Date

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Fee Agreement and Financial Policy

Thank you for choosing Pacific Pain & Wellness Group. The Fee Agreement and Financial Policy (the "Agreement and Policy") describes our schedule of fees for no shows and rescheduled appointments. Please be sure you understand the policies regarding cancellations, missed appointments, rescheduled appointments, and methods of payment. If you have any questions about anything, please ask our administrative staff prior to signing this Agreement and Policy.

Cancellations and Missed Appointments

Due to the time-intensive nature of consultations, Pacific Pain & Wellness Group requires a 48-hour notice for new patients and 24-hour notice for returning patients to cancel or reschedule a scheduled appointment (excluding weekends). Under such a policy, the patient who fails to give appropriate notice for canceling or rescheduling an appointment will be responsible for a late cancellation or a no-show fee. Insurance carriers will not pay for late cancellations or missed appointments. Once an appointment is scheduled, that time is reserved specifically for you. Cancellations and rescheduling must be made at least 24 hours in advance (excluding weekends). Although 24 hours (excluding weekends) is the minimum, if you need to cancel or reschedule, please give as much notice as possible. You may notify our office of cancellation by phone or email to your provider. If there are two or more missed appointments without 24 hours' notice within a 6-month period, please understand this may lead to termination from the practice.

Pacific Pain & Wellness Group provides courtesy reminders via email and phone to confirm all appointments before your scheduled time. Providing the required notice gives us the opportunity to schedule patients from our waiting list in the event your appointment is rescheduled or canceled.

Note: Courtesy calls are just that, a courtesy. Not receiving a reminder call does not change the no show/late cancellation policy. Your credit card on file will be charged on the day of the missed appointment.

Our Late Cancellation/No Show Fees and Policy is as follows:

- New Patient Appointments require 2 Business Day notice (48 Hours) or will incur a fee of **$275.00**
- Follow Up Appointments require 1 Business Day notice (24 Hours) or will incur a fee of **$175.00**
- Therapy Visits require 1 Business Day notice (24 Hours) or will incur a fee of **$125.00**

If you are unable to keep an appointment because of a sudden illness or an unexpected personal emergency, notify our office at (310) 437-7399 or email our office at main@pacificpaingroup.com as soon as you know you will not be able to attend your appointment.

The missed appointment fees are charges your insurance company is not responsible for and will not pay for; they are your financial obligation. If you are requesting to waive your fee for a late cancellation/missed appointment because you were ill, we will require a physician's note or documentation for the request to be considered. Patients who fail to pay the no show fees will not be allowed to schedule future appointments until the fee is paid or payment arrangements are made. Multiple late cancellations or no shows will result in dismissal from our practice.

Pacific Pain & Wellness Group is committed to helping you with your pain and mental needs.

_____ _____

Patient Signature Date