COMPREHENSIVE ORTHOPEDIC & SPINE CARE

Patient Intake

Name(Nombre) :	DOB(Fecha de Nacimiento) :
Address (Dirección) :	
City(Cuidad):	Zip code(Codigo Postal):
Tel. number (Numero de Telefono):	
Email (Correo Electronico):	
Gender(Genero): M F	Status: Single(Soltero) Married(Casado) other:
Pharmacy name (Farmacia): _____	In case of emergency (en caso de emergencia):
Address(Dirrecion): _____	Name & relationship (Nombre) : _____
Tel No.(Numero):	Tel No.(Numero)
Family Doctor (doctor primario):	Referred by (Referencia):

Commercial/Private Insurance:

Insurance company (Seguro medico):
Policy Number (Numero de Póliza):
ID number (Numero de ID):
Policy holder name (Nombre del titular de la Póliza): ☐ Same as above (Lo Mismo Que Arriba) ☐ Other:
If the patient isn't the policy holder, indicate relationship (Si el paciente no es el titular de la póliza, indique la relación): Spouse (Esposo/a) Child (hijo/hija) Other:
Policy Holder's DOB (Fecha de Nacimiento del titular de la póliza)

Worker's Compensation/ Motor Vehicle Accident Patients: ONLY

Insurance company (Compania)	
Address (Dirección)	
Adjuster's name (Nombre de Ajustador)	
Tel No. (Numero)	
Claim # (Numero de Reclamo)	
Date of accident (Dia de Accidente)	
Employer (Empleador)	
Employer's address (Dirección de Empleador)	

Attorney Information (Información del abogado):

Name (Nombre)	
Address (Dirección)	
Tel No. (Numero de Telefono)	

Comprehensive Orthopedic and Spine Care does not participate in all Commercial Insurances, however we will submit all claims to your insurance carrier if your carrier accepts out-of-network claims. We only accept as payment the allowed amount under the Assignee's insurance plan and we do not bill for uncovered charges. *Comprehensive Orthopedic and Spine Care no participa en todos los seguros comerciales, sin embargo, presentaremos todos los reclamos a su compañía de seguros; para ver si su compañía acepta reclamos afuera de la red. Solo aceptamos como pago la cantidad permitida bajo el plan de seguro del Cesionario y no facturamos por cargos no cubiertos.*

Signature _____ Date: _____

Insurance Assignment and Release

I certify that the information that I have reported with regards to my insurance coverage is correct. I also authorize the release of any medical information necessary to process this claim. I also authorize payment of medical benefits to COSC, for anesthesia and orthopedic surgical services provided to me. I fully understand that payment for services is not contingent upon recovery and this does not relieve me of my primary obligation to pay. (Certifico que la información que he reportado con respecto a la cobertura de mi seguro es correcta. También autorizo la divulgación de cualquier información médica necesaria para procesar este reclamo. También autorizo el pago de beneficios médicos a COSC, por los servicios de anestesia y cirugía ortopédica que me brinden. Entiendo completamente que el pago de los servicios no depende de la recuperación y esto no me exime de mi obligación principal de pagar.)

Signature _____ Date: _____

Medicare Patients ONLY

In Medicare cases, COSC agrees to accept the charge determination of Medicare as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductibles are based upon the charge determination of Medicare.(En los casos de Medicare, COSC acuerda aceptar la determinación del cargo de Medicare como el cargo total, y el paciente es responsable únicamente por el deducible, el coseguro y los servicios no cubiertos. El coseguro y los deducibles se basan en la determinación de cargos de Medicare.)

Signature _____ Date: _____

COMPREHENSIVE ORTHOPEDIC & SPINE CARE™

Name(Nombre):_____
DOB (Fecha de Nacimiento):_____

Medical History (Historial medico)

Age(Edad): _____ Height(Altura):_____ Weight(Peso):_____

Why are you seeing the doctor today? ¿Por qué estás viendo al doctor hoy?_____

Date of Injury/Onset of Problem (Fecha de la lesión / aparición del problema):_____

Current problem is a result of (El problema actual es el resultado de):

Car Accident / Accidente automovilístico — Work Accident / Accidente laboral — Other / Otro

Medications (Medicamentos):

Medication Name (Nombre de la medicación)	Reason (Razón)

Allergies (Alergias):

Allergy to (Alergia a)	Reaction (Reacción)

☐ No known drug allergies (Ningun alergia a medicamentos)

Do you, or your family have any of the following? ¿Tiene usted o su familia alguno de los siguientes?

Diabetes (Diabetes)	Y	N	FAMILY
Heart Trouble (Problemas del corazón)	Y	N	FAMILY
Epilepsy (Epilepsia)	Y	N	FAMILY
High blood pressure(Alta presión)	Y	N	FAMILY
DVT/Blood Clots(TVP/coágulos de sangre)	Y	N	FAMILY
Circulation problems(Problemas de circulacion)	Y	N	FAMILY
Osteoprosis (Osteoprosis)	Y	N	FAMILY
Arthitis (Artitis)	Y	N	FAMILY
Bowel/Bladder Problem	Y	N	FAMILY
AIDS/HIV (SIDA / VIH)	Y	N	FAMILY
Cancer (Cáncer)	Y	N	FAMILY

If so, Type(Que Tipo):_____

Bleeding Disorder (Desorden de sangre)	Y	N	FAMILY
Stroke/TA	Y	N	FAMILY
Alzhemir's (Alzhemir)	Y	N	FAMILY
Hepatitis (Hepatitis)	Y	N	FAMILY

Any other issue(cualquier otro problema):_____

Are you/could you be pregnant? ¿Estás o podrías estar embarazada?

Y N

Social History (Historial social)

Do you smoke or chew tobacco? ¿Fuma o mastica tabaco?

Y N

Do you drink alcholic beverages? ¿Bebes bebidas alcohólicas?

Y N

Do you use recreational drugs? ¿Usa drogas recreativas?

Y N

Have you had any previous surgeries?¿Ha tenido cirugías previas?

Surgery type (Tipo de cirugia)	When?

Review of Systems (check if you experience symptoms)
Revisión de sistemas (verifique si experimenta síntomas)

GENERAL
- ☐ Fever (Fiebre)
- ☐ Weight change(Cambio de peso)
- ☐ Hormonal
- ☐ Other
- ☐ NONE

CARDIOVASCULAR
- ☐ Chest pain (Dolor de pecho)
- ☐ Palpitations (Palpitaciones)
- ☐ Fluid/Swelling in extremities (Líquido/hinchazón en las extremidades)
- ☐ Other
- ☐ NONE

KIDNEY/BLADDER
- ☐ Painful urination (Dolor al orinar)
- ☐ Frequent urination (urinación frequente)
- ☐ Incontinence (Incontinencia)
- ☐ Other
- ☐ NONE

EYES (OJOS)
- ☐ Glasses/Contacts (Gafas/Contactos)
- ☐ Cataracts (Cataratas)
- ☐ Glaucoma
- ☐ Other
- ☐ NONE

RESPIRATORY(RESPIRATORIO)
- ☐ Shortness of Breath (Dificultad para respirar)
- ☐ Sleep apneas(Apneas del sueño)
- ☐ Wheezing (sibilancies)
- ☐ Other
- ☐ NONE

ENT
- ☐ Difficulty swallowing(Dificultad para tragar)
- ☐ Ear pain (Dolor de oído)
- ☐ Seasonal allergies (Alergias Estacionales)
- ☐ Hard of hearing (Problemas de Audición)
- ☐ Other
- ☐ NONE

GASTROINTESTINAL
- ☐ Heartburn (Acidez)
- ☐ Diarrhea/Constipation (Diarrea / estreñimiento)
- ☐ Nausea/Vomiting (Náuseas / vómitos)
- ☐ Abdominal pain(Dolor abdominal)
- ☐ Other
- ☐ NONE

SKIN
- ☐ Rashes (sarpullido)
- ☐ Lumps (bultos)
- ☐ Other
- ☐ NONE

HEMATOLOGY / LYMPHATIC
HEMATOLOGÍA / LINFÁTICO
- ☐ Anemia
- ☐ Blood problems (problemas de sangre)
- ☐ Clotting disorder (Trastorno de la coagulación)
- ☐ Lymph problems (Problemas linfáticos)
- ☐ Other
- ☐ NONE

NEUROLOGICAL
- ☐ Headaches (dolor de cabeza)
- ☐ Numbness (entumecido)
- ☐ Tingling (Hormigueo)
- ☐ Seizures (Convulsiones)
- ☐ Weakness (Debilidad)
- ☐ Other
- ☐ NONE

PSYCHOLOGICAL
- ☐ Anxiety (Ansiedad)
- ☐ Depression (Depresión)
- ☐ Mood Swings (Cambios de humor)
- ☐ Other
- ☐ NONE

To the best of my knowledge, the above information is complete and correct. Understand that it is my responsibility to inform my doctor if I ever have a change in health. (Certifico que la información que he reportado con respect a salud es correcta.Entiendo que es mi responsabilidad informar a mi médico si alguna vez tengo un cambio de salud.)

Signature_____

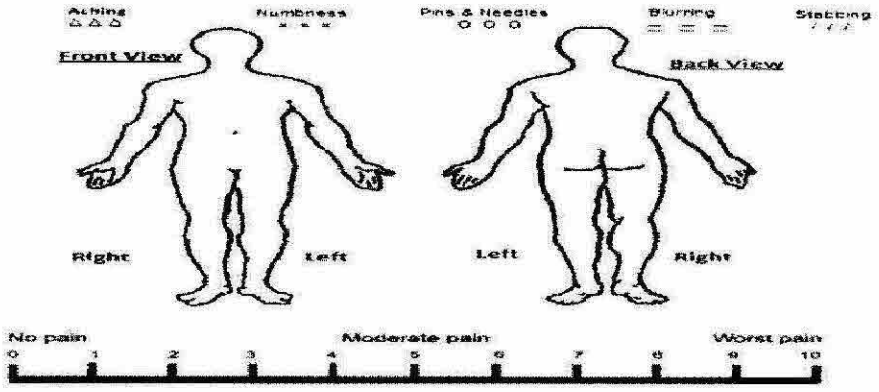
Date_____

COMPREHENSIVE
ORTHOPEDIC & SPINE CARE™

Name(Nombre):_____
DOB (Fecha de Nacimiento):_____

New Problem Questionnaire (Cuestionario de problemas nuevos)

1. What is your main problem? ¿Cuál es su principal problema?
   - ☐ Pain (Dolor)
   - ☐ Numbness (Entumecimiento)
   - ☐ Weakness (Debilidad)
   - ☐ Stiffness (Rigidez)
   - ☐ Unstable or Dislocating Joint (Articulación Inestable o Dislocada)
   - ☐ Swelling (Hinchazón)
   - ☐ Other:_____
2. How did your problem start? ¿Cómo empezó su problema?
   - ☐ Work Injury (Accidente de Trabajo) Date of Accident(Fecha del accidente):_____
   - ☐ Car accident (Accidente Automovilistico)
   - ☐ Sports injury (Lesion deportiva) ☐ Suddenly (Repentinamente) ☐ Gradually (Gradualmente)
   - ☐ Other:_____
3. Does your pain awaken you from sleep? ¿Su dolor lo despierta del sueño?
   - ☐ Yes ☐ No
4. Is your pain intermittent or constant? ¿Su dolor es intermitente o constante?
   - ☐ Intermittent ☐ Constant
5. What worsens your problem? ¿Qué empeora su problema?
   - ☐ Exercise (Ejercicio)
   - ☐ Sitting (Sentarse)
   - ☐ Standing (Estar de Pie)
   - ☐ Rest (Descansar)
   - ☐ Nothing (nada)
   - ☐ Repetitive Motions (Movimientos repetitivos)
   - ☐ Overhead Activities (Actividades generals)
   - ☐ Coughing, Sneezing, Straining (Toser, estornudar, hacer esfuerzos)
   - ☐ Walking (Caminar)
   - ☐ Other: _____
6. What helps your pain? ¿Qué ayuda a aliviar su dolor?
   - ☐ Rest (Descansar) ☐ Nothing (Nada) ☐ Other:_____
7. Are your regular activities limited specifically because of your problem? ¿Están limitadas sus actividades habituales específicamente debido a su problema?
   - ☐ No ☐ Yes (Give details/ Dar detalles):_____
8. Have you had this problem before? ¿Ha tenido este problema antes? ☐ No ☐ Yes When (Cuando) _____
9. Have you had previous medical treatment for this? ¿Ha tenido tratamiento médico anteriormente por esto?
   - ☐ None (Ninguno)
   - ☐ Emergency room (Sala de emergencias)
   - ☐ Surgery (Cirugía)_____
   - ☐ Other_____
   - ☐ Injection (Inyección)_____
   - ☐ Physical therapy (Terapia física)_____
   - ☐ Physician (Medico)_____
10. What tests have you had? ¿Qué examenes te has hecho?
    - ☐ X-Rays ☐ CT scan ☐ MRI ☐ EMG ☐ Ultrasound
11. Are you currently working? ¿Estás trabajando actualmente?
    - ☐ Not working Date last worked (Ultimo dia de Trabajo)
    - ☐ Light duty (Trabajo ligero) ☐ Regular job (Trabajo regular)
12. Please mark the areas on your body where you feel pain. Also, rate your pain on scale. (Marque las áreas de su cuerpo donde siente dolor. Además, califique su dolor en la escala.)



To the best of my knowledge, the informnation above is complete and correct.(Certifico que la información que he reportado es completa y correcta)

Signature:_____ Date:_____

COMPREHENSIVE
ORTHOPEDIC & SPINE CARE™

COVID-19 INFORMED CONSENT

I understand I am giving this informed consent to Joseph Weinstein,D.O., P.C. d/b/a Comprehensive Orthopedic & Spine Care (the practice) evidencing my eduated decision to receive services at the practice prior to any known effective treatment to the CoronaVirus-COVID-19. I have been advised that the pratice has adopted recommended protocols for the prevention of COVID-19 at it's facility. I have been advised I can request additional information prior to signing this consent, and at any time thereafter, as to the specific protocols in place regarding the practice response to COVID-19.

By signing below, I acknowledge my understanding that the COVID-19 virus has a period during which carriers of the virus may not show symptoms and may still be highly contagious. I understand the practice will be treating patients other than myself at its facility, as well as employing personnel who may be asymptomatic or qualifed as "recovered" in accorance with CDC guidelines. I understand that it is impossible to determine who has it and who does not, at any given time. I understand it is my responbility to notify the practice if I am medically "high risk" for any reason.

By signing below, I hereby agree to release the practice, and its owners, members, officers, employees, contractors, agents, and representatives (practice representatives) and not to commence or maintain any action or proceeding against any practice representative, for or from any and all claims, causes of action, liabilities, damages, fees (including attorney fees and costs of defense) and demands whatsoever, in law or equity (claims), which I (and my heirs, executors, administrators and assigns) shall or may have, or from any person or entity other than myself, for , upon, or by reason of my contracting COVID-19, including any claim resulting from my transmission of COVID-19 to any other person or thing. I hereby agree to indemnify and hold the practice representatives harmless from and against any and all claims from or against any person or entity other than myself relating to my having or transitting COVID-19.

By signing below, I acknowledge I have read this informed consent and I hereby agree to its terms and I assume the risk of potiental COVID-19 exposure by receiving treatment at the practice.

Patient Name (Nombre): _____

Patient Signature (Firma):_____ Date (Fecha):_____

OCA Official Form No.: 960

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

[This form has been approved by the New York State Department of Health]

Patient Name (NOMBRE DE PACIENTE)	Date of Birth (FECHA DE NACIMIENTO)	Social Security Number
Patient Address (DIRECCION DE PACIENTE)		

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to **ALCOHOL** and **DRUG ABUSE, MENTAL HEALTH TREATMENT**, except psychotherapy notes, and **CONFIDENTIAL HIV* RELATED INFORMATION** only if I place my initials on the appropriate line in Item 9(a). In the event the health information described below includes any of these types of information, and I initial the line on the box in Item 9(a), I specifically authorize release of such information to the person(s) indicated in Item 8.
2. If I am authorizing the release of HIV-related, alcohol or drug treatment, or mental health treatment information, the recipient is prohibited from redisclosing such information without my authorization unless permitted to do so under federal or state law. I understand that I have the right to request a list of people who may receive or use my HIV-related information without authorization. If I experience discrimination because of the release or disclosure of HIV-related information, I may contact the New York State Division of Human Rights at (212) 480-2493 or the New York City Commission of Human Rights at (212) 306-7450. These agencies are responsible for protecting my rights.
3. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be redisclosed by the recipient (except as noted above in Item 2), and this redisclosure may no longer be protected by federal or state law.
6. **THIS AUTHORIZATION DOES NOT AUTHORIZE YOU TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THE ATTORNEY OR GOVERNMENTAL AGENCY SPECIFIED IN ITEM 9 (b).**

7. Name and address of health provider or entity to release this information:

8. Name and address of person(s) or category of person to whom this information will be sent:

COMPREHENSIVE ORTHOPEDIC & SPINE CARE 62-54 97th Place Rego Park NY 11374 T.718-313-0766 F.347-507-5553

9(a). Specific information to be released:

- ❑ Medical Record from (insert date) _____ to (insert date) _____
- ❑ Entire Medical Record, including patient histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent to you by other health care providers.
- ❑ Other: _____

Include: (*Indicate by Initialing*)

_____ **Alcohol/Drug Treatment**

_____ **Mental Health Information**

_____ **HIV-Related Information**

Authorization to Discuss Health Information

(b) ❑ By initialing here _____ I authorize _____

Initials — Name of individual health care provider

to discuss my health information with my attorney, or a governmental agency, listed here:

_____

(Attorney/Firm Name or Governmental Agency Name)

10. Reason for release of information:	11. Date or event on which this authorization will expire:
☑ At request of individual ❑ Other:	**END OF CARE**
12. If not the patient, name of person signing form:	13. Authority to sign on behalf of patient:

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of the form.

_____ Date: _____

Signature of patient or representative authorized by law.

* **Human Immunodeficiency Virus that causes AIDS. The New York State Public Health Law protects information which reasonably could identify someone as having HIV symptoms or infection and information regarding a person's contacts.**

NEW YORK MOTOR VEHICLE NO-FAULT INSURANCE LAW
ASSIGNMENT OF BENEFITS FORM

(FOR ACCIDENTS OCCURRING ON AND AFTER 3/1/02)

I, _____ ("Assignor") hereby assign to Joseph Weinstein DO, P.C. DBA Comprehensive Orthopedic & Spine Care ("Assignee")
PATIENT NAME (NOMBRE DE PACIENTE) (Print hospital or health care provider name)
all rights privileges and remedies to payment for health care services provided by assignee to which I am entitled under Article 51 (the No-Fault statute) of the Insurance Law.

The Assignee hereby certifies that they have not received any payment from or on behalf of the Assignor and shall not pursue payment directly from the Assignor for services provided by said Assignee for injuries sustained due to the motor vehicle accident which occurred on _____, not withstanding any other agreement
Date of Accident (Fecha de Accidente)
to the contrary.

This agreement may be revoked by the assignee when benefits are not payable based upon the assignor's lack of coverage and/or violation of a policy condition due to the actions or conduct of the assignor.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR COMMERCIAL INSURANCE OR A STATEMENT OF CLAIM FOR ANY COMMERCIAL OR PERSONAL INSURANCE BENEFITS CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, AND ANY PERSON WHO, IN CONNECTION WITH SUCH APPLICATION OR CLAIM, KNOWINGLY MAKES OR KNOWINGLY ASSISTS, ABETS, SOLICITS OR CONSPIRES WITH ANOTHER TO MAKE A FALSE REPORT OF THE THEFT, DESTRUCTION, DAMAGE OR CONVERSION OF ANY MOTOR VEHICLE TO A LAW ENFORCEMENT AGENCY, THE DEPARTMENT OF MOTOR VEHICLES OR AN INSURANCE COMPANY, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE VALUE OF THE SUBJECT MOTOR VEHICLE OR STATED CLAIM FOR EACH VIOLATION.

_____ _____
Print Name of Patient (Nombre de la Paciente) Signature of Patient (Firma de Paciente)

_____ _____
Date of Signature (Fecha)

_____
Address of patient (Direccion de Paciente)

Joseph Weinstein, DO
Print name of Provider (Nombre del Proveedor)

Signature of Provider (Firma de Proveedor)

62-54 97th Place Ste.2C

Date of Signature (Fecha)

Rego Park, NY 11374
Address of Provider (Direccion del Proveedor)

NYS FORM NF-AOB (Rev 1/2004)

COMPREHENSIVE
ORTHOPEDIC & SPINE CARE™

LIEN ASSIGNMENT AGREEMENT

Patient name (Nombre de Paciente):_____

Address (Direccion):_____

Date of Accident (Fecha de Accidente):_____

I do hereby enter into the following agreement with Dr. Joseph Weinstein, hereinafter known as "the provider" in order to guarantee payment for services rendered by "the provider" to me. I understand that I am directly and fully responsible to "the provider" for all medical bills for services rendered to me and for any remaining balance on all medical bills for services rendered to me that were submitted on my behalf to the responsible insurance carrier and applicable. This document further serves to acknowledge my responsibility to repay all remaining balances subsequent to all applicable insurance payments, I agree to make myself available to appear or correspond with "the provider" as often as may be necessary for any collections effort that is undertaken. I have been made aware of the charges for the services rendered under this lien assignment and acknowledge responsibility for the repayment of all outstanding balances I further direct that my attorney shall not subsequently dispute these amounts and will contact this office to arrange for full payment at the time a settlement, trail or motion proceed becomes ready for disbursement.

To the extent applicable, I agree to comply with all Insurance Company regulations including, but not limited to examinations under oath and independent medical examinations. I understand that any failure on my part to comply with any condition precedent to insurance coverage, may at the election of the medical provider, server to revoke any assignment of NO-Fault benefits. The patient herein further acknowledges their responsibility to file a timely notice of claim to the applicable insurance carrier and that any subsequent No-Fault claim denied based on the failure to provide a timely notice, at the election of the provider, may result in recovery efforts in reliance of this lien.

The Provider agrees to seep compensation from the appropriate insurance carrier prior to invoking the terms of this lien based on the accuracy of the information the patient has provided and to the extent applicable. The patient shall provide all necessary insurance information, [police reports, and any aforementioned insurance claim as applicable. Failure to provide accurate insurance information leading to a viable source of coverage may serve to invalidate any executed assignment of No-Fault and result in the reliance on this lien for reimbursement purposes.

I hereby give and grant this lien in my case to "the provider" against any and all proceeds of any settlement, judgement, verdict, or other disposition of any litigation filed or contemplated on my behalf that may be paid to me or my ATTORNEY as a result of the injuries for which I have been treated. I grant "the provider" the aforesaid lien against such sums of the aforesaid settlement, judgement, verdict, or other disposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me and towards all outstanding balances. I hereby agree to provide accurate contact information for the attorney pursuing any litigation on my behalf.

I hereby direct and authorize direct payment to "the provide", such sums as may be due and owing for medical services rendered to me. I further direct my ATTORNEY to honor and aforesaid lien and to withhold such sums from any settlement, judgement, verdict, or other deposition of any litigation filed or contemplated on my behalf as may be necessary to adequately reimburse "the provider" for services rendered to me towards all outstanding balances.

I understand that this document may not be rescinded and that my ATTORNEY shall not honor any such recession. I hereby instruct that in the event another ATTORNEY is substituted in my case, I direct the substitute attorney to provide the incoming ATTORNEY with a copy of this lien and that I direct any incoming ATTORNEY to honor this lien as inherent to the settlement, judgement, verdict, or other disposition of any litigation filed or contemplated on my behalf and enforceable upon the case as if it were executed by him/her. I hereby direct and authorize my attorney, on demand, to provide the status of such litigation to "the provider" or his attorney engaged I any collection efforts. Furthermore, I direct my attorney to contact "the provider" or the attorney representing the provider prior to disbursement of any fund to ascertain any outstanding balances due to Dr. Joseph Weinstein.

In the event ATTORNEY or I do not honor this agreement, ATTORNEY and I shall be liable to the provider for all services rendered, attorneys fees in the amount of 15% of the outstanding balance, costs involved in the litigation that may arise from the breach of this agreement and liquidated damages of $25,000.00

_____

Date (Fecha)

_____ _____

Patient name (Nombre de paciente) Attorney's name & Address (Nombre de abogado & direccion)

_____ _____Patient

signature (Firma de paciente) Attorney signature (Firma de abogado)