Information Sheet

FOUNTAIN MEDICAL CLINIC

4352 Fountain Avenue · Los Angeles, CA 90029 · Tel (323) 913-9094 · Fax (323) 913-2492

Patient _____ AGE _____ BIRTHDATE _____

Address _____ City _____ State/Zip _____

Phone # _____ D.L.# _____ S.S.#_____

Occupation _____ Employer _____ Phone # _____

NO TREATMENT WILL BE ADMINISTERED UNTIL SIGNED
(YOU MUST BE OF LEGAL AGE)

It is understood and agreed that I authorize and direct Evelyn C. Rivero, M.D. and/or her associates and employees to perform the procedures that in her judgment are considered advisable or necessary for the patient whose name appears above.

Arbitrary Clause: Any claim or dispute in connection with fees or treatment involving the Doctor and/or her associates and employees participating in examinations or care shall be settled by arbitration at the option of any party bound of the agreement under the rules of the American Arbitration Association.

BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.

I have read and fully understand all of the above and have answered all questions true and correct to the best of my knowledge.

Signed _____ Date _____

Or, Signed _____ Date _____