

MUTUAL BINDING ARBITRATION AGREEMENT

This mutual binding agreement constitution an integral part of a contract for medical services by and between

Compassionate Care for Women and _____

Who agree to be bound as described hereunder;

1. It is understood that any dispute as that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided in Nevada law, and not by lawsuit or resort to court process except as Nevada law provides for judicial review or arbitration proceedings. Both parties to the contract, by entering into it, are giving up their constitutional right to have any dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.
2. Such arbitration shall be in accordance with the arbitration rules of the Nevada Revised Statutes. This Mutual Binding Arbitration Agreement shall apply to any legal claim or civil action in connection with any and all medical care or medical services rendered, whether inpatient or outpatient, against Compassionate Care for Women employees, or contracted staff.
3. The execution of this Mutual binding Arbitration Agreement shall not be a precondition of the furnishing of medical services by Compassionate Care for Women. This Mutual Binding Arbitration Agreement may be rescinded by written notice from the patient's legal representative within 30 days of signature.
4. The Mutual Binding Arbitration Agreement shall bind the parties hereto, including newborns, and heirs representatives, executors, administration, successors, and assigns of such parties and newborns.

NOTICE: 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 CONTRACT TRIAL, SEE ARTICLE 1 OF THIS CONTRACT

Date: ____/____/____

Time: _____ A.M./P.M.

Signature: _____

If signed by other than patient, indicate relationship: _____

CCFW Witness: _____ Print _____