















**ARBITRATION AGREEMENT**

Article 1: Agreement to Arbitrate: The undersigned patient agrees that any dispute regarding the care and treatment or medical services provided by MonteSol Medical Centers, LLC and its physicians and employees (collectively “MonteSol Medical Centers”), including any claim that services rendered were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to binding arbitration as provided by Florida law, and not by a lawsuit or resort to court process except as Florida law provides for judicial review of arbitration proceedings.

Article 2: All Disputes Must be Arbitrated: It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to the care and treatment or medical services provided by MonteSol Medical Centers including claims brought by any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean the mother and the mother’s expected child or children. This agreement includes all claims against MonteSol Medical Centers, its employees and physicians, and all affiliated group practice physicians, partners, associates, clinicians, association, corporation or partnership, and the employees, agents and estates of any of them. All such claims and disputes must be arbitrated including, without limitation, all claims for damages, loss of consortium, wrongful death, emotional distress and consequential or punitive damages.

Article 3: Notice and Demand for Arbitration: Patient must provide not less than a sixty (60) day advance written notice and demand for arbitration. Such notice and demand for arbitration must be submitted in writing by certified or registered mail to the following address:  
2669 Forest Hill Blvd, Suite 100, West Palm Beach, FL 33406  
Attention: Corporate Manager

Article 4: Arbitration Procedure: Arbitration shall be conducted by a single arbitrator in accordance of the Rules of the American Arbitration Association. The parties consent to venue exclusively in Palm Beach County Florida and the parties agree that any dispute regarding the arbitrability of such claim or dispute shall be determined by such arbitration proceeding. Each party to the arbitration shall share equally in the expenses and fees of the arbitration, not including attorney’s fees, witness fees, or other expenses incurred by a party for such party’s own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract and the determination of the arbitrator shall be binding and enforceable by any state court of competent jurisdiction.

Article 5: General Provisions: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable Florida statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the Florida Code of Civil Procedure provisions relating to arbitration. If any provision if this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

**NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY DISPUTE REGARDING YOUR HEALTHCARE TO BE DECIDED BY BINDING ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL.**

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship if not Patient