PATENT REGISTRATION FORM

HAGATNAMED CLINIC POLICY AGREEMENT

We understand that your time is valuable, so, to ensure that you receive both personalized and efficient treatment during your visit with us, we have implemented the following office policies:

◊ Office visits for routine care (i.e., physical examinations, follow-up, quarterly check-ups, etc.) require a proof of identification. Please bring your insurance card(s) and a valid photo ID with you to each appointment.

◊ Patients with conditions outside routine will be assessed and treated accordingly. When appropriate, an appointment will be scheduled to complete your treatment.

◊ If you are unable to keep your scheduled appointment, please notify our office 24 hours prior to your scheduled appointment time. If we do not receive notice, a fee of $75.00 will be charged to you. Any future appointments may be affected due to none payment of this fee.

◊ The safety of your children is extremely important to us. We request that you maintain close supervision of your children at all times while visiting our facilities.

◊ All of our patients are required to maintain appropriate conduct while visiting HagatnaMED Clinic.

◊ We reserve the right to refuse service to any patient who causes disruption to our operations and presents potential harm to other patients & employees in our facility.

FINANCIAL RESPONSIBILITY

◊ Payment for services rendered is due and payable upon completion of your visit. We accept payments in the form of cash, debit cards and all major credit cards. Certain restrictions apply to self-pay patients, and debit cards.

◊ All co-payments are due and payable upon check-in. All deductibles and co-insurance amounts require a $50.00 deposit due and payable upon check-in. All non-covered charges are 100% due and payable upon check-in. All other services provided during your treatment that are not part of your co-payment are due and payable upon completion of your visit.

◊ Self-pay patients are responsible for payment in full at the time of service and is required to pay a $200.00 deposit prior to service, with the remaining balance in full if any at discharge. Any refunds due will be provided at discharge.

◊ If we do not have an agreement with your insurance carrier, we require that you pay for services in full and seek reimbursement from your insurer.

◊ If we have an agreement with your insurance carrier, we will bill the carrier for the insurance portion of your visit expenses. While we make every effort to coordinate payment for services with your insurance carrier, you are still primarily responsible for all fees for services rendered. Your insurance card will be required at each visit.

◊ While we will make every effort to provide you with the total amount due for services rendered upon completion of your visit, HagatnaMED Clinic reserves the right to later bill you for services provided but not billed during the visit or services provided and denied by your insurance company.

◊ It is important you notify us of any changes regarding your insurance coverage and of any other insurance you may have. Failure to report other insurance coverage may be considered fraudulent and may result in legal matters against you.

◊ A copy of your medical records may be requested. A fee of .25 cents per sheet and $15 per CD is charged per request.

◊ All fees are subject to change.

CONSENT FOR MEDICAL OR SURGICAL PROCEDURE

◊ Risks and Benefits of Proposed Procedure(s): I understand that medical and surgical procedures involve risks. These risks include allergic reaction, bleeding, blood clots, infections, adverse side effects of drugs, blindness and even loos of bodily function or life, as well as risks of transfusion reactions and the transmission of infectious disease, including Hepatitis and Acquired Immune Deficiency Syndrome, from the administration of blood and/or blood components.

◊ Complications, Unforeseen Conditions, Results: I am aware that in the practice of medicine, other unexpected risks or complication not discussed may occur. I also understand that during the course of the proposed procedure(s) unforeseen conditions may be revealed requiring the performance of additional procedures, and I authorize such procedures to be performed. I further acknowledge that no guarantees or promise have been made to me concerning the results of any procedure or treatment.

◊ Acknowledgements: Available alternative have been explained to me. I understand what has been discussed with me as well as the consents of this consent form. I have been given the opportunity to ask questions and have received satisfactory answers.

◊ Consent to Procedure(s) and Treatment: Having read this form and spoken with the physician, my signature below acknowledge that I voluntarily give my authorization and consent to the performance of the procedure(s) described above.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge a copy of the Notice of Privacy Practices has been provided to me to review outlining my Personal Health Information (PHI) and how that information is used.

AGREEMENT FOR BINDING ARBITRATION

Any disputes or claims of the patient, his or her dependents, or the patients designated representative (hereinafter collectively referred to as "patient") against the Guam Urgent Care, LLC dba HagatnaMED Clinic, or any other their staff, nurses, technicians, physicians, employees or personal (hereinafter collectively referred to as "HagatnaMED Clinic") such as but not limited to claims for medical malpractice (including without limitation whether any services rendered or omitted were necessary or authorized or were improperly, negligently, or incompletely rendered or omitted), shall be submitted to binding arbitration; and shall not be resolved by a lawsuit or resort to court process, except as the applicable law provides for judicial review or confirmation of arbitration proceedings.

The arbitration shall be conducted consistent with the Federal Arbitration Act (9 U.S.C., et seq.) to the extent it is applicable, and to the exclusion of any provision of any local law purporting to qualify, limit, or foreclose the rights of the parties to arbitrate disputes, and such arbitration shall be subject to the substantive law of Guam including, without limitation, the applicable standard of care and any medical malpractice liability caps applicable under Guam law. Any dispute as to whether a particular matter is subject to arbitration shall itself be decided by the arbitrators.

The patient acknowledges that by agreeing to arbitrate he or she, and those on whose behalf he or she are acting, give up any rights they might otherwise have to have any such dispute decided in a court of law or before a jury. The decision of the arbitrators shall be final and binding unless duly vacated by a court of competent jurisdiction pursuant to the Federal Arbitration Act; and there shall be no right to a court trial de novo in the event that a patient/patient representative is dissatisfied with any arbitral award rendered.

Arbitration is initiated by a patient sending a written demand for arbitration detailing with the reasonable specificity the nature and details of the claim. This written demand should be sent via registered mail to HagatnaMED clinic, 250 Nanbo Building Suite 203 Hagatna, Guam 96910. A claim shall be waived and forever barred if, on the date the demand for arbitration is mailed, the applicable statute of limitations would bar the claim or if the claim is not pursued with reasonable diligence.

Any and all disputes to be arbitrated shall be submitted to a single arbitrator chosen by the mutual agreement of the patient and HagatnaMED Clinic. In the event the parties are unable to agree upon a single arbitrator within sixty (60) days of the demand for arbitration, each party to such arbitration shall choose one arbitrator; and the two arbitrators so selected shall name a third arbitrator. Once a single arbitrator has been agreed upon, or the three arbitrators have been empaneled, they shall order the parties to promptly exchange copies of all exhibits and witness lists and, if requested by a party, to produce other relevant

documents, to answer up to twenty (20) interrogatories (which total shall include any subparts), to respond to up to ten (10) requests for admissions (which shall be deemed admitted if not denied within thirty (30) days), and to produce for deposition and, if requested, at the hearing up to four (4) witnesses that such party had previously listed. Any additional discovery shall only occur by agreement of the parties or as ordered by the Arbitrators upon a finding of good cause. All discovery shall be completed thirty (30) days prior to commencement of the hearing process. If any dispute or disagreement arises with respect to the discovery contemplated herein, the Arbitrator(s) shall preside over the Arbitration, shall accept relevant evidence, and may (in their discretion) hear live testimony of the parties and their exert and other witnesses, examine and cross-examine witnesses, allow counsel to examine and cross-examine witnesses, hear arguments of attorneys, and otherwise conduct and control the hearing(s).

The arbitrator(s) shall issue a concise, written award, and in the case of three arbitrators, the award shall be joined in by two or more of the arbitrators. Each party shall bear its own costs and fees unless found to be substantially prevailing party. The expenses of the single arbitrator shall borne jointly and equally by the parties. In the case of three arbitrators, each party shall bear the costs and fees for their own selected arbitrator unless found to be the substantially prevailing party, and the expenses of the neutral arbitrator shall borne jointly and equally by the parties. The substantially prevailing party shall be entitled to recover from the losing party or parties (jointly or severally) its reasonable attorneys' fees and court or arbitration costs incurred in resolving or settling the dispute.

The Arbitrator(s) shall not have the power or authority to award any amount in the nature of character of punitive or exemplary damages, but shall have the power to issue an award for compensatory damages, and to issue injunctive or equitable relief as appropriate.

By signing below, the patient or designated representative, acknowledges receiving a copy of the HAGATNAMED CLINIC POLICY AGREEMENT, CONSENT FOR MEDICAL OR SURGICAL PROCEDURE AND AGREEEMNT FOR BINDING ARBIRATION and understands and agrees with the policies as stated above, and accepts primary responsibility for all fees and services rendered which may include costs not covered by any health insurance or plan.

Print Patient Name:_____

Signature of Patient/Designated Representative:_____Date: _____

CONSENT TO TREAT A MINOR

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor, and hereby authorize HagatnaMED Clinic to administer treatment, as it so deems necessary to the minor. In the event that the minor has received treatment at HagatnaMED Clinic prior to the date of this consent, I confirm my authorization of such treatment in addition to the current treatment.

Name of Custodial parent/Legal guardian:_____Date: