Innovative Medicine

AGREEMENT AS TO RESOLUTION OF CONCERNS

"I", "Patient/Guardian" shall be understood to mean _____,
"Physician" shall be understood to mean C.Turner,M.D./ C. Turner, M.D., P.C.

Further, I understand that I am entering into a contractual relationship with Physician for profession care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by Physician, I, the patient/guardian and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I (the patient) and/or my representative agree to use board-certified expert medical witness (es) in the same specialty as Physician. Furthermore, I agree that these expert witnesses will be members in good standing of and adhere to the guidelines and/or code of conduct defined for expert witnesses by the American Society of Addiction Medicine.

In further consideration for this Physician agrees to the same stipulations.

Patient/guardian and Physician acknowledge that monetary damages may not provide an adequate remedy for breach of this Agreement. Such breach may result in irreparable harm to Physicians' reputation and business. Patient/guardian and Physician agree in the event of a breach to allow specific performance and/or injunctive relief.

_____ _____
Physician Patient/Guardian Date

_____
Effective from date of treatment: (this means the first time the patient was seen in our clinic)

Binding Arbitration

I agree that any controversy, including any malpractice claim, arising out of or in any way relating to the diagnoses, treatment, or care of me by Dr. Turner or his employees, shall be submitted to binding arbitration. This also includes past diagnoses and treatment.

Patient or guardian signature _____ Date_____