Medical Services Arbitration Consent Form

Patient Information

Full Name

Date of Birth

Address

Consent to Arbitration

I acknowledge and agree to resolve any dispute arising from the medical services provided by this facility through binding arbitration, rather than in court. I understand and voluntarily consent to this process.

☐ I have read and understand this consent for arbitration.

Additional Comments (optional)

Patient/Representative Signature

Date

Provider/Witness Signature

Date