

Medical Arbitration Agreement Consent Form

This agreement is entered into between the patient and the medical provider, agreeing to resolve all medical disputes or claims through binding arbitration, waiving the right to a jury or court trial. Please read this agreement carefully.

Patient Information

Patient Name

Date of Birth

Address

Provider Information

Provider Name

Practice Name

Consent

I understand and voluntarily agree to submit any dispute, claim, or controversy arising out of or relating to the medical care provided, including claims of medical malpractice, to final and binding arbitration. I acknowledge that by signing this agreement, I am waiving my right to a jury or court trial.

Patient/Representative Signature

Date

Provider Signature

Date

