



INSTRUCTIONS FOR USE OF THE PHYSICIAN/PATIENT
ARBITRATION AGREEMENT

- Use FPIC Arbitration Agreement forms ONLY! ALWAYS PRINT OR PHOTOCOPY FORMS IN COLOR.
Offer Agreement to new and continuing patients.
If a translator is used, translator's name must appear on the agreement, preferably as "Physicians' Authorized Representative", on the first line in the lower left corner.
On the lower right side, have patient sign their full name and date the form (parent or legal guardian's signature if patient is a minor or incompetent adult).
On the next line under the signature, have patient PRINT their name (this must be name of patient, even if parent or guardian has signed the form).
If applicable, on the next line under the patient's printed name, have the parent or legal guardian PRINT their name and how they are related to the patient; for example, "mother".
On the lower left side, sign your name and date the form.
On the next line under your signature and date, PRINT or STAMP the physician's or group name. (The stamp must appear on both white and yellow copies).
Make one copy for the patient and place the original in the patient's chart.
If patient refuses to sign the agreement, follow this procedure:
Write "REFUSED" on the Patient/Guardian signature line of the blank agreement and date.
PRINT patient's name below the signature line.
Sign your name and date the form on the lower left side.
File BOTH copies in the patient chart.
Should a patient refuse to sign the arbitration form, you should kindly and gently advise them to seek care and treatment elsewhere - unless you are compelled by law to treat such patients. Electing to see patients without the signed form may jeopardize your coverage; please refer to Policy Form FWY-07 for details.

ORDER FORM

If your office does not have the capacity to print the forms in color, hard copies are available free of charge to FPIC members. Forms are shipped 50 per pack; a minimum of one pack may be ordered. Please indicate below the number of packs you wish for each selected language.

NUMBER OF PACKS NEEDED: (50 Per Pack)

q English \_\_\_\_\_
q Spanish \_\_\_\_\_
q Vietnamese \_\_\_\_\_
q Korean \_\_\_\_\_
q Other: \_\_\_\_\_
q Russian \_\_\_\_\_
q Armenian \_\_\_\_\_
q Farsi \_\_\_\_\_
q Chinese \_\_\_\_\_
q Other: \_\_\_\_\_

PLEASE PRINT:

Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_
Fairway Policy #: \_\_\_\_\_
Mailing Address: \_\_\_\_\_

FAX ORDER TO:

Thorson Specialty Insurance Services, Attn: Operations Department, at (818) 979-2501.