COMMONWEALTH
EYE SURGERY

(859) 224-2655 | 2353 Alexandria Drive, Suite 260 | Lexington, KY 40504
Lance S. Ferguson, M.D. | Gary N. Wörtz, M.D. | Howell M. Findley, O.D. | R. Marty Smith, O.D. | Lance Long, O.D.

REQUEST FOR MEDICAL/SURGICAL SERVICES

I am requesting medical care from Commonwealth Eye Surgery, Lance S. Ferguson M.D. P.S.C., Commonwealth Eye Clinic, Inc., and their physicians, Dr. Lance Ferguson, Dr. Gary Wörtz, Dr. Howell Findley, Dr. R. Marty Smith, and Dr. Lance Long (collectively, referred to as "Medical Providers").

1. I am having an emergency at this time.

   Write "YES" or "NO"_____ **Patient's Initials** _____

   If the answer is "Yes," stop now and request emergency help immediately.
   If you answer "NO" to any of the following questions, the above Medical Providers will not see you and you will need to consult with another doctor.

2. I understand that my treatment is elective. In other words, I may choose NOT to undergo surgery or receive medical treatment.

   Write "YES" or "NO"_____ **Patient's Initials** _____

3. I irrevocably agree (i) to submit any and all claims against any of the entities listed above, individually or collectively, to arbitration rather than to a judge or jury, (ii) that any of the entities listed above, individually or collectively, may submit any claim by me to binding arbitration, and (iii) to be bound by the result even if I decline to participate. The arbitration shall be administered by the National Arbitration Forum under the Code of Procedure then in effect, and judgment on the award rendered by the arbitrator(s) may be interested in any court having jurisdiction thereof. Arbitration is a process by which patients and doctors and other Medical Providers hire an impartial person to settle their disagreements.

   Write "YES" or "NO"_____ **Patient's Initials** _____

4. I irrevocably agree to limit any claim relating to any diagnosis, treatment or care by any of the entities listed above, collectively, to $250,000 for all non-economic damages, including pain and suffering and/or inconvenience. This provision does not limit a recovery for economic damages, such as lost wages.

   Write "YES" or "NO"_____ **Patient's Initials** _____

5. In the event I assert a claim against any of the entities listed above, individually or collectively, and it is denied, then I agree to pay for reasonable attorney and expert fees of the defense of any of the entities listed above, individually or collectively.

   Write "YES" or "NO"_____ **Patient's Initials** _____

I request services from one or more of the entities listed above in full agreement with and understanding of the agreements I have initialed above. I have not relied on any oral representations by anyone on staff in completing this form and am not under any pressure to sign. This form applies to all past and present and future services rendered by any of the entities listed above, individually or collectively, and shall bind me and my heirs, legal representatives and assigns. Each provision shall be sever able from the remainder and enforceable to the fullest extent of the law.

Patient Signature _____ Patient Name (Printed) _____ Date _____

A copy of the signed form was received from the patient by:

Staff Signature _____ Staff Name (Printed) _____ Date _____