Ultimate Image **The Angelic Body, LLC.**

Todd A. Besnoff

Doctor – Patient Arbitration Agreement

(Please read carefully)

This agreement is made between Ultimate Image, The Angelic Body LLC., Todd A. Besnoff M.D. , and their agents, employees, servants, or any of the foregoing referred to hereinafter as "doctors", and ____ hereinafter referred to as "patient". I have been advised that I may consult with counsel before signing this agreement.

It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians, or any persons deriving their claims through, and on behalf of the patient.

It is understood and agreed by the patient that he or she has voluntarily selected these doctors for treatment and he or she is not required to use these doctors and that there are other competent medical doctors in Florida who perform the same or similar medical procedures.

It is further understood that in the event of any controversy or dispute which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever, then the parties agree that the dispute shall be resolved by arbitration as provided by the Florida Arbitration Code, Chapter 682, Florida Statues.

This arbitration shall be binding and shall be in lieu of, and instead of, any trial by judge or jury. Both the procedural and substantive laws of the State of Florida shall apply to the proceeding. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. The panel of three (3) arbitrators shall hear and decide the controversy, and the decision shall be binding on all parties, and be enforced by a count of competent jurisdiction in, and for, Pinellas County, Florida.

This agreement shall remain in effect for all treatment and surgery provided the patient, presently and at any future date.

IN WITNESS WHEREOF, we have hereunto set our hands this ______ day of ____, 20____

PATIENT:

By: ________________________________
(Patient Signature as Authorized Agent)

WITNESS:

by: ________________________________

____
(Patient's Spouse-if available)

STATE OF FLORIDA

COUNTY OF PINELLAS

The foregoing document was acknowledge before me this the _____ day of _________, 20___

By____, who is personally known to me or who produced ____ as identification, and who did/ did not take an oath.

____

NOTARY PUBLIC

My commission expires: ____________