ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided a copy of the Florida Atlantic University Notice of Privacy Practices and have thereby been advised of how my health information may be used and/or disclosed, and how I may obtain access to and control this information.

Signature of Patient (or Authorized Personal Representative) _____ Date _____

Print Name of Patient (or Authorized Personal Representative) _____ Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate) _____

NOTICE OF LIMITED LIABILITY PURSUANT TO SECTION 1012.965, FLORIDA STATUTES

I, on behalf of myself, my child, and/or my ward, acknowledge that I have been notified that:

I, my child, and/or my ward, will receive medical care and treatment provided by employees and/or agents of the Florida Atlantic University Board of Trustees (hereafter referred to as "FAU") at this facility.

The FAU employees and/or agents providing this medical care and treatment may include, but are not limited to: faculty, clinical supervisors, and graduate clinicians, who will at all times be under the exclusive supervision and control of FAU.

I, on behalf of myself, my child, and/or my ward, understand that the employees of FAU are not employees or agents of any entity other than FAU.

Additionally, I, on behalf of myself, my child, and/or my ward, understand that liability, if any, which may arise from the care rendered by FAU health care providers is limited as provided by law. The law provides that "Neither the state nor its agencies or subdivisions shall be liable to pay a claim or a judgment by any one person which exceeds the sum of $200,000 or any claim or judgment, or portions thereof, which, when totaled with all other claims or judgments paid by the state or its agencies or subdivisions arising out of the same incident or occurrence, exceeds the sum of $300,000." (Section 768.28(5), Florida Statutes)

Signature of Patient (or Authorized Personal Representative) _____ Date _____

Print Name of Patient (or Authorized Personal Representative) _____ Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate) _____

Printed Name of Witness _____ Date _____

AGREEMENT TO MEDIATE

In accepting care at this facility where FAU employees and/or agents provide medical care and treatment, I agree that before I file any lawsuit against the FAU Board of Trustees for medical care and treatment rendered by its health care providers, I will first attempt to resolve my claim through confidential mediation. Mediation is a process through which a neutral third party who has been certified to be a mediator tries to help settle claims. FAU will pay the cost of the mediator. I further agree that any mediation must take place in the state and county where my treatment was rendered, unless all parties agree otherwise. This agreement is binding on me and any entity or individual making a claim on my behalf. This agreement does not waive my right to file a lawsuit if the mediation process fails to resolve my claim. I understand that lawsuits must be filed within a certain time period and that the time for me to file a lawsuit is not extended as a result of my participation in mediation.

Signature of Patient (or Authorized Personal Representative) _____ Date _____

Print Name of Patient (or Authorized Personal Representative) _____ Authority of Personal Representative (e.g., parent, legal guardian, health care surrogate) _____

Witness _____ Date _____

COPIES OF THIS STATEMENT SHALL BE VALID AS THE ORIGINAL/ORIGINAL SIGNATURES ON FILE WITH FAU