

PHYSICIAN/PATIENT DISCLOSURE FORM

- John Hoffman, M.D. (The "Physician") NPI: 1649241589
- Tuvi Mendel, M.D. (The "Physician") NPI: 1033189535
- Kristyn Darmafall, M.D. (The "Physician") NPI: 1902190879
- Michael Dolphin, D.O. (The "Physician") NPI: 1588635502
- Megan Crosmer, M.D. (The "Physician") NPI: 1770874034

I _____ hereby acknowledge the receipt of the Patients' Rights, Advance Directives and Ownership Notification Form for Mississippi Valley Surgical Center (the "Notification Form") this _____ day of _____ 20_____. I further acknowledge that I have been given the opportunity to ask questions of my physicians regarding the Notification Form and request an advance directive form prior to any procedure at a Mississippi Valley Surgical Center if I so desire.

During the course of your physician/patient relationship with the Physician, the Physician may at a future time refer you to Mississippi Medical Plaza, L.C., which operates an ambulatory surgery center located at 3400 Dexter Court, Suite 200, Davenport, Iowa 52807 and Plaza Physical Therapy located at 3385 Dexter Court, Suite 301 and North Scott Physical Therapy at 811 E. LeClaire Road, Eldridge, Iowa.

In connection with any such referral or referrals, the Physician hereby advises you that the Physician has an investment interest in Mississippi Medical Plaza, L.C. and thus in its ambulatory surgery center and, Plaza Physical Therapy and North Scott Physical Therapy are an ancillary resource, as is the x-ray equipment, and durable medical equipment supplied at the practice. The Physician has an investment interest in Orthopaedic Specialists, P.C. and Plaza Physical Therapy and North Scott Physical Therapy.

Please be advised that you have the right to obtain the health care items and services, which the Physician refers you, at any location or from any ambulatory surgery center, hospital, provider or supplier of your choice, including Mississippi Medical Plaza, L.C., Plaza Physical Therapy and North Scott Physical Therapy.

Please be advised that your physician may have a financial or consulting relationship with a medical device company or may have developed or own proprietary information relating to the design of instrumentation that maybe used during a procedure. Please be advised that the physician's decision to use a device is in no way related to this relationship.

I, the undersigned patient (the "Patient"), received this Physician/Patient Disclosure Form from the above-referenced Physician, and I read and understood the information contained in this Physician/Patient Disclosure Form. The Physician furnished me with this Physician/Patient Disclosure Form prior to the Physician's referral of me to Mississippi Medical Plaza, L.C., North Scott Physical Therapy and/or Plaza Physical Therapy.

Date: _____ 20_____

(Signature of Patient)

(Printed Name of Patient)

Please sign below if the person signing this form is the parent, legal representative or guardian of the Patient. I, the undersigned, am parent, legal representative or guardian of the Patient. The Patient either is a minor or is not physically able or competent to sign this disclosure on his or her behalf. I received this Physician/Patient Disclosure Form from the Physician, and I read and understood the information contained.

The Physician furnished me with this form prior to the Physician's referral of the Patient to Mississippi Medical Plaza, L.C., Plaza Physical Therapy or North Scott Physical Therapy. I hereby sign this Physician/Patient Disclosure Form on behalf of the Patient, and I swear that I am legally authorized and empowered to sign this Physician/Patient Disclosure Form on behalf of Patient.

Date: _____ 20_____

(Name of Patient)

(Signature of Parent/Legal Representative/Guardian)

(Printed Name of Parent/Legal Representative/Guardian)

(Relationship to Patient)