GUIDELINES FOR PEER REVIEW MEDIATION

The peer review program is a public service of the Northwest District Dental Association (hereafter "we" or "us"). The primary purpose of peer review mediation is to resolve problems between you and the dentist in a fast, cost effective manner. In exchange for the committee agreeing to mediate your case, you agree to abide by the following guidelines:

1. Complaints must be made in writing on this form. Letters or other complaint forms will not be accepted.

2. Cases involving the following are not eligible for review: malpractice litigation; formal regulatory investigation; dental fees; treatment which occurred more than 12 months before the patient's last appointment with the dentist; where the patient has posted a negative on-line review about the doctor; and dentists who are not members of the Florida Dental Association.

3. We will not correspond with attorneys or send reports to attorneys. All correspondence will be with the patient, or if the patient is a minor, with the guardian.

4. Mediation is voluntary. You do not have a "right" to have us mediate your dispute. We do not have the power to award damages, we merely recommend settlement amounts.

5. If necessary to facilitate your request, the patient agrees to be present for examination by the committee at a time and place designated by the committee. Failure to keep the appointment may be grounds for dismissal of your request.

6. After reviewing your request, a mediator will contact you to discuss the case.

7. By your signature on the reverse side of this form, and in consideration for the committee agreeing to mediate your case, you agree to indemnify and hold the Association and its agents harmless from any and all liability, loss, damages, cost or expense which they may hereafter incur, suffer or be required to pay that are related to or arise out of your request or the peer review.

8. Peer review is performed by volunteer dentists and delays occur. It is solely your responsibility to take timely action to protect your dental health or legal rights and neither peer review nor its volunteers assume any responsibility in this regard.

9. You hereby give permission for the peer review committee to perform a clinical examination on the patient, if necessary.

10. A copy of this form is as valid as the original and you have a right to a copy of this form.

11. If you do not sign this form or revoke it, we will be unable to review your complaint.

12. The authorization given under this form does not expire until such time as we determine we no longer need access to your patient record(s) in order to provide you with peer review services or we conclude your case (the time frame for appeals has expired or the final appellate committee has acted).

13. You may revoke this form but only in writing delivered to the address below. Revocation will not affect any action taken by us in reliance on the form before it was properly revoked.

DO NOT ATTACH ADDITIONAL PAGES

CANCELLED CHECKS OR PAID BILLS ARE UNNECESSARY

Sign and mail this completed form to: Northwest District Dental Association
2910 Kerry Forest Parkway, D4-309
Tallahassee, FL 32309
Fax 850.391.9311

PEER REVIEW MEDIATION REQUEST

Name of person filing request: _____ Date: _____

Name of patient (if different from above): _____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (day): _____ Phone (evening): _____

Name of dentist: _____ Date of last appt: _____

Address: _____ City: _____

State/Zip: _____ Phone: _____

DO NOT request a refund of fees or money in this or any correspondence provided to the committee.

Check procedures that apply:

_____ Crown(s)
_____ Bridge - removable
_____ Bridge - fixed
_____ Periodontics
_____ Endodontics (root canal)
_____ Oral Surgery (extraction)
_____ Orthodontics (braces)
_____ Fillings
_____ Denture (upper/lower)
_____ Implants

Check problems that apply:

_____ Pain
_____ Discomfort
_____ Color
_____ Shape
_____ Bite
_____ Doesn't fit
_____ Appearance
_____ Loose
_____ Treatment plan not followed
_____ Treatment unsuccessful

I have _____ have not _____ filed similar or related peer review requests involving the dental treatment.

I have _____ have not _____ filed a complaint with the Board of Dentistry.

I have _____ have not _____ filed litigation involving the dental treatment.

I have _____ have not _____ filed a negative comment or review about the dentist on the internet.

I am _____ am not _____ represented by legal counsel on this complaint.

By my signature below, I have read, understood and agree to abide by guidelines on the reverse side of this form. I further authorize copies of my patient record(s), including but not limited to billing and insurance information, as the minimum amount necessary to accomplish the peer review program's purpose, to be disclosed to or used by the Florida Dental Association, the component and/or affiliate dental association(s) involved in the peer review mediation, and their agents or employees. I understand that they may use this information for peer review purposes only and otherwise further disclose it only to governmental agencies as required by law, in which case it will no longer be confidential.

_____ _____

Signature (patient or legal guardian) Date