Rhode Island Dental Association's Agreement to Submit to Peer Review

• This page is to be filled out by the **PATIENT**

Patient Name: _____

Parent/Guardian: _____

Address: _____

Home Phone: _____ Work Phone: _____

Patient's Statement (your specific problem(s) with the treatment to be reviewed)
My dentist, Dr. _____ performed the following treatments: Complaint about treatment: Attach additional pages if needed

• Date of last appointment for this treatment: _____month _____year
• The total fee agreed upon for the treatment under review is $_____
• My dentist has been paid $_____ for the treatment under review.
• I understand that if there is an outstanding balance. I will be required to place this amount in the Rhode Island Dental Association's escrow account pending the outcome of the Peer Review. (Enclose copies of relevant billing statements, cancelled checks, insurance statements, etc.)
• I have recently consulted with or been treated by the following dentist(s): _____
_____
• I will request that the above dentist(s) forward copies of my records to the Rhode Island Dental Association.
• I understand that if the Committee finds that the treatment performed on my behalf is not appropriate or does not meet acceptable standards for quality, the amount of the feeds held in escrow by the Dental Society for this treatment will be returned to me. If the Committee finds the treatment to be appropriate and performed consistent with the standards of care – or if I breach this Agreement – the remainder of the fees for my treatment will be disbursed to my treating dentist.
• Read and sign the back page of the Agreement.

• This page is to be filled out by the **DENTIST:**

Dentist Name: _____

Address: _____

Office Phone: _____ Office Phone: _____

Dentist's Employer/Partner/Associate (if applicable): _____

Treating Dentist's Statement (your experience with the treatment under review)
Date treatment completed: _____ Date patient last presented regarding this treatment: _____ Additional relevant information regarding the treatment: Attach additional pages if needed

• The total fee for the treatment under review is $ _____

• I have been paid $ _____ for this treatment by the patient and/or their benefit company leaving an outstanding balance of $ _____

• Enclose a copy of the patient's treatment and payment records and x-rays in accordance with paragraph #7

• Read and sign the back page of the Agreement.

1. This is a legally binding contract to enter into an alternative dispute resolution process for the purpose of finally resolving the stated dispute between the parties. Each party to this contract specifically agrees that they **WAIVE THE RIGHT TO SUBSEQUENTLY SUE THE OTHER PARTY, ON THE FACTS OR ISSUES SUBMITTED TO THE PEER REVIEW COMMITTEE, IN ANY COURT ACTION OR PROCEEDING, INCLUDING BUT NOT LIMITED TO ANY MALPRACTICE ACTION OR COLLECTION ACTION, EXCEPT TO BRING AN ACTION OR PROCEEDING TO ENFORCE THIS CONTRACT AND/OR THE AWARD OF THE PEER REVIEW COMMITTEE.**
2. We appoint the Peer Review Committee to hear and decide the dispute between the patient and the dentist(s). We understand and agree that the Peer Review Committee will not keep a verbatim record of this proceeding. We understand that we have the right to be represented by our own attorneys and acknowledge that we were given the opportunity to have our attorneys review this *Agreement* before signing it.
3. We acknowledge, understand, agree to, consent to, and accept that the rights afforded under the Rhode Island Superior Court Rules Governing the Arbitration of Civil Actions, including but not limited to the rights under Rule 2 – Arbitrators - Selection, Rule 3 – Arbitration Hearings, Rule 7 – Administration, and Rule 7.1 – Administration and Proration of Reasonable Costs of Arbitration, which rights include the right to cross-examination of witnesses, are hereby expressly waived and are not applicable to the Peer Review proceedings, except that the right to be represented by an is not waived.
4. Each party of this contract specifically agrees that the decision and award of the Peer Review Committee shall be binding.
5. We agree that if the Peer Review Committee orders the return of any money from the dentist to the patient, the amount to be returned shall not be more than the amount of the fee actually paid by the patient, or on behalf of the patient, to the dentist for the treatment that is the subject of this dispute. Further, we agree that the amount of monies paid to the dentist by the patient shall not be more than the amount of the agreed upon fee for the treatment under review, if the Peer Review Committee finds the treatment under review to be appropriate and satisfactory. We agree that any award granted following a Peer Review hearing will not be paid until the period for appeal has expired.
6. We agree that the Peer Review proceedings are to be kept in strict confidence and we will not disclose any information regarding the proceedings to anyone not a party thereto. We agree that any such disclosure will result in irreparable harm. Notwithstanding the above, we may disclose that we have submitted to Peer Review and/or a decision has been rendered and provide a copy of this *Agreement* and/or any such decision only in the following circumstances: 1) a court proceeding to enforce the terms of this *Agreement*; 2) a request from the patient's benefit provider requiring payment information and 3) a request for the information as otherwise mandated by law. Nothing in this *Agreement* changes or affects the patient confidentiality or the confidentiality afforded the Peer Review proceedings as otherwise protected by the law including, but not limited to, Chapter 5-37.3 of the Rhode Island General Laws.
7. In order that the Peer Review Committee may make a full and fair review of the dental treatment received by the patient, the patient expressly consents to the release to the Peer Review Committee of any dental records or other relevant information by any dentist who has examined the patient. The Peer Review Committee has the patient's permission to perform clinical examinations deemed necessary by the Peer Review Committee for the fair resolution of this dispute.
8. We agree not to make any claims against any members of the Peer Review Committee for their acts while performing their duties as members of the Peer Review Committee.
9. Non-payment of any award will constitute a breach of this contract, entitling the non-breaching party the right to enforce the award in the courts of this State or commence any other proceedings based on the same or similar facts without the limited imposed by Paragraph 1 herein.
10. Appeal of the decision of the Peer Review Committee must be made in writing within **thirty days** of the date of the decision letter. The Council on Peer Review of the Rhode Island Dental Association shall decide upon any such appeal. We agree further that the grounds for appeal of the Peer Review Committee's decision are limited to procedural irregularities or the discovery of significant new evidence. The original Peer Review decision shall remain in full force and effect until after a new, final decision is made following a rehearing.
11. At the conclusion of the Peer Review process, the Rhode Island Dental Association shall retain the *Agreement to Submit to Peer Review* and the Committee's decision letter. No other materials submitted to the Committee will be retained.
12. We further understand that the Dentist is obligated as a member of the Rhode Island Dental Association to participate in the Peer Review proceeding upon the request of the patient.
13. Once the parties have signed this Peer Review *Agreement* it is understood and agreed that all settlement discussions and other efforts to resolve the case without a hearing shall be conducted only through the Peer Review mediator. It shall be deemed a violation of the terms of this Peer Review *Agreement* to fail to use the Peer Review mediator for any settlement discussion or attempt to resolve the case without a hearing.

This process is explained more fully in the pamphlet *A Guide to Peer Review*. We acknowledge that we have received and read both a copy of *A Guide to Peer Review* and this *Agreement* before signing, and that we fully understand and accept the terms of this contract, including the specific waivers of rights contained in this contract.

PATIENT *Signature (Parent must sign for a minor)* Date

DENTIST *Signature* Date

DENTIST'S EMPLOYER/PARTNER/ASSOCIATE (IF APPLICABLE) *Signature* Date

Return this completed and signed *Agreement* to the Rhode Island Dental Association.