ARTHRITIS
AND
RHEUMATISM
ASSOCIATES, P.C.

Patient Experience Testimonial

If you would like to recognize one of our doctors or staff members who provided exceptional service during your office visit, kindly take the time to fill out this form and submit your testimonial to us. Your testimonial may serve as inspiration and encouragement for others who are suffering from arthritis or other musculoskeletal conditions.

Your Story:

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Some questions to reflect on:
How did the care from our physicians help you? How has your daily life improved?

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Would you recommend ARA to a friend or relative? Why?

_____
_____

What do you consider to be the most valuable aspect of your experience with us?

_____
_____

As it relates to the medical care, what sets us apart from others?

_____
_____

I, _____, being over the age of 18 (and the parent or legal guardian of the patient identified below), hereby give Arthritis and Rheumatism Associates, P.C. and is physicians, staff, subsidiaries, affiliates and successors (the "Practice") the absolute, royalty-free, irrevocable right and permission to use 1) my first name and last initial, 2) age (but not my birth date), 3) my story as set forth above (as the same may be edited), and 4) background about my history and condition ("My Information"), for the purpose of advertising and/or promoting the Practice, education, training or other lawful purpose. I hereby consent to My Information being used in printed materials, electronic media (e.g., electronic mail, Internet web sites, etc.), and other trade, display, exhibit and/or other promotional materials. I waive my right to inspect and approve any finished product including My Information, including, without limitation, any written copy that may be used or created in connection with My Information.

By signing this Patient Experience Testimonial, I further agree that I will not hold the Practice or any publisher of the Practice's materials including My Information responsible for any liability or damages resulting from the Practice's use of My Information, including, without limitation, any claim for violation of copyright or other intellectual property rights, damages, judgments, losses, expenses or reasonable attorneys' fees.

Patient Name: _____

Signature: _____ Date: _____