



**Jeanne Teleia, LMFT, CSAC
Nai'a Aloha, LLC
Honoka'a, HI 96727**

**Phone: 224-5008
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Arbitration Agreement

I authorize the release of any medical information necessary to process medical claims. I permit a copy of this authorization to be used in place of the original. I also authorize payment from my insurance company to be made directly to JEANNE TELEIA, dba Nai'a Aloha, LLC. I hereby agree that if payment on my account is not made in full when due, I agree to be responsible for all collection costs including attorney fees. Except for collection actions against me, I agree that any controversy or claim arising out of our relations to the psychotherapist-client relationship herein, or the breach thereof, shall be settled by Arbitration in accordance with the Commercial Arbitration rules of the American Arbitration Association, and Judgment upon the award rendered by the Arbitrator may be entered in any court having jurisdiction thereof. I understand by agreeing to Arbitration, I am waiving my rights to a jury trial.

Date _____ Signature _____

Printed Name _____