

PATIENT INFORMATION

Date: _____

Name: _____ Preferred Name: _____

Mailing Address: _____ Apt# _____ City _____ State _____ Zip _____

Street Address: _____ Apt# _____ City _____ State _____ Zip _____

Preferred Phone:() _____ Alternate Phone:() _____ Date of Birth: ____/____/____
(Mo.) (Day) (Year)

Sex: M F Email: _____ Marital Status: Married Single Other

Preferred Language: _____ Ethnicity: Hispanic Non-Hispanic

Race: Caucasian Native American Asian African American Pacific Islander Other _____

Social Security No.: _____ Employer: _____ Employer Phone: () _____

Primary Care Physician: _____

Whom We Can Thank for Referring You to Us: _____

RESPONSIBLE PARTY INFORMATION (If different from patient.)

Name: _____

Relationship to Patient: (Circle One) Spouse Father Mother Other: _____

Mailing Address: _____ Apt# _____ City _____ State _____ Zip _____

Preferred Phone:() _____ Date of Birth ____/____/____ Social Sec. No.: - - -
(Mo.) (Day) (Year)

Employer: _____ Employer Phone: () _____

PERSON TO CONTACT IN CASE OF EMERGENCY (If possible, list someone with a different phone number than your own.)

Name: _____ Relationship to Patient: (Circle One) Spouse Father Mother Other: _____

Home Phone: _____ Mobile Phone: _____

INSURANCE INFORMATION

1) Primary Insurance Company: _____

Claims Address: _____ City _____ State _____ Zip _____

Group No. _____ ID No. _____

Relationship of Patient to Insured: (Circle One) Self Spouse Child Other

Policy Holder: _____ Date of Birth: ____/____/____
(Mo.) (Day) (Year)

2) Secondary Insurance Company: _____

Claims Address: _____ City _____ State _____ Zip _____

Group No. _____ ID No. _____

Relationship of Patient to Insured: (Circle One) Self Spouse Child Other

Policy Holder: _____ Date of Birth: ____/____/____
(Mo.) (Day) (Year)

(CONTINUED ON BACK)

MEDICAL INFORMATION RELEASE

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of Central Utah Clinic, P.C. (the "Clinic") and that the Clinic may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or worker's compensation carriers. I further acknowledge that the Clinic may disclose my patient information to referring or treating health care providers, and for payment and health care operations. I hereby authorize the Clinic to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnostic test reports, films/images, and other clinic information deemed necessary by the Clinic physicians or representatives. I understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with the Clinic's privacy policy.

Patient/Responsible Party Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby consent to the medical treatment, diagnostic and laboratory tests, and other procedures, which the physician(s) may deem advisable in treatment of my case (or as legal guardian for patient). The Clinic will determine the proper disposition of any tissues, parts, or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.

Patient/Responsible Party Signature: _____ Date: _____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I hereby authorize any benefits due me to be paid directly to the Clinic, 1055 North 500 West, Provo, Utah 84604. I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

A finance charge (1.5% per month/APR 18%) may be added to any amount for which payment has not been received within 60 days from the date of the statement on which the amount first appears. I hereby agree to pay a service charge of \$20.00 for each check or other instrument tendered by me but returned to this facility. Additional service charges may be levied for accounts placed with third-party collection agencies, or failure to make necessary co-payments at the time of service.

It is understood and agreed that if I fail to pay this account in accordance with policy, then I will pay all reasonable attorney fees and other costs incurred for collection of this account.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of the Clinic's financial policy and agree to pay for said medical services according to such terms.

Patient/Responsible Party Signature: _____ Date: _____

MEDICARE PATIENT AGREEMENT
(Required by Medicare for all Medicare claims)

Entitlee's Name _____

Medicare Subscriber Number _____

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to CENTRAL UTAH CLINIC, P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to release to Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

This authorization is in effect until I choose to revoke it in writing.

Signature: _____ Date: _____

Employee Signature: _____ Date: _____

Central Utah Clinic, PC
ARBITRATION AGREEMENT

Article 1 Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2 Definitions

- A. The term "we," "parties" or "us" means you, (the Patient), and the Provider.
- B. The term "Claim" means one or more Malpractice actions defined in the Utah Health Care Malpractice Act (Utah Code 78-14-3 (15)). Each party may use any legal process to resolve non-medical malpractice claims.
- C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.
- D. The term "Patient" or "you" means:
 - (1) you and any person who makes a Claim for care given to YOU, such as your heirs, your spouse, children, parents or legal representatives, AND
 - (2) your unborn child or newborn child for care provided during the 12-months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

Article 3 Dispute Resolution Options

- A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:
 - (1) working directly with each other to try and find a solution that resolves the Claim, OR
 - (2) using non-binding mediation (each of us will bear one-half of the costs); OR
 - (3) using binding arbitration as described in this Agreement.You may choose to use any or all of these methods to resolve your Claim.
- B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.
- C. Arbitration - Final Resolution. If working with the Provider or using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4 How to Arbitrate a Claim

- A. Notice. To make a claim under this Agreement, mail a written notice to the Provider by certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the Provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.
- B. Arbitrators. Within 30-days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.
 - (1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.
 - (2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider(s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.
- C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.
- D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

Chart # _____

DOB: _____

- E. All Claims May Be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a Provider" for all other purposes of this Agreement.

Article 5 Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 Venue / Governing Law

The arbitration hearings will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provision of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the pre litigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 Term / Rescission / Termination

- A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.
- B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is post marked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of the Agreement (see Article 4(E)).
- C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8 Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10 Receipt of Copy I have received a copy of this document.

Provider

Central Utah Clinic, PC

Name of Physician, Group or Clinic

Name of Patient (Print)

By: _____

Signature of Physician or Authorized Agent

Date: _____

Signature of Patient or Patient's Representative



Central Utah Clinic
Your Health, Your Choice.SM

1055 N. 500 W. Provo, UT. 84604

P| 801-429-8062 F| 801-374-2615

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

I, _____, authorize Central Utah Clinic, P.C. to disclose to:
(Patient or Legal Representative(s))

Name: _____ DOB: _____ Phone: _____

Name: _____ DOB: _____ Phone: _____

Name: _____ DOB: _____ Phone: _____

The following protected health care information (check one):

- Entire medical record (NOTE: This may include records from other health care providers, patient history forms, insurance information, correspondence, etc. It is NOT strictly limited to records generated by the physician/health care provider indicated above.)
- Entire medical record for specified date(s) of service: From: _____ To: _____

ONLY the following specific information: _____

I understand that information disclosed pursuant to this authorization may include information relating to the following, unless specifically restricted below:

- Psychological / psychiatric conditions • Drug and/or alcohol abuse diagnosis and/or treatment • Genetic testing
- HIV/AIDS diagnosis and/or testing • Sexually transmitted disease(s) diagnosis and/or testing

List any restrictions: _____

The purpose of the disclosure is: _____

Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.

Right to Refuse to Sign this Authorization: I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.

Right to Revoke: I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy. To revoke this authorization, I will provide the Privacy Officer at the above listed physician/health care provider's office with a written revocation.

Right to Inspect: I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form.

Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

Photocopy: A photocopy of this authorization, including a copy that is received by fax or electronically transmitted, shall be considered as effective and valid as the original.

Expiration Date: I understand that unless I provide a written revocation at an earlier date, this authorization will expire in one year or as otherwise noted below.

Expiration Date: ____/____/____

Signature of Patient or Legal Representative(s): _____
(Note: If patient is a minor child, both parents may be required by law to sign)

Date: ____/____/____ Printed Name(s): _____

Relationship to Patient (if signed by other than patient) _____



Name: _____

MR# _____
(For Office Use Only)

In January 2011, the Federal Government launched its Electronic Health Record Initiative and one of the Core Objectives of the program is maintain complete Patient Demographics, including the following information. Your quick response to these questions would be very appreciated in assisting us to meet this objective.
Thank you for your participation.

Preferred Language: English Spanish Other _____

Race: Caucasian Native American Asian African American Pacific Islander
 Other _____

Ethnicity: Hispanic Non-Hispanic

Decline to participate:

HEALTH HISTORY

Confidential

Patient Name _____ Today's Date _____

Age _____ Birth date _____ Date of last physical examination _____

What is your reason for visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year

<p>GENERAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p>EYE, EAR, NOSE, THROAT</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision – Flashes <input type="checkbox"/> Vision – Halos	<p>MEN only</p> <input type="checkbox"/> Breast lump <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other	
<p>MUSCLE/JOINT/BONE Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	<p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p>WOMEN only</p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other	
<p>GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination				<p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? Yes No</p> <p>Number of Children _____</p>

CONDITIONS Check (✓) conditions you have or have had in the past

<input type="checkbox"/> AIDS <input type="checkbox"/> Alcoholism <input type="checkbox"/> Anemia <input type="checkbox"/> Anorexia <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Bronchitis <input type="checkbox"/> Bulimia <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts	<input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Glaucoma <input type="checkbox"/> Goiter <input type="checkbox"/> Gonorrhoea <input type="checkbox"/> Gout <input type="checkbox"/> Heart Disease <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> Herpes	<input type="checkbox"/> High Cholesterol <input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Miscarriage <input type="checkbox"/> Mononucleosis <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio	<input type="checkbox"/> Prostate Problem <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide Attempt <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tonsillitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid Fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Venereal Disease
---	--	---	--

MEDICATIONS List medications you are currently taking **ALLERGIES** to medications or substances

Pharmacy Name _____ Phone _____

All information is strictly confidential

FAMILY HISTORY (Fill in health information about patient's immediate family)

Relation	Age	State of Health	Age at Death	Cause of Death	Check if your blood relatives had any of the following:	
					√ Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS **PREGNANCY HISTORY**

Year	Hospital	Reason for Hospitalization & Outcome	Year of Birth	Sex of Birth	Complications if any

HEALTH HABITS Check (√) what substances you use and describe how much you use

	Caffeine	
	Tobacco	
	Street Drugs	
	Other	

Have you ever had a blood transfusion?
If yes, please give approximate dates:

SERIOUS ILLNESS/INJURIES **DATE** **OUTCOME**

OCCUPATIONAL CONCERNS Check (√) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other
Your Occupation:	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child or I ever have a change in health.

Patient/Responsible Party Signature

Date

Print Name of Patient/Responsible Party

Relationship to Patient

Reviewed by

Date