



PATIENT

All new patients				Complete this section if patient is not the guarantor					
Last Name		First Name		Last Name		First Name		Relationship to Patient Spouse Parent Other	
Address				Address					
City		ST	Zip	City		ST	Zip		
Primary Phone		Phone 2	Phone 3	Primary Phone		Phone 2	Phone 3		
Email Address				Email Address					
Social Security Number		Date of Birth (MM-DD-YY)	Age	Sex M F	Social Security Number		Date of Birth (MM-DD-YY)	Age	Sex M F
Emergency Contact			Emergency Phone	Emergency Contact			Emergency Phone		
Marital Status S M W Other			Maiden Name	Marital Status S M W Other			Maiden Name		
Patient Employment/Student Status <input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time				Guarantor Employment/Student Status <input type="checkbox"/> Employed <input type="checkbox"/> Student <input type="checkbox"/> Part-time <input type="checkbox"/> Full-time					
Occupation				Occupation					
Employer or School		Phone Number		Employer or School		Phone Number			
Please list any known allergies									

REFERRING DOCTOR

Last Name		First Name		Referring Doctor's Phone Number		Primary Care Physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	
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INSURANCE INFORMATION

Primary Insurance		Secondary Insurance		Other Insurance	
Insurance Company	Phone	Insurance Company	Phone	Insurance Company	Phone
Subscriber's Name		Subscriber's Name		Subscriber's Name	
Subscriber's Birthdate		Subscriber's Birthdate		Subscriber's Birthdate	
Social Security Number		Social Security Number		Social Security Number	
Insured ID (Policy No.)	Group/FECA#	Insured ID (Policy No.)	Group/FECA#	Insured ID (Policy No.)	Group/FECA#

AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND BENEFITS:

I/We hereby authorize Utah County Surgical Associates, P.C. to release any medical information that may be necessary for either medical care or in processing insurance for financial benefit. I/We will be responsible for payment for the services rendered, and furthermore agree to pay attorney fees, court costs, collection and filing fees, including charges or commission up to fifty percent that may be assessed to us by any collection agency retained to pursue this matter. I/We further agree to pay interest at the rate of 1.5% per month (18% per year). I/We understand and agree that I/we are financially responsible for all deductible amounts, Co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier.

Patient/Guarantor Signature		Date	Spouse Signature		Date
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MEDICARE PATIENT AGREEMENT:

I request that payment of authorized Medicare benefits be made on my behalf to Utah County Surgical Associates for any service rendered to me by such provider. This authorization will remain in effect until I choose to revoke it in writing.

Signature _____ Date _____



(CONFIDENTIAL)

Please fill out this health information form as completely as possible.

Name _____ Birth Date _____ Today's Date _____

MAIN REASON YOU ARE HERE _____

SYMPTOMS YOU ARE HAVING _____

MEDICAL ILLNESS

List all illnesses that you have or have had.

SURGERIES

List each surgery with the year it was done (include biopsies and tonsils).

MEDICATIONS

List all that you are taking (including vitamins and BCP).

Drug Name	Dosage	Prescribed by
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List drugs or medications to which you are allergic and the reaction _____

Preferred Pharmacy _____

(SEE NEXT PAGE)



	Living		Age or age at time of death	Cause of death or current health problems
Father	YES	NO	_____	_____
Mother	YES	NO	_____	_____

List any health problems in brothers or sisters _____

Check any of these illnesses that have occurred in your family and list who:

- Gallbladder _____
- Diabetes _____
- Strokes _____
- Heart Disease _____
- Blood Pressure _____
- Breast Cancer _____
- Other Cancer-*list type* _____
- Problems with Anesthesia-*what problems* _____

Marital Status: Single Married Divorced Widowed

Occupation _____ Other _____

Do you use tobacco? _____ How Much? _____

Do you drink alcohol? _____ How Much? _____

Do you use illicit drugs? _____ Which ones? _____

Do you follow a special diet? _____ What Type? _____

PATIENT NAME: _____

In each category, check all symptoms that apply.

CONSTITUTIONAL: ~~None~~ None Fever Chills Weight loss Weight gain Fatigue
~~None~~ Body aches Night sweats

HENT: None Sore throat Nasal congestion Headaches

BREASTS: None Lumps Nipple Discharge

CARDIOVASCULAR: None Chest Pain Heart murmur Irregular heart rate Swelling in legs
Trouble breathing with exertion Pain in legs while walking

RESPIRATORY: None Wheezing Cough Hoarseness Sleep apnea Blood in sputum
Problems with anesthesia Shortness of breath Abnormal sputum production

GASTROINTESTINAL: None Heartburn Nausea Vomiting Bloating Loss of appetite
Difficulty swallowing Diarrhea Constipation Jaundice Blood in stool Abdominal pain
Black, tarry stools Hemorrhoids Pain with swallowing Mucous in stool Narrow stools
Early fullness with eating Feeling of incomplete bowel emptying

GENITOURINARY: None Painful urination Urinating at night Blood in urine
Change in urine color Difficulty with urination

INTEGUMENT: None Rash Itching New skin lesions/moles Change in skin lesions/moles

NEUROLOGIC: None Numbness Tingling Seizures

MUSCULOSKELETAL: None Bone pain Back pain Joint pain Muscle pain Muscular weakness

ENDOCRINE: None Cold intolerance Heat intolerance

PSYCHIATRIC: None Depression Anxiety

HEME-LYMPH: None Easy bleeding Easy bruising Enlarged lymph nodes
Painful lymph nodes



ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and had an opportunity to ask questions concerning the above named practice's Notice of Privacy Practices.

Dated: _____

Signed: _____
Patient or Patient's Representative

Print Patient's Name: _____

If signed by Representative, state name of Representative.

Representative: _____

Relationship to Patient: _____



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.
- 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 provisions 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 postmarked. 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 this 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:
 UTAH COUNTY SURGICAL ASSOCIATES, P.C.

PATIENT:
 Name of Patient (Print) _____

BY: 

 Signature of Physician or Authorized Agent

 Signature of Patient or Patient's Representative (Date)

WRITTEN EXPLANATION OF ARBITRATION

A binding arbitration agreement requires a patient to submit all future malpractice claims to arbitration instead of having the claim heard in a court by a judge or jury.

An arbitrator is a person chosen to resolve disputes after hearing the information presented by both sides. You select an arbitrator, your doctor selects one, and you and the doctor agree on a third arbitrator. In the event we cannot agree, the third arbitrator will be selected by the other two arbitrators from a court-issued list of arbitrators.

You pay for the fees and expenses of your arbitrator, the doctor pays for his or her arbitrator, and the fees and expenses of the third arbitrator are shared equally.

You have the right, at your expense, to be represented in your arbitration by an attorney.

By choosing arbitration, you also have the right to require mediation. Mediation occurs before arbitration. Mediation is a process by which a neutral person tries to help the parties reach a mutually agreeable resolution of their dispute. The cost of mediation is shared equally.

Whether you sign the arbitration agreement or not is up to you. You will not be treated any differently if you choose not to sign the agreement.

You have the right to rescind the agreement within (10) days of signing the agreement.

The arbitration agreement is renewed each year unless it has been cancelled in writing before the renewal date.

You have the right to have all of your questions about arbitration answered.



FILL THIS FORM OUT IF YOU ARE BEING SEEN FOR A BREAST PROBLEM.

PATIENT NAME: _____

Do you feel a breast lump? Y N Which side? R L

How long? _____ Change in size? _____

Discovered by whom? _____

Do you do monthly self-breast exams? Y N

Any skin changes? Y N Describe: _____

Nipple discharge? Y N Which side? R L

What color? _____ Spontaneous? Y N

Mammogram? Y N Abnormal? _____

Ultrasound? Y N Abnormal? _____

Previous breast biopsy? Y N Results? _____

History of breast cancer? Y N Other breast problems? _____

Family history of breast cancer? Y N Who? _____

Hysterectomy? Y N Ovaries also? _____

Hormone replacement? Y N How long? _____

Age at first period? _____ Last menstrual period? _____

Pregnancies? _____ Live births? _____

Breast fed? Y N No. of children? _____ No. of months each? _____