Summit Primary Care & Clinical Services

PATIENT INFORMATION:	**FOR MINOR PATIENT-PARENT/GUARDIAN INFORMATION**
Patient legal name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Mobile Phone#	Mobile Phone#
Home Phone# Work#	Home Phone# Work#
Birthdate: Gender:	Birthdate: Gender:
Social Security#	Relationship
E-mail Address:	Would you like to participate in our patient portal? Yes No

Responsible Party is the person who will be paying per-visit for services (leave blank if same as Patient)

Responsible Party:	Mobile Phone#
Address:	Home Phone#
City, State, Zip:	Birthdate:
Relationship to Patient:	

Insurance Information

Primary Insurance:	Policyholder Name:
Company Address:	Policyholder Birthdate:
City, State, Zip:	Identification #
Company Phone:	Policy/Group#
Employer:	Policyholder SSN:
Secondary Insurance:	Policyholder Name:
Company Address:	Policyholder Birthdate:
City, State, Zip:	Identification #
Company Phone:	Policy/Group#
Employer:	Policyholder SSN:

Emergency Contact

Emergency Contact:	Name:
Address:	City, State, Zip:
Mobil #	Work #
Home #	Relationship to Client:

Person Completing Form/Providing Information

If you are the client, you may leave this section blank.

Name:_____ Relationship to Client:_____ Date:_____

Provider that you are seeing (Circle one): Austin Francom Mark Francom Tamara Broadhead

HIPAA Form: Consent to Use and Disclosure of Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to it. Please review carefully.

1. Your medical records are used to provide treatment, bill and receive payments, and conduct health care operations. Examples of these activities include but not limited to review of treatment records to ensure appropriate care, electronic or mail delivery of billing for treatment to you or other authorized payers, appointment reminder telephone calls, and records review to ensure completeness and quality of care. Use and disclosure of medical records is limited to the internal used outlined above except required by law or authorized by the patient or legal representative.

2. Federal and State laws require abuse, neglect, domestic violence and threats to be reported to social services or other protective agencies. If such reports are made they will be disclosed to you or your legal representative unless disclosure increases risk of further harm.

3. Disclosed information will be limited to the minimum necessary. You may request an account for any uses or disclosures other than those described in Sections 1 and Sections 2.

4. You, or your legal representative, may request your records to be disclosed to yourself or any other entity. Your request must be made in writing, clearly identify the person authorized to request the release, specify the information you want disclosed, the name and address of the entity you want the information released to, purpose and the expiration date of the authorization. Any authorization provided may be revoked in writing at any time. Psychotherapy notes are part of your medical records. We have 30 days to respond to a disclosure request and 60 days if the records are stored off site.

5. You may request corrections to your records.

6. A request for disclosure may be denied under the following circumstances: disclosure would likely endanger the life or physical safety of you or another person, requested information references other persons, except another healthcare provider, or if released to a legal representative would likely result in harm.

7. If a request for disclosure is denied for reasons outlined in Section 6, you or your legal representative may request review of the denial. A review will be conducted by another licensed healthcare provider appointed by the original reviewer, who was not involved in the original decision to deny access. A review will be concluded within 30 days.

8. You may request that we restrict uses and disclosures outlined in Section 1. However, we are not required to agree to the restrictions. If an agreement is made to restrict use or disclosure, we will be bound by such restriction until revoked by you or your legal representative orally or in writing except when disclosure is required by law or in an emergency. We may also revoke such restrictions but information gathered while required by law or in a emergency. We may also revoke such restrictions but information gathered while the restriction was in place will remain restricted by such an agreement.

9. If you wish to complain about privacy related issues you may contact the Secretary of the Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington DC, 20201. In any case there will not be any retaliation against you or your legal representative for filing a complaint.

10. This agreement may be modified or amended as required by law or in the course of health care operations.

11. Summit Primary Care and Clinical Services. Providers: Austin Francom APRN-FNP, Mark Francom APRN-FNP and Tamara Broadhead DNP-APRN.

I HAVE READ AND UNDERSTOOD THIS PRIVACY NOTICE AND MY RIGHTS CONCERNING USE AND DISCLOSURE OF PROTECTED HEALTHCARE INFORMATION.

Print Name of Patient if Patient is a Minor _____

_____ _____

Print Name of Individual or Legal Representative Date

_____ _____

Signature of Individual or Legal Representative Date

Person(s) that may access your medical information_____

_____

PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

PATIENT FINANCIAL RESPONSIBILITY & AUTHORIZATION FORM

Thank you for choosing Summit Primary Care & Clinical Services for your medical needs. We are committed to providing you with the highest quality of care. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

- The patient (or patient's guardian) is ultimately responsible for the payment of treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the correct and up to date information regarding insurance.
- Patients are responsible for payment of co-pays, coinsurance, deductibles, and all other procedures or treatments not covered by insurance.
- Co-pays, Deductibles and Coinsurances are DUE at the time of service. Any balances remaining after these point of service collections and insurance billed are due 15 days from the time you receive notification.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include:
    - Charge for returned checks - $30.00
    - No show fee - $50.00
        - If a scheduled appointment is missed without prior notice of at least 24 hours.
    - Late cancellation fee - $25.00
        - If an appointment is canceled or rescheduled within 24 hours of the scheduled time.

By signing below, I hereby accept the financial responsibility of either myself or any associated healthcare entities that I am responsible for. I understand that I am responsible for charges not covered by insurance.

Patient Acknowledgement and authorization

- We respect patient confidentiality and only release health information about you in accordance with the State and Federal law.

By signing below, I acknowledge that I have read the privacy notice provided by Summit Primary Care & Clinical Services. I hereby authorize the physicians, staff, and hospitals associated with Summit Primary Care & Clinical Services to release any medical or other information acquired in the course of my examination and/or treatment to the necessary insurance companies, third-party payers, and/or other physicians or health care entities required to participate in my care.

Patient Name _____

Patient/Guardian Signature _____

Date _____

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. 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 prelitigation 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.** Recession. 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 these Agreement and I have been verbally encouraged to read it and this Agreement. I have had the right to ask questions, I have been verbally encouraged to ask any questions, and I have had all 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.

Provider

Summit Primary Care and Clinical Services _____

Name of Physician, Group or Clinic | Name of Patient (print)

By:_____ _____ _____

Signature of Physician or Authorized Agent | Signature of Patient or Patient's Representative | (Date)