

**Basin Clinic &
Basin Clinic Urgent Care Center**

Patient Name _____

Chief Complaint/Reason For Visit _____

Date of Birth _____ S.S.# _____

Responsible Party S.S.# _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Guardian (if patient is under 18) _____

Emergency Contact _____ Phone _____

Primary Insurance _____

Do you have a regular physician you would like a copy of this visit sent to?

Dr. Name: _____ Patient Signature _____

In accordance with the Federal Truth-In-Lending Act, all doctors are required to give their patients complete information in connection with the extension of credit.

Basin Clinic Policy: The patient is responsible for all medical bills. Our staff will help with completion of insurance forms. It is the patient's responsibility to know their contract benefits, assure collection of insurance payments to us and negotiate with your insurance company over disputed claims.

If You Don't Have Insurance: Our policy requires payment in full at the time of service. We offer a 25% cash discount when paid in full at the time of service. If you cannot make complete payment we require that you make payment arrangements with the receptionist prior to service and make a \$100 partial payment on the day service is rendered.

If You Have Insurance: We will be glad to bill your insurance for you as long as we have correct insurance information. We require a one time \$50 deposit for new patients with insurance in case the visit is applied to your yearly deductible. We require you as a patient to be responsible for any balance your insurance does not pay. Any balance over 30 days is your responsibility. If we are a provider for your insurance, be aware that if the patient needs to be referred to another doctor or hospital, that provider may not be a preferred provider for your insurance and the patient/policy holder will be responsible for any amount not paid by their insurance to that non-preferred provider.

Forms of Payment: We accept payment in cash, check, money order, Visa, MasterCard,

American Express or Discover. There will be a \$30.00 charge on all returned checks.

Delinquent Accounts: Those accounts not paid within 90 days will be turned over to collections or taken to small claims court. We reserve the right to add late charges for delinquent accounts. Should collection be necessary, the responsible party agrees to pay and additional 33% collection fee charged by the collection service and all legal fees of collection, with or without suit, including attorney fees and court costs. We will no longer provide medical care once an account has gone to collection.

Monthly Statements: You will receive an itemized monthly statement until your bill is paid in full whether you have insurance or not. Interest of 1.5% per month will be applied to any amount over 30 days if a payment has been received.

To the extent necessary to determine liability for payment and to obtain reimbursement for this account, I authorize disclosure of portions of the patients record. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled including Medicare, private insurance, and other health plans to Rodney S. Anderson, M.D.; Karl L. Breitenbach, M.D.; Laura B. Arnold, M.D.; Kirk J. Woodward, M.D.; Mike Olsen, M.D.; Amy Olsen, FNP; Aaron Fausett, PA-C; Scott Frisby, PA-C; Michael Wilson, PA-C and Carolyn Henry, LCSW . This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original. I understand that I am financially responsible for all charges incurred.

I certify that the above information is accurate to the best of my knowledge. I have read and agree to the Financial Policy of this office.

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 see 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 on-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 you 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 resolutions 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 bequest 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 arbitrations panel finds liability, the parties may agree to wither continue to arbitrate damages with the initial panel or wither party may cause that a second panel be selecte 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. 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 the 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 Acknowledgment 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 if signing it.

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

Provider

Name of Physician, Group or Clinic: Basin Clinic

Name of Patient (Print) _____

By: _____
Signature of Physician or Authorize Agent

Signature: _____
Patient or Patient's Representative

Date _____

(05/03/04)