

## Basin Clinic Consent to Obstetrical Treatment

The goal of obstetrics is that every pregnancy be wanted and culminated in a healthy mother and a healthy baby. Advances in medicine have reduced some of the risks of injury and death, but especially in obstetrics there is no guarantee of a successful outcome. Your baby may suffer serious problems at birth because of natural processes and complications that are beyond your control, the control of your physician, and the control of the hospital where you plan your delivery.

During the pregnancy, your doctor may recommend limitations on your activities, referral to other physicians, hospitalization or other medical treatment. Unexpected complications can occur during your pregnancy or labor which may require prompt delivery of your baby. Drugs are available to stimulate labor, instruments called forceps may be used and delivery by cesarean section may be recommended. Each of these procedures involves substantial and significant risks.

**You should discuss with your doctor any proposed treatment and other alternatives available to you and make sure your questions are answered. It is your right and responsibility to share in all decisions about the care you will receive.**

Should an emergency arise, the availability of hospital anesthesia and surgery personnel may affect how quickly your baby can be delivered. In the hospital where your delivery is planned, anesthesia and surgery personnel are not present but are available on an “on call basis” 24 hours each day. Past experience has shown that in most cases and emergency delivery CAN be accomplished within 30 minutes after notification of personnel. You have the option of planning your delivery at a facility where anesthesia and surgery personnel are present at all times or are planning your delivery in another community with another physician.

By signing this document you acknowledge that there are substantial and significant risks to both mother and child in the childbirth process and that there can be no guarantees of successful outcome.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

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

Patient Name \_\_\_\_\_

Chief Complaint/Reason For Visit \_\_\_\_\_

Date of Birth \_\_\_\_\_ S.S.# \_\_\_\_\_

Email Address: \_\_\_\_\_

Ethnicity: \_\_\_\_\_ Marital Status: \_\_\_\_\_

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 \_\_\_\_\_

**Financial Policies**  
**Basin Clinic & Basin Clinic Urgent Care Center**

In accordance with the Federal Truth-In-Lending Act, all providers 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. We bill your insurance as a courtesy. Payment is expected within 30 days of date of service. 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 Basin Clinic and negotiate with your insurance company over disputed claims.

**If You Do NOT Have Insurance:** Our policy requires payment in full at time of service. If you can't make complete payment, we require that you make payment arrangements with the receptionist prior to services and make partial payment including a \$50 deposit on the date of service.

**If You Have Insurance:** It is your responsibility to provide us with the correct insurance information. We will bill your insurance for you as long as we have the correct insurance information. However, we require you as a patient to be responsible for any balance your insurance does not pay. Any balance over 30 days is the patients responsibility. Waiting for the insurance payment is a courtesy and it may be withdrawn under certain circumstances. This office does not warrant or guarantee that your insurance company will pay, nor do we promise that an insurance company will pay the fees charged. Insurance policies are an arrangement between the insurance carrier and the patient/insured. 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.

**If You Have Medicare:** We will bill Medicare for you, but due to the length of time for reimbursement, we do ask that you monitor your statement to see that nothing is missed and to inform us if something needs re-billed.

**If You Have Medicaid:** We require you to pay the co-payment on the date of service. A statement will not be mailed for unpaid co-payments. A hold will be placed on your account and future appointments will not be scheduled until the unpaid co-payment is paid in full.

**Co-payments, Deductibles and Non-covered Benefits:** As a patient, it is your responsibility to take care of the co-payments or deductible on the date of service. Any non-covered service shall be paid within 30 days of the date of service.

**Missed Appointment Policy:** We require that you notify us at least 24 hours in advance as to any appointment changes. There will be a missed appointment fee of \$25.00 for the first missed appointment. Missed appointment fees will be increased by \$25.00 for each additional missed appointment. Future appointments will not be scheduled until all previous missed appointment fees are paid in full.

**Forms Of Payment:** We accept payment in cash, check, money order, or credit card. There will be a \$20.00 charge on all returned checks.

**Delinquent Accounts:** Accounts not paid within 60 days will be placed in an in-office collection hold, turned over to a collection agency, or taken to small claims court. This action may negatively impact your credit score. We reserve the right to add charges for delinquent accounts, including the cost of sending notification via priority mail, up to a 33.33% collection fee, attorney and court costs and any additional collection fees obtained by our third party collection agency. I authorize disclosure of portions of the patient's records to the extent necessary to determine liability for payment and to obtain reimbursement should this account be turned over to collections.

**Monthly Statements:** You will receive an itemized monthly statement until your bill is paid in full, placed in an in-office collection hold, or turned over to a collection agency, whether you have insurance or not.

**Assignment of Benefits:** 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. This assignment is to be considered as valid as the original. I understand that an insured retains ultimate responsibility for paying for health care services received. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I have read and fully understand the financial office policy and agree to abide by these terms.

\_\_\_\_\_  
Printed Name of Patient and/or Responsible Party

\_\_\_\_\_  
Signature of Patient and/or Responsible Party

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

NAME \_\_\_\_\_ PATIENT SSN# \_\_\_\_\_ DATE \_\_\_\_\_  
 Last First Middle

\_\_\_\_\_  
 FATHER OF BABY NEWBORN'S PHYSICIAN REFERRED BY

BIRTHDATE: AGE: RACE: MARITAL STATUS:		MAILING ADDRESS:	
MO DAY YR		S M W D SEP	
OCCUPATION: ___HOMEMAKER ___OUTSIDE WORK _____ Type of Work ___STUDENT		EDUCATION: LAST GRADE COMPLETED _____	
PHONE: (Daytime)		(Evening)	
INSURANCE CARRIER/MEDICAIDE #			
EMERGENCY CONTACT:		RELATIONSHIP:	
PHONE:			
TOTAL PREG	FULL TERM	PREMATURE	ABORTIONS: INDUCED SPON.
			ECTOPICS
			MULTIPLE BIRTHS
			LIVING

**MENSTRUAL HISTORY**

LMP: DEFINATE APPROXIMATE (MONTH KNOWN) UNKNOWN NORMAL AMOUNT/DURATION	MENSES MONTHLY: YES NO MENARCHE: _____ (AGE ONSET) ON BCPS AT CONCEPT. YES NO Hcg + ___/___/___
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**PAST PREGNANCIES (LAST SIX)**

DATE MO/YR	SEX M/F	GA WEEKS	LENGTH OF LABOR	BIRTH WEIGHT	TYPE DELIVERY	ANES.	PLACE OF DELIVERY	PERINATAL MORTALITY YES/NO	TREATMENT PRETERM LABOR YES/NO	COMMENTS/COMPLICATIONS

**PAST MEDICAL HISTORY**

	0 NEG + POS	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT		0 NEG + POS	DETAIL POSITIVE REMARKS INCLUDE DATE & TREATMENT
1. DIABETES			16. Rh SENSITIZED		
2. HYPERTENSION			17. TUBERCULOSIS		
3. HEART DISEASE			18. ASTHMA		
4. RHEUMATIC FEVER			19. ALLERGIES (DRUGS)		
5. MITRAL VALVE PROLAPSE			20. GYN SURGERY		
6. KIDNEY DISEASE/UTI			21. OPERATIONS/HOSPITALIZATIONS (YEAR & REASONS)		
7. NEUROLOGIC/EPILEPSY					
8. PSYCHIATRIC					
9. HEPATITIS/LIVER DISEASE			22. ANESTHETIC COMPLICATIONS		
10. VARICOSEITIES/PHLEBITIS			23. HISTORY OF ABNORMAL PAP		
11. THYROID DYSFUNCTION			24. UTERINE ANOMALY		
12. MAJOR ACCIDENTS			25. INFERTILITY		
13. HISTORY OF BLOOD TRANSFUS.					
	AMT/DAY PREPREG	AMT/DAY PREG	# YRS USE		
14. TOBACCO				26. STREET DRUGS	
15. ALCOHOL				27. OTHER	

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

GENETICS SCREENING					
INCLUDES PATIENT, BABY'S FATHER, OR ANYONE IN EITHER FAMILY WITH:					
	YES	NO		YES	NO
1 PATIENT'S AGE ≥ 35 YEARS			10 HUNTINGTON CHOREA		
2 THALASSEMIA			11 MENTAL RETARDATION		
3 NEURAL TUBE DEFECT (MENINGOMYELOCELE, OPEN SPINE, OR ANENCEPHALY)			IF YES, WAS PERSON TESTED FOR FRAGILE X?		
4 DOWN SYNDROME			12 OTHER INHERITED GENETIC OR CHROMOSOMAL DISORDER		
5 TAY-SACHS {EG. JEWISH BACKGROUND}			13. PATIENT OR BABY'S FATHER HAD A CHILD WITH BIRTH DEFECTS NOT LISTED ABOVE		
6 SICKLE CELL DISEASE OR TRAIT			14. ≥ FIRST-TRIMESTER SPONTANEOUS ABORTIONS OR A STILLBIRTH		
7 HEMOPHILIA			15 MEDICATIONS OR STREET DRUGS SINCE LAST MENSTRUAL PERIOD		
8 MUSCULAR DYSTROPHY			IF YES, AGENT(S)		
9 CYSTIC FIBROSIS			16 OTHER SIGNIFICANT FAMILY HISTORY (SEE COMMENTS)		

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

INFECTION HISTORY	YES	NO	4 PATIENT OR PARTNER HAVE HISTORY OR GENITAL HERPES	YES	NO
1 HIGH RISK AIDS			5 RASH OR VIRAL ILLNESS SINCE LAST MENSTRUAL PERIOD		
2 HIGH RISK HEPATITIS B			6 HISTORY OF STD, GC, CHLAMYDIA, HPV, SYPHILIS		
3 LIVE WITH SOMEONE WITH TB OR EXPOSED TO TB			7 OTHER (SEE COMMENTS)		

COMMENTS: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

INTERVIEWER'S SIGNATURE \_\_\_\_\_

INITIAL PHYSICAL EXAMINATION					
DATE ___/___/___	PREPREGNANCY WEIGHT _____		HEIGHT _____	BP _____	
1. HEENT	___ NORMAL ___ ABNORMAL	12. VULVA	___ NORMAL ___ CONDYLOMA	___ LESIONS	
2. FUNDI	___ NORMAL ___ ABNORMAL	13. VAGINA	___ NORMAL ___ INFLAMMATION	___ DISCHARGE	
3. TEETH	___ NORMAL ___ ABNORMAL	14. CERVIX	___ NORMAL ___ INFLAMMATION	___ LESIONS	
4. THYROID	___ NORMAL ___ ABNORMAL	15. UTERUS	___ NORMAL ___ ABNORMAL	___ FIBROIDS	
5. BREASTS	___ NORMAL ___ ABNORMAL	16. ADNEXA	___ NORMAL ___ MASS		
6. LUNGS	___ NORMAL ___ ABNORMAL	17. RECTUM	___ NORMAL ___ ABNORMAL		
7. HEART	___ NORMAL ___ ABNORMAL	18. DIAGONAL CONJUGATE	___ REACHED ___ NO	___ CM	
8. ABDOMEN	___ NORMAL ___ ABNORMAL	19. SPINES	___ AVERAGE ___ PROMINENT	___ BLUNT	
9. EXTREMITIES	___ NORMAL ___ ABNORMAL	20. SACRUM	___ CONCAVE ___ STRAIGHT	___ ANTERIOR	
10. SKIN	___ NORMAL ___ ABNORMAL	21. ARCH	___ NORMAL ___ WIDE	___ NARROW	
11. LYMPH NODES	___ NORMAL ___ ABNORMAL	22. GYNECOID PELVIC TYPE	___ YES ___ NO		

COMMENTS: (Number and explain abnormalities): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Exam by \_\_\_\_\_

Basin Clinic  
379 N. 500 W. Ste. 1A  
Vernal, UT 84078  
435-789-1165

### Financial Arrangements

The exact cost of the doctor's obstetrical management of your pregnancy cannot always be predetermined. However, we can provide you with a usual physician's fee for a normal, uncomplicated pregnancy and delivery, with a single hospital admission. This includes the following:

Initial and subsequent history, physical exams, weight and blood pressure checks, fetal heart tones, routine urine check, routine iron level check, monthly visits up to 32 weeks, bimonthly visits to 36 weeks, and weekly visits until delivery.

Examples of typical situations requiring additional charges are:

- 1) Situations necessary for operative delivery, such as cesarean section or complication of abortion (miscarriage), including assistant surgeon fee when necessary.
- 2) Admission to a hospital during pregnancy or after delivery of obstetrical, surgical, or medical complications.
- 3) Consultive services by our doctors or consultants for non-pregnancy related illnesses.
- 4) Medications administered to support or relieve illness during pregnancy.
- 5) Advancement to "high-risk" category of care requiring more than the expected normal care.
- 6) Hospital and office emergency care.
- 7) Laboratory fees.
- 8) Ultrasound(s) and/ or amniocentesis.
- 9) Non-stress test(s).

To assist in your financial planning and approach an equitable understanding, we have arranged for a convenient "pay as you grow" plan. Based on your insurance benefits, we will take the amount your insurance estimates is your responsibility, and divide it into convenient, monthly OB installments. You will receive a monthly statement where no finance charge is assessed if paid by the due date. Please be aware, your portion must be paid in full prior to delivery.

Estimated Price	\$ _____
(Medical fee for normal, uncomplicated prenatal care & delivery)	
Less	\$ _____
(Approximate insurance payment or self-pay discount if pd. Prior to delivery)	
Balance	\$ _____
(Amount financed)	

Annual percentage rate is 18% on unpaid balance beginning 30 days post delivery.

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I have read this information, understand the arrangement, and all questions have been answered to my satisfaction.

I \_\_\_\_\_ (patient) hereby agree to pay Basin Clinic, in ( ) monthly OB installments of \$ \_\_\_\_\_ per month, beginning \_\_\_\_\_ (date).

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Patient Signature

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Date

\*\*\*YOU MUST CONTACT YOUR INSURANCE & ADD YOUR BABY TO YOUR POLICY WITHIN 30 DAYS

AFTER DELIVERY OR THE CHILD WILL NOT BE COVERED UNDER YOUR INSURANCE PLAN!\*\*\*

## AVMC Birth Place

### Visitors Guidelines

Our visitor guidelines are to provide a safe and professional atmosphere in the care of our patients as well as protect their privacy.

Please limit the number of visitors to no more than 3 at a time during labor and delivery. Visitors may wait in the waiting area. A courtesy phone - ext. 203 - is available in the waiting area to keep family and friends informed.

Fathers (or significant other) are welcome at anytime and may stay overnight with the patient.

Delivery and patient hallways must always remain clear for medical staff and equipment. Visitors must be in patient rooms or in the waiting area in order to keep the hallways clear.

Children are welcome as visitors; however, a visiting adult must accompany them at all times. They must not be allowed to run or play in the hallways or touch the medical equipment. During the RSV season, children under 12 years old and younger will not be allowed to visit in patient rooms.

All visitors must be free of colds or other contagious illnesses. We expect that all visitors wash their hands or use our hand hygiene product before touching or picking up the baby.

Visitors in the nursery will be limited to persons wearing specified identification armbands.

BASIN CLINIC HIV PATIENT CONSENT FORM

**Purpose for HIV test:** The HIV antibody or antigen test is NOT an AIDS test. The test is performed as a screening test to determine if you are infected with HIV, the causation agent for AIDS. If you have any questions about why this test is being done, please ask your physician.

**Procedure for Obtaining Sample:** A blood sample will be obtained by trained personnel using a sterile needle and syringe. Only a small amount of blood is necessary for the test.

High Risk Behaviors or Factors Which Can Lead to Infection with HIV:

- a) Receipt of multiple transfusions of blood or blood products prior to July 1985.
- b) Sharing of needles and syringes during intravenous drug use.
- c) The practice of high risk sexual behaviors which includes any man who has had sex with another man, persons with multiple sex partners, and sexual partners of a person listed in a and/or b.
- d) Infants born to mothers infected with HIV.

Interpretation of Test Results: If your test result is positive, it means you are probably infected with HIV, but not that you have AIDS. The diagnosis of AIDS is based on an evaluation of a number of factors including immune or equivocal, it means that the result is uncertain. Your physician will discuss what the results mean in relation to your risk behaviors or risk factors. A repeat test at a later date may be advisable. If your test is negative, it means that you probably are not infected. However, it takes approximately 2-12 weeks after exposure to HIV to develop a positive result. Your physician may request a repeat test at a later date if you have risk factors.

Release Information: Information documented in the medical record can be accessed by your insurance company with you sign a release of information. The results are reported to your physician and if positive, to the Utah Department of Health. Your physician may inform other health care providers responsible for your care.

Consequences of HIV Testing: Having this test performed may have important consequences for you. Adverse is positive it allows your physician to monitor your health status and initiate appropriate therapy. Adverse consequences are more likely to occur if your test result is positive, but may occur even if the test is negative since insurance agents, employers, and other contacts who find out that you had the test may assume that you belong to one of the high risk groups.

The following was discussed with the patient:

- Purpose for HIV test is to determine the presence of HIV antibody of antigen.
- Procedure for obtaining blood sample.
- High risk behaviors or factors may affect interpretation of HIV test results such as multiple blood transfusions prior to 1985, sharing of needles & syringes, and high risk sexual behavior.
- Interpretation of test results: positive, indeterminate or equivocal, and negative
- Confidentiality issues/Release of Information
- Consequences of HIV testing

I have counseled the patient with the information above.

Physician or Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_

I have been given all of the above information and have had all my questions answered. I acknowledge that I have been counseled about the consequences if HIV in pregnancy and the available treatment options.

I DO wish to have HIV testing \_\_\_\_\_ I DO NOT wish to have HIV testing \_\_\_\_\_

Patient 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 of Patient or Patient's Representative \_\_\_\_\_

Date \_\_\_\_\_

(05/03/04)



# Breathe Tobacco-Free Baby & Me

The best change you can make for you and your baby!

## About the Program

*Breathe Tobacco Free-Baby & Me* is a program designed to help women who are pregnant and up to one year post-partum AND their significant other quit tobacco and create a tobacco-free environment for themselves & their baby!

As you participate in this program, you will learn the benefits of living tobacco free for your family, create a quit plan, learn ways to manage withdrawal symptoms, avoid relapse, and manage stress.

- You may be each rewarded a monthly diaper voucher up to \$10.00 to be redeemed at Kmart if you quit successfully and remain quit!



## Eligibility

The following are eligible for the *Breathe Tobacco Free-Baby & Me* Program:

- Women who are pregnant and currently using tobacco or have quit within the last 30 days
- Women who are less than 1 year post-partum currently using tobacco or have quit within the last 30 days
- Spouses or significant other of an enrolled woman in the program



Contact TriCounty Health Department to enroll

(435) 247-1174

Or talk to your Healthcare Provider at Basin Clinic