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_____

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_____

DATE_____

NAME_____PATIENT SSN#_____
Last First Middle

_____ _____ _____
FATHER OF BABY NEWBORN'S PHYSICIAN REFERRED BY

BIRTHDATE: AGE: RACE: MARITAL STATUS: MO DAY YR S M W D SEP	MAILING ADDRESS:
OCCUPATION: ___HOMEMAKER ___OUTSIDE WORK _____ Type of Work ___STUDENT EDUCATION: LAST GRADE COMPLETED_____	PHONE: (Daytime) (Evening) INSURANCE CARRIER/MEDICADE #
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 AMOUND/DURATION	MENSES MONTHLY: YES NO FREQUENCY: Q ___DAYS MENARCHE:_____(AGE ONSET) ON BCPS AT CONCEPT. YES NO Hcg + ___/___/___

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							
7. NEUROLOGIC/EPILEPSY					21. OPERATIONS/HOSPITALIZATIONS (YEAR & REASONS)		
8. PHYCHIATRIC							
9. HEPATITIS/LIVER DISEASE							
10. VARICOSEITIES/PHLEBITIS					22. ANESTHETIC COMPLICATIONS		
11. THYROID DISFUNCTION					23. HISTORY OF ABNORMAL PAP		
12. MAJOR ACCIDENTS					24. UTERINE ANOMALY		
13. HISTORY OF BLOOD TRANSFUS.					25. INFERTILITY		
	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	_____NOMRAL	_____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 abnormals):_____

_____**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.

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).

_____ _____
Patient Signature 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 preformed 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 n 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. Eash 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 fo this Agreement. A "Joined Party" does not participate in the selection of the arbitrators byt 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