Basin Clinic
379 N. 500 W. Suite 1A
Vernal, Utah 84078

Basin Clinic Urgent Care
475 N. 500 W.
Vernal, Utah 84078

Patient Information:
Patient Name:_____

Patient Date of Birth:_____S.S. #_____

Email Address: _____

Ethnicity:_____ Marital Status: _____

Responsible Party:_____

Responsible Party Date of Birth:_____S.S.#_____

Mailing Address:_____

City, State, Zip:_____

Home Phone:_____Work Phone:_____

Cell Phone:_____Cell Phone Carrier:_____

Email address:_____

Employer:_____

Emergency Contact:_____Phone:_____

Office Visit Information:

Chief Complaint/Reason for visit:_____

Is this visit due to an accident:_____Yes_____No If yes, what type:_____

Has this accident been reported: _____Yes_____No If yes, to whom:_____

********Additional paperwork is required if answered yes to above and is a work injury********

Financial Information:

Primary Insurance:_____Secondary Insurance:_____

Policy Holder Name:_____ID #_____

Relationship to Policy Holder:_____DOB:_____

I certify that I (or my dependent) have insurance coverage with _____. I authorize the provider to release all information necessary, including the diagnosis and the records of any exams or treatment rendered to me in order to secure payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

Signature:_____Date:_____

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

HIPPA ACKNOWLEDGEMENT

I hereby acknowledge that I have had the opportunity to review and/or receive a copy of HIPPA Notice of Privacy Practices for Basin Clinic.

AUTHORIZATION

My signature below authorizes the staff of Basin Clinic to verbally (by telephone of in person) share all of my medical information without limitation with the following individuals:

Name: Relationship

_____

Name: Relationship

_____

Name: Relationship

_____

Print Name: **Date of Birth:**

_____

Signature: **Date:**

_____

This form does not entitle these persons copies of medical records. Consent expires with the end of my care with Basin Clinic.

Written Explanation Of Arbitration

* A binding arbitration agreement requires a patient to submit all future medical 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 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 ot to sign the agreement.

* You have the right to rescind the agreement withing then (10) days of signing the agreement.

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

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

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 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 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 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.

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

Provider

_____	_____
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)

(06/2011)