

### **Medical Consent for Treatment**

I am voluntarily seeking health care and hereby consent to medical treatment, procedures, x-rays, laboratory test, and other healthcare services. I have the right to refuse specific treatments and procedures. This agreement can be revoked by me at any time with written notification and is valid until revoked.

I authorize the employees of **Utah Partners for Health (UPFH)** to render primary care and related services. I understand **UPFH** is committed to offering superior quality of care to all patients regardless of race, ethnicity, religion, sex, age, or handicap status.

I understand that I will be fully informed of anticipated benefits, possible discomforts, and potential side effects prior to the performance of any medical treatment, and I release **UPFH** from liability that may arise as the result of such treatment, unless due to sole negligence of its staff. I consent to examinations, treatments, procedures and blood tests ordered by my physician and health care providers. I understand my medical record and information related to my care at **UPFH** is confidential. I have been provided a Summary Notice of Privacy Practices that details the various ways that information about me may be disclosed for treatment, payment, healthcare operations, and other purposes permitted or required by law, as applicable. I understand that state law requires the reporting of certain positive results such as hepatitis and the antibody for the AIDS virus to the health department. I authorize the release of any medical or other information necessary to process a claim for payment.

### **Services Provided**

Language translation and sign language services can be provided at no cost to both insured and uninsured patients. These services will be arranged by the staff member who is creating the appointment for the patient, and will be available throughout the entire visit.

### **Financial Policy**

- Payment is due for services rendered at the time of the visit.
- Patients are responsible to know the coverage for services of their insurance plan including; co-payments, co-insurance, deductible, and provider participation.
- Patients with household incomes below 200% of the Federal Poverty Guidelines (FPG) may qualify to have their services, deductible and/or co-payment discounted on the sliding fee scale.
- Insurance co-payment and deductibles, or the discounted fee based on your income & family size, are expected to be paid at the time of service. This is an agreement you have with your insurance company and with us as your Community Health Center. If you do not have your co-pay at the time of service, we will be happy to reschedule you for a more convenient time.
- A valid insurance card and/or ID is needed at each visit.
- UPFH will bill your insurance company as a courtesy. You will be responsible for keeping the account in good standing and also be responsible for any balances denied by insurance.
- If there is an outstanding balance 90 days after the date of service we may turn your account over to a collection agency. In the event that your account does go to an outside agency you agree to pay any court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance. A collection fee 40%, up to a maximum of \$10, of the outstanding balance will be added to cover as compensation to this office for any commission it must pay to a collection agency in collecting any outstanding balance.
- Patients who have simply refused to pay or who have shown an unwillingness to pay established amounts within a reasonable period of time after billing may be terminated as a patient.
- Personal pay patients must pay for their visit in full at the time of service.
- Any payments can be made by cash or credit/debit card.

**Assignment of Benefits**

I hereby assign **UPFH** my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare, or Medicaid in my name or in my behalf. I further authorize payment of benefits directly to **UPFH**. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my insurance.

**PF-1000 Acknowledgement of Receipt of Notice of Privacy Practices**

I have received a copy of the PF-1000 Notice of Privacy Practices of **UPFH**. **UPFH** reserves the right to modify the privacy practices outlines in the notice. I understand that my signature below indicates that I have read and understand the financial policy, medical consent for treatment, assignments of benefits, and the Privacy Practices of **UPFH**. This agreement can be revoked by me at any time with

**Patients qualifying For the Sliding Fee Schedule**

You may qualify for the sliding fee schedule. The sliding fee scale is based on your household size and income. In order to qualify for the sliding fee scale, you must provide one of the following sources of information:

- |                            |  |
|----------------------------|--|
| Current pay stub           | Copy of a disability check                         |
| Copy of your SSI check     | Court order settlements                            |
| Child support check        | Current unemployment or workers comp check         |
| Military Family Allotments | Pension, retirement, insurance or annuity payments |
| Income tax statement       | Any other written verifiable statement of income   |

**Services rendered are due on the date of service. A minimum charge for services is \$ \_\_\_\_\_ which will cover the estimated cost of your office visit. Other services may require additional charges. Sources of acceptable payments are:**

- |                       |   |
|-----------------------|---|
| Cash                  | Medicare  |
| Medicaid              | Private Insurance                               |
| ATM card (debit card) | Major Credit Cards (MasterCard, VISA, Discover) |

I have read and understand the above information and hereby consent to care at **Utah Partners for Health**. I further understand that if I do not provide the necessary information, I will be expected to pay 100% for all services rendered.

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**\*PATIENT NAME (PRINTED)**

**\*DATE OF BIRTH**

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**\*PATIENT'S SIGNATURE (Parent if minor)**

**\*RELATIONSHIP TO PATIENT**

**\*DATE**

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**\*EMPLOYEE VERIFIED**

**\*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:
  - a. 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
  - b. 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:
  - a. Working directly with each other to try and find a solution that resolves the Claim, OR
  - b. Using non-binding mediation (each of us will bear one-half of the costs); OR
  - c. 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 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.
  - a. Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.
  - b. 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 cost 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. 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 of signing it.

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

I agree  / disagree  to the terms outlined in this document.

**UTAH PARTNERS FOR HEALTH  
DBA: MID-VALLEY HEALTH CLINIC**

\_\_\_\_\_  
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 (MM/DD/YY) \_\_\_\_\_



## Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

**Please review it carefully.**

### Your Rights

**When it comes to your health information, you have certain rights.** This section explains your rights and some of our responsibilities to help you.

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#### Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

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#### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

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#### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say “yes” to all reasonable requests.

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## Your Rights *continued*

### Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say “yes” unless a law requires us to share that information.

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### Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

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### Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

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### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

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### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.
- We will not retaliate against you for filing a complaint.

## Your Choices

**For certain health information, you can tell us your choices about what we share.** If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

**In these cases, you have both the right and choice to tell us to:**

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

**In these cases we never share your information unless you give us written permission:**

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

**In the case of fundraising:**

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

**How do we typically use or share your health information?** We typically use or share your health information in the following ways.

**Treat you**

- We can use your health information and share it with other professionals who are treating you.

**Example:** A doctor treating you for an injury asks another doctor about your overall health condition.

**Run our organization**

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

**Example:** We use health information about you to manage your treatment and services.

**Bill for your services**

- We can use and share your health information to bill and get payment from health plans or other entities.

**Example:** We give information about you to your health insurance plan so it will pay for your services.

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**How else can we use or share your health information?** We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

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**Help with public health and safety issues**

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone’s health or safety

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**Do research**

- We can use or share your information for health research.

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**Comply with the law**

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we’re complying with federal privacy law.

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**Respond to organ and tissue donation requests**

- We can share health information about you with organ procurement organizations.

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**Work with a medical examiner or funeral director**

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

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**Address workers’ compensation, law enforcement, and other government requests**

- We can use or share health information about you:
  - For workers’ compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

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**Respond to lawsuits and legal actions**

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

## Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

**This Notice of Privacy Practices applies to the following organizations.**