RIVERSIDE MEDICAL ARTS

Received and completed by _____

PATIENT INFORMATION

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Jr ☐ Sr ☐ II ☐ I

Sex: ☐ Female ☐ Male

Date of Birth: mm / dd / yyyy

First Name | Middle Initial | Last Name

Social Security Number: - -

Physical Address | City | State | Zip

Mailing Address | City | State | Zip

Preferred Phone Number: ( ) -

Home Phone Number: ( ) -

Cell Phone Number: ( ) -

Work Phone Number: ( ) -

Email Address

Confidential Communication Preference: ☐ Email ☐ Letter ☐ Other _____ ☐ Patient Portal

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Unknown

Preferred Language

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino ☐ Unknown

Race: ☐ American Indian ☐ Asian ☐ Black /African American ☐ Native Hawaiian ☐ Other Pacifica Islander ☐ White ☐ Other

Employer Name

Preferred Provider: ☐ Benjamin G Carter, MD

PARENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE INFORMATION

Title: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss ☐ Dr ☐ Jr ☐ Sr ☐ II ☐ I

Sex: ☐ Female ☐ Male

Date of Birth: mm / dd / yyyy

First Name | Middle Initial | Last Name

Social Security Number: - -

Address | City | State | Zip

Email Address

Relation to Patient

Home Phone Number: ( ) -

Cell Phone Number: ( ) -

Work Phone Number: ( ) -

PRIMARY INSURANCE

Insurance Carrier Name

Group Name | Group Number

Subscriber Name

Subscriber ID

Subscriber Date of Birth | Relation to Patient

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

SECONDARY INSURANCE

Insurance Carrier Name

Group Name | Group Number

Subscriber Name

Subscriber ID

Subscriber Date of Birth | Relation to Patient

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student

SPOUSE OR EMERGENCY CONTACT

First Name | Last Name | Relation to Patient

Home Phone Number | Cell Phone Number

REFERRAL

How did you hear about our clinic?

Referred by

SIGNATURE

Signature of Patient or Legal Guardian

Date: mm / dd / yyyy

Patient Account # _____

RIVERSIDE MEDICAL ARTS

Patient First Name	Patient Last name
Parent / Guardian Name	Relation to Patient

NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts Notice of Privacy Practices.

PATIENT RIGHTS AND RESPONSIBILITIES

My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts patient rights and responsibilities.

DISCLOSURE OF OWNERSHIP INTEREST

My signature below indicates that I have been offered / provided with a copy of Riverside Medical Arts disclosure of ownership interest.

LABORATORY

My signature below indicates I understand that all lab work ordered by my physician and sent to an outside lab will be billed separately by that lab to my insurance company. I understand that I am responsible to pay for all lab charges, whether or not I have insurance and whether or not it is a covered benefit of my insurance. I understand that the laboratory will bill me separately for these lab charges.

FINANCIAL RESPONSIBILITY / ASSIGNMENT OF BENEFITS / BILLING AGREEMENT

Insurance is a way for you to receive repayment for fees you have paid to a physician for services rendered. Having insurance is not a substitute for payment. Even though insurance companies have a fixed allowance or percentage based on your policy with them, your policy is with your insurance company, not with this office. It is your responsibility to provide payment for the deductible, co-insurance, and any other balances not paid for by your insurance. We will assist you in receiving reimbursement in any way possible, but you are ultimately responsible for the payment of your bill. Please provide complete insurance information to our office prior to your visit. If this information is not produced, payment for the services rendered will be due at the time of your visit. It is your responsibility to know the benefits provided by your insurance carrier. Please direct questions regarding your benefits to your insurance carrier or your human resources department. Riverside Medical Arts will make a reasonable attempt to inform you if your insurance is out of network. However, if your insurance is out of network you are responsible to pay for all services rendered. Payment in full will be due at the time of service if a particular service is not covered, we are unable to verify coverage, your coverage is pending or you are ineligible for coverage. Our office will file a claim with your primary insurance carrier. If a service requires additional information from the patient / guarantor, you are required to provide the necessary information to your insurance company or our office as soon as possible. If this information is not received by either the insurance company, or our office the payment for services rendered will then be the responsibility of the patient / guarantor. As a courtesy our office will file a claim with your secondary insurance company. If the services are unpaid by your secondary insurance carrier or require follow up, payment for services rendered are the responsibility of the patient / guarantor. In the event that your insurance company refuses payment for services rendered, you will be responsible for payment in full. A denial from your insurance company does not release you from your financial obligation to us. Payments on accounts billed are expected within 30 days of the statement date. A $25.00 returned check fee will apply for every returned check that is received by our office. Delinquent accounts will be charged interest at 1.5% per month. The undersigned specifically agrees to pay all reasonable attorneys' fees and court costs in the event legal action is taken to collect on an account. The undersigned further agrees to pay an additional amount representing up to 40% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with the said collection action processing.

I hereby authorize the physician(s) of Riverside Medical Arts to release any information acquired in the course of my examination to my insurance company, another physician or hospital, adjuster or attorney. I authorize payment directly to Riverside Medical Arts for surgical and/or medical benefits, if any, otherwise payable to me for services as described. I understand that I am financially responsible for all charges whether or not paid by my insurance company. A photocopy of this assignment of benefits shall be considered as effective and valid as the original. I also authorize the physician to initiate a complaint to the insurance commissioner for any reason on my behalf. Any lab testing done in the office or outside laboratory will be billed separately by the laboratory. I consent to any medical treatment deemed medically necessary by the provider. I understand that these treatments will be discussed with me and all questions will be answered before it is rendered.

SIGNATURE

Signature of Patient or Legal Guardian	Date mm / dd / yyyy

Patient Account # _____

RIVERSIDE MEDICAL ARTS

REVISED 06/2011

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 the 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 selects 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 Jointed. Any person or entity that could be appropriately named in a court proceeding ("Jointed 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

Patient Account # _____

	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 pre litigation 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 the 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 of 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 upon my request.

PROVIDER		
Name of Physician, Group or Clinic Southern Utah Surgical & Laser Aesthetics, LLC DBA: Riverside Medical Arts	Signature of Physician or Authorized Agent	Date mm / dd / yyyy
PATIENT		
Name of Patient	Signature of Patient or Patient's Legal Representative	Date mm / dd / yyyy

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RIVERSIDE MEDICAL ARTS

PATIENT HISTORY AND INTAKE FORM

First Name	Middle Initial	Last Name	Date of Birth mm / dd / yyyy

Preferred Pharmacy	Pharmacy Location
Primary Care Physician	**Primary Care Physician Phone Number**

PAST MEDICAL HISTORY (Please check all that apply)

☐ Anxiety	☐ Depression	☐ Lymphoma
☐ Arthritis	☐ Diabetes	☐ Pacemaker
☐ Artificial joints	☐ GERD	☐ Prostate cancer
☐ Asthma	☐ End stage renal disease	☐ Radiation treatment
☐ Artrial fibrillation	☐ Hearing loss	☐ Seizures
☐ BPH	☐ Hepatitis	☐ Stroke
☐ Bone marrow transplantation	☐ Hypertension/High Blood Pressure	☐ Thyroid Disease
☐ Breast cancer	☐ HIV /AIDS	☐ Valve replacement
☐ Colon cancer	☐ Hypercholesterolemia	☐ NONE
☐ COPD	☐ Leukemia	☐ Other _____
☐ Coronary artery disease	☐ Lung Cancer	☐ Other _____

PAST SURGICAL HISTORY (Please check all that apply)

☐ Appendix removed	☐ Kidney stone removal
☐ Basal cell cancer	☐ Kidney transplant
☐ Biological valve replacement	☐ Lumpectomy (right, left, bilateral)
☐ Bladder removed	☐ Mastectomy (right, left, bilateral)
☐ Breast biopsy (right, left, bilateral)	☐ Mechanical valve replacement
☐ Breast implants	☐ Melanoma surgery
☐ Breast reduction	☐ Ovaries removed: Cyst
☐ Colectomy: Colon cancer resection	☐ Ovaries removed: Endometriosis
☐ Colectomy: Diverticulitis	☐ Ovaries removed: Ovarian cancer
☐ Colectomy: Irritable bowel disease	☐ Percutaneous transluminal coronary angioplasty (PTCA)
☐ Coronary artery bypass	☐ Prostate biopsy
☐ Gallbladder removed	☐ Prostate removed: Prostate cancer
☐ Heart transplant	☐ Skin biopsy
☐ Hysterectomy: Fibroids	☐ Spleen removed
☐ Hysterectomy: Uterine cancer	☐ Squamous cell carcinoma surgery
☐ Joint replacement, hip (right, left, bilateral)	☐ Testicles removed (right, left, bilateral)
☐ Joint replacement, knee (right, left, bilateral)	☐ Transurethral resection of the prostate (**TURP**)
☐ Joint replacement within last 2 years	☐ NONE
☐ Kidney biopsy	☐ Other _____
☐ Kidney removed (right, left)	☐ Other _____

PEDIATRIC HISTORY (For patients **2 years old and younger**)

Gestational Age at Birth	Birth weight	Forceps delivery
_____ weeks	_____lbs _____oz	☐ Yes ☐ No

Maternal illness during pregnancy

SKIN CONDITIONS (Please check all that apply)

☐ Acne	☐ Dry skin	☐ Poison ivy
☐ Allergies	☐ Eczema	☐ Precancers
☐ Asthma	☐ Flaky itchy scalp	☐ Precancerous moles
☐ Basal cell skin cancer	☐ Hay fever	☐ Psoriasis
☐ Blistering sunburns	☐ Melanoma	☐ Squamous cell skin cancer

Other skin conditions:

Do you wear SPF (sun block)?	Do you tan in a tanning bed?
☐ Yes ☐ No If YES, what strength:	☐ Yes ☐ No If YES, how often:

Is there a history of melanoma in your family? ☐ Yes ☐ No If YES, which family member:

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RIVERSIDE MEDICAL ARTS

CURRENT MEDICATIONS AND OVER THE COUNTER MEDICATIONS

Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started
Name of medication	Dose / Strength	Frequency	Date Started

ALLERGIES AND REACTIONS

Allergy	Describe Reaction	Allergy	Describe Reaction
Allergy	Describe Reaction	Allergy	Describe Reaction
Allergy	Describe Reaction	Allergy	Describe Reaction

SOCIAL HISTORY

Smoking/ Tobacco History

☐ Never smoked ☐ Quit – former smoker ☐ Smokes less than daily ☐ Smokes daily

Illicit Drug Use

☐ Drug use ☐ IV drug use ☐ None

Alcohol Use

☐ None ☐ Less than 1 drink a day ☐ 1 – 2 drinks a day ☐ 3 or more drinks a day

Safety

☐ I feel safe at home ☐ I do not feel safe at home

Other:

REVIEW OF SYMPTOMS (Please check all that apply)

☐ Abdominal pain	☐ Hay fever	☐ Problems with scarring (hypertrophic or keloid)
☐ Anxiety	☐ Headaches	☐ Chest Pains
☐ Bloody stool	☐ Immunosuppression	☐ Rash
☐ Bloody urine	☐ Joint aches	☐ Seizures
☐ Blurry vision	☐ Muscle weakness	☐ Shortness of breath
☐ Chest pain	☐ Neck stiffness	☐ Sore throat
☐ Cough	☐ Night sweats	☐ Thyroid problems
☐ Depression	☐ Problems with bleeding	☐ Unintentional weight loss
☐ Fever or chills	☐ Problems with healing	☐ Wheezing

Other symptoms:

ALERTS (Please check all that apply)

☐ Allergy to adhesive	☐ Blood thinners	☐ Pregnancy or planning a pregnancy
☐ Allergy to lidocaine	☐ Breastfeeding	☐ Premedication prior to procedures
☐ Allergy to topical antibiotics/ointments	☐ Defibrillator	☐ Rapid heartbeat with epinephrine
☐ Artificial heart valve	☐ MRSA	
☐ Artificial joint within past 2 years	☐ Pacemaker	

Other alerts:

Patient Account # _____