

PATIENT INFORMATION

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Jr <input type="checkbox"/> Sr <input type="checkbox"/> II <input type="checkbox"/> I				Title		<input type="checkbox"/> Female <input type="checkbox"/> Male		Sex		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 <input type="checkbox"/> Email <input type="checkbox"/> Letter <input type="checkbox"/> Other _____ <input type="checkbox"/> Patient Portal							
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed											
Preferred Language				Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> NOT Hispanic or Latino <input type="checkbox"/> Unknown							
Race <input type="checkbox"/> American Indian <input type="checkbox"/> Asian <input type="checkbox"/> Black /African American <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacifica Islander <input type="checkbox"/> White <input type="checkbox"/> Other											
Employer Name											
Preferred Provider <input type="checkbox"/> Gayle M Carter, MD <input type="checkbox"/> Allie Blazzard, FNP - C											

PARENT / LEGAL GUARDIAN / LEGAL REPRESENTATIVE INFORMATION

<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Jr <input type="checkbox"/> Sr <input type="checkbox"/> II <input type="checkbox"/> I				Title		<input type="checkbox"/> Female <input type="checkbox"/> Male		Sex		Date of Birth mm / dd / yyyy	
First Name			Middle Initial			Last Name			Social Security Number - -		
Address						City		State		Zip	
Relation to Patient						Home Phone Number () -			Cell Phone Number () -		
						Work Phone Number () -					

PRIMARY INSURANCE
SECONDARY INSURANCE

Insurance Carrier Name				Insurance Carrier Name			
Group Name		Group Number		Group Name		Group Number	
Subscriber Name				Subscriber Name			
Subscriber ID				Subscriber ID			
Subscriber Date of Birth		Relation to Patient		Subscriber Date of Birth		Relation to Patient	
Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Student				Employment Status <input type="checkbox"/> Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> 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			
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SIGNATURE

Signature of Patient or Legal Guardian						Date mm / dd / yyyy	
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PATIENT HEALTH INFORMATION

First Name		Middle Initial	Last Name		Date of Birth mm / dd / yyyy
Preferred Pharmacy			Pharmacy Location		
Primary Care Physician			Primary Care Physician Phone Number		
How would you describe your overall health <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair		Smoking/Tobacco History <input type="checkbox"/> Never <input type="checkbox"/> Previous <input type="checkbox"/> Current	Alcohol Use <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Use <input type="checkbox"/> Yes <input type="checkbox"/> No	Caffeine use <input type="checkbox"/> Yes <input type="checkbox"/> No

ALLERGIES AND REACTIONS

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

CURRENT MEDICATIONS/HORMONES/SUPPLEMENTS/VITAMINS

Name	Dose / Strength	Frequency	Date Started
Name	Dose / Strength	Frequency	Date Started
Name	Dose / Strength	Frequency	Date Started
Name	Dose / Strength	Frequency	Date Started
Name	Dose / Strength	Frequency	Date Started
Name	Dose / Strength	Frequency	Date Started
Name	Dose / Strength	Frequency	Date Started

FEMALE HEALTH HISTORY

Age of first menstrual cycle	Duration of menstrual cycle	Frequency of menstrual cycle	
Would YOU consider your cycle <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	Date of last period # of days	Date of last Mammogram	Date of last pap / annual exam
Do you have, or have you ever had premenstrual syndrome (PMS)? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, Please explain symptoms:			
Contraception <input type="checkbox"/> Birth control pills <input type="checkbox"/> IUD <input type="checkbox"/> Tubal ligation <input type="checkbox"/> Vasectomy <input type="checkbox"/> Other		History of contraception problems <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, please explain:	

OBSTETRICAL HISTORY

Please list the total number of each occurrence in the boxes below

Pregnancies	Full Term	Premature	Ectopic	Induced Abortions	Miscarriages	Multiple Births	Living Children
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PREVIOUS HOSPITALIZATIONS OR SURGICAL PROCEDURES

Date / /	Date / /	Date / /	Date / /
Date / /	Date / /	Date / /	Date / /

FAMILY MEDICAL/CANCER HISTORY

<input type="checkbox"/> Anemia	Relation to patient	<input type="checkbox"/> Fibrocystic Breast	Relation to patient	<input type="checkbox"/> Breast Cancer	Relation to patient
<input type="checkbox"/> Bleeding Disorder	Relation to patient	<input type="checkbox"/> Heart Disease	Relation to patient	<input type="checkbox"/> Ovarian Cancer	Relation to patient
<input type="checkbox"/> Diabetes	Relation to patient	<input type="checkbox"/> Hypertension	Relation to patient	<input type="checkbox"/> Uterine Cancer	Relation to patient
<input type="checkbox"/> Endocrine Problem	Relation to patient	<input type="checkbox"/> Osteoporosis	Relation to patient	<input type="checkbox"/> Other:	Relation to patient

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

(Please check all applicable symptoms that you have or have had)

<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Acne <input type="checkbox"/> Altered sense of smell <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Arthritis <input type="checkbox"/> Ataxia <input type="checkbox"/> Black stools <input type="checkbox"/> Bladder infections <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Blood clots <input type="checkbox"/> Blood in mucus <input type="checkbox"/> Blood in stool <input type="checkbox"/> Blood in urine <input type="checkbox"/> Blood transfusions <input type="checkbox"/> Blurry vision <input type="checkbox"/> Bowel problem <input type="checkbox"/> Cancer <input type="checkbox"/> Change in hair growth <input type="checkbox"/> Change in skin color <input type="checkbox"/> Chest pain – exerted <input type="checkbox"/> Chest pain – resting <input type="checkbox"/> Chills <input type="checkbox"/> Cold hands or feet <input type="checkbox"/> Constipation <input type="checkbox"/> Coordination problems <input type="checkbox"/> Coughing up of blood <input type="checkbox"/> Depression <input type="checkbox"/> Dermatitis <input type="checkbox"/> Diabetes <input type="checkbox"/> Diarrhea <input type="checkbox"/> Dizziness <input type="checkbox"/> Double vision <input type="checkbox"/> Dry eyes <input type="checkbox"/> Dry mouth <input type="checkbox"/> Dry skin <input type="checkbox"/> Dysphagia (difficulty swallowing) <input type="checkbox"/> Ear pain <input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Epilepsy <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Exercise intolerance <input type="checkbox"/> Extremity weakness <input type="checkbox"/> Eye disease (Glaucoma, etc) <input type="checkbox"/> Eye pain	<input type="checkbox"/> Fatigue <input type="checkbox"/> Fecal incontinence <input type="checkbox"/> Fever <input type="checkbox"/> Food allergies <input type="checkbox"/> Fractures <input type="checkbox"/> Gait disturbance <input type="checkbox"/> Genital discharge <input type="checkbox"/> Genital infections <input type="checkbox"/> Goiters <input type="checkbox"/> Hay fever <input type="checkbox"/> Headaches / Migraines <input type="checkbox"/> Hearing loss <input type="checkbox"/> Heartburn <input type="checkbox"/> Heart disease/Heart failure <input type="checkbox"/> Heart problems <input type="checkbox"/> Heavy bleeding <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol or lipids <input type="checkbox"/> Hives <input type="checkbox"/> Insomnia <input type="checkbox"/> Intolerance to heat or cold <input type="checkbox"/> Irregular periods <input type="checkbox"/> Joint instability <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint stiffness <input type="checkbox"/> Joint swelling <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney problems <input type="checkbox"/> Liver disease <input type="checkbox"/> Lung problems <input type="checkbox"/> Lupus <input type="checkbox"/> Lymph node enlargement <input type="checkbox"/> Medication allergies <input type="checkbox"/> Mouth pain <input type="checkbox"/> Muscle pain (myalgias) <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Neck pain <input type="checkbox"/> Night sweats <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Ovarian problems <input type="checkbox"/> Pain in feet or hands <input type="checkbox"/> Pain with inhalation	<input type="checkbox"/> Pain with intercourse <input type="checkbox"/> Palpitations <input type="checkbox"/> Paresthesias (tingling/pricking) <input type="checkbox"/> Post nasal drip <input type="checkbox"/> Productive cough <input type="checkbox"/> Rapid heart rate <input type="checkbox"/> Rash <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Seasonal allergies <input type="checkbox"/> Seizures <input type="checkbox"/> Sever itching (pruritis) <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Skin cancer <input type="checkbox"/> Skin disease <input type="checkbox"/> Skin lesions <input type="checkbox"/> Skin nodules <input type="checkbox"/> Skin ulcers <input type="checkbox"/> Sore throat <input type="checkbox"/> Speech disturbance <input type="checkbox"/> Sprain <input type="checkbox"/> Stomach problems <input type="checkbox"/> Suicidal <input type="checkbox"/> Syncope (fainting) <input type="checkbox"/> Thyroid disease/ problems <input type="checkbox"/> Tingling <input type="checkbox"/> Tinnitus (ringing in ears) <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Ulcers <input type="checkbox"/> Urinary incontinence <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Venereal disease <input type="checkbox"/> Visual acuity <input type="checkbox"/> Visual changes <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss <input type="checkbox"/> Wheezing <input type="checkbox"/> Yeast infections
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HORMONE REPLACEMENT THERAPY

First Name	Middle Initial	Last Name	Date of Birth mm / dd / yyyy
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How did you arrive at the decision to consider Bio-Identical Hormone Replacement Therapy?
 Doctor Self Friend / Family member Other:

What are your goals with taking Bio-Identical Hormone Replacement Therapy?

Please write down any questions that you have about Bio-Identical Hormone Replacement Therapy:

CURRENT SYMPTOMS	RATE SEVERITY OF EACH SYMPTOM			
ACNE	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
ANXIETY	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
ARTHRITIS	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
BLADDER SYMPTOMS	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
BREAKTHROUGH BLEEDING	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
BREAST TENDERNESS	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
CRAMPS	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
DECREASED SEX DRIVE	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
DEPRESSION	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
DRY SKIN/HAIR	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
DRY THINNING SKIN	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
FATIGUE/LACK OF ENERGY	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
FIBROCYSTIC BREAST	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
HAIR LOSS	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
HARDER TO REACH CLIMAX	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
HEADACHES	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
HEAVY / IRREGULAR MENSES	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
HOT FLASHES	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
IRRITABILITY	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
LOSS OF MEMORY	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
MOOD SWINGS	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
NIGHT SWEATS	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
SENSITIVITY TO COLD	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
SLEEP DISTURBANCES / INSOMNIA	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
THINNING BONES	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
WEIGHT GAIN	<input type="checkbox"/> Absent	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

ADDITIONAL SYMPTOMS

Please list any additional symptoms you may be experiencing:

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	
<p>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.</p> <p>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.</p>	

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

ARBITRATION AGREEMENT

ARTICLE 1	<p><u>Dispute Resolution</u> 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.</p>
ARTICLE 2	<p><u>Definitions</u></p> <p>A. The term “we,” “parties” or “us” means you, (the Patient), and the Provider.</p> <p>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.</p> <p>C. The term “Provider” means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.</p> <p>D. The term “Patient” or “you” means:</p> <ol style="list-style-type: none"> (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	<p><u>Dispute Resolution Options</u></p> <p>A. <u>Methods Available for Dispute Resolution.</u> We agree to resolve any Claim by:</p> <ol style="list-style-type: none"> (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. <p style="padding-left: 40px;">You may choose to use any or all of these methods to resolve your Claim.</p> <p>B. <u>Legal Counsel.</u> 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.</p> <p>C. <u>Arbitration – Final Resolution.</u> 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.</p>
ARTICLE 4	<p><u>How to Arbitrate a Claim</u></p> <p>A. <u>Notice.</u> 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.</p> <p>B. <u>Arbitrators.</u> 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.</p> <ol style="list-style-type: none"> (1) <u>Appointed Arbitrators.</u> You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing. (2) <u>Jointly-Selected Arbitrator.</u> 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. <p>C. <u>Arbitration Expenses.</u> 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.</p> <p>D. <u>Final and Binding Decision.</u> 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.</p> <p>E. <u>All Claims May be Jointed.</u> 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</p>

	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	<p><u>Liability and Damages May Be Arbitrated Separately</u></p> <p>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.</p>	
ARTICLE 6	<p><u>Venue / Governing Law</u></p> <p>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.</p>	
ARTICLE 7	<p><u>Term / Rescission / Termination</u></p> <p>A. <u>Term</u>. 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.</p> <p>B. <u>Rescission</u>. 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).</p> <p>C. <u>Termination</u>. 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.</p>	
ARTICLE 8	<p><u>Severability</u></p> <p>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.</p>	
ARTICLE 9	<p><u>Acknowledgement of Written Explanation of Arbitration</u></p> <p>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.</p>	
ARTICLE 10	<p><u>Receipt of Copy</u></p> <p>I have received a copy of this document upon my request.</p>	
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

Allie Blazzard, FNP-C

Benjamin Carter, MD

Gayle M. Carter, MD

 (435) 628-6466 ▪ Fax (435) 628-3845 ▪ Dermatology Fax (435) 986-9355
 1068 E Riverside Dr. St. George, Utah 84790

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

ONGOING AUTHORIZATION TO RELEASE THE LABORATORY RESULTS OF			
First Name	Middle Initial	Last Name	Date of Birth <small>mm / dd / yyyy</small>
Address		City	State Zip
Phone Number		Alternate Phone Number	
<p>I the patient listed above hereby release Riverside Medical Arts and its staff from all legal responsibility that may arise from the release of the medical information hereby authorized. Once Riverside Medical Arts discloses my health information by my request, it cannot guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this authorization or applicable federal and state law governing the use and disclosure of my health information. This authorization will remain in effect until I provide written notice of revocation to Riverside Medical Arts.</p>			

SIGNATURE	
Signature of Patient or Legal Guardian	Date <small>mm / dd / yyyy</small>