PATIENT REGISTRATION

Date: _____

Patient Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security #: _____

Home Address: _____
(Street & House #) (City) (State) (Zip Code)

Primary Phone #: _____ Alternate Phone #: _____

Employer: _____ Work Phone #: _____

Occupation: _____ E-Mail Address: _____

Relationship to Responsible Party (circle one): Self Spouse Child Other: _____

Emergency Contact Relationship: _____
Name: _____ Emergency Phone: _____

Contact Address: _____
(Street & House #) (City) (State) (Zip Code)

Responsible (insured) Party Information

Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security #: _____

Home Address: _____
(Street & House #) (City) (State) (Zip Code)

Primary Phone #: _____ Alternate Phone #: _____

Employer: _____ Phone #: _____

City: _____ Supervisor #: _____

Insurance Information

Primary Insurance: _____ Address#: _____

Contact (ID) #: _____ Phone #: _____

Group Name: _____ Group #: _____

Co Pay $: _____ Subscribers Name: _____

Date of Birth: _____ Social Security #: _____

Please Circle: ☐Male ☐Female

Patient Relationship to Insurance Subscriber (Circle one): ☐Self ☐Spouse ☐Child

Financial Agreement

Thank you for choosing The Alpine Clinic as your health care provider. It is our goal to make medical care accessible and affordable. Please understand that payment of your bill is necessary for us to continue to provide high quality health care. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. In the event that we are not participating with your insurance company, payment is expected at the time of service. We will be happy to provide you with any necessary information for you to submit your claim and pursue reimbursement from your insurance carrier. If we are a participating provider with your insurance plan, we agree to the assigned insurance benefits from that plan. However, it is the patient's responsibility to make sure that their insurance has paid the claim in a timely fashion. We allow 60 days for the claim to be paid by your insurance, after which time the balance due is your responsibility. Generally, you are responsible to collect payment from your secondary insurance company. We will gladly supply you with the necessary documentation to bill your secondary plan after the primary insurance has paid. **All co-payments and deductibles are due prior to treatment.** A billing fee of $5.00 will be assessed to all co-payments and deductibles that are not paid at the time services are rendered. **It is also your responsibility to inform our office in a timely manner of any changes in insurance coverage.** Often insurance will deny a claim because of changes in coverage, and there is no time left within the allowed submission period to re bill it correctly. Under these circumstances, the patient will be held responsible for payment in full for services rendered, regardless of our status with the insurance carrier. A minimum of $2.00 per month, or 18% APR. will be charged as a billing charge for all unpaid balances over 30 days. All collections and legal fees associated with a bad debt will be the responsibility of the patient. In addition, due to the difficulties associated with missed appointments, we reserve the right to bill a service charge for appointments that are not canceled within 24 hours of the appointment. If complete payment cannot be made at the time of service, definite arrangements for payments must be made at that time. We cannot extend a line of credit through our office; however, we will try to be as helpful as possible in determining the most convenient payment option for you.

*******Important:* **Some of the services offered at The Alpine Clinic may not be covered by or billable to your insurance and are therefore the responsibility of the patient.****

I have read, understood and agree to the provisions of the financial policy :

Patient/Parent (guardian): _____ Date: _____

I have received a copy of the form entitled "notice of privacy practices" for the Alpine Clinic:

Patient/Parent (guardian): _____ Date: _____

Alpine Clinic

Consent to Receive Text Messages

Patient Name: _____

Date of Birth:_____

Mobile Phone Number:_____

Please read and sign below to authorize our clinic to send you these messages, unless otherwise indicated by marking the box below. You can notify the Clinic at any time of what type of text messages you prefer receiving or opting out of all text messages.

To receive **billing and account-related** text messages (e.g., invoices, payment reminders, insurance updates)

To receive **event and class notifications** (e.g., health classes, events, special pricing)

Standard Messaging Rates: I understand that standard messaging and data rates may apply, depending on my mobile carrier and plan.

Confidentiality and Privacy: I understand that my phone number will not be shared or sold to third parties for marketing purposes.

Opt-Out Option: I understand that I can opt out of receiving text messages at any time by replying "STOP" or contacting the clinic by calling 801-407-3000

Correct contact Information: I confirm that the phone number provided is correct and belongs to me. I will notify the clinic if my contact information changes.

☐ By marking this box, you are stating you do **NOT** want to receive any text messages from Alpine Clinic

Patient Signature:_____ **Date:**_____

NON STANDARD CARE CONSENT

In addition to standard medical treatments, the Alpine Clinic offers several treatment options that are considered non-standard, or alternative care. These modalities are offered for patients for a variety of medical indications. However, these treatments are considered by many physicians and insurance companies to be alternative and many have not been tested through prevailing double-blind methods of medical research. In addition, they are often not covered by insurance and are usually the financial responsibility of patients. If you have questions about whether treatment options are covered by your plan, please consult with your insurance company for more information. These include the following specific modalities.

Homeopathy/ Nutritional Counseling
Homeopathy and natural medicine are distinct, specialized medical services apart from conventional allopathic medical practice. Benefits from this treatment are unique and can be an important complement to conventional techniques. There are no risks or side effects associated with this care. The homeopathic examination and interview requires an extensive office visit that is not recognized or reimbursed by health insurance. Patients are responsible for the full payment of fees associated with this treatment.

Electrodermal Analysis
This is designed to help identify particular patterns of stress throughout the body. This is a totally non-invasive procedure where a metal probe is touched to the skin to measure electrical conductivity at responsive points, typically on hands and feet. Remedies that bring abnormal electrical patterns into balance are then recommended. This procedure is extremely safe. There may be mild discomfort associated with the pressure of the probe on the skin. While there are no documented risks associated with remedies or recommended substances, please report any concerns to your practitioner.

Microcurrent (Electrical Stimulation)
Healing effects are produced by using specific frequencies of microamperage current to treat specific tissues. This therapy is useful for trauma, overuse injuries, fibromyalgia and other chronic pain syndromes. Side effects may include a post-detoxification reaction, including nausea, mild aching and fatigue. This is usually preventable by good hydration before treatment.

Manipulation
Manual traction and pressure on muscles and connective tissue to relieve imbalances in opposing muscle groups and bring the muscles into balance. We do not use chiropractic adjustment techniques. No side effects have been identified from this gentle technique.

Trigger-point injections
Injection of local anesthetic, homeopathics and possibly low dose steroids into precise loci of pain to break cycles of myo-fascial pain and speed healing. Side effects are those of any injection: pain at injection site, possible bruising, risk of infection or rare allergic reaction.

I have been informed of these alternative treatment options with their accompanying benefits and risks. I acknowledge that I have had and will have the opportunity to ask questions about treatment and to have my questions answered to my full satisfaction. I acknowledge and accept these therapies when requested as an adjunct therapy to the standard drug therapies. I acknowledge that no guarantees or claims have been made to me regarding the efficacy or results of any of the above therapies. I have been informed that my insurance company is not likely to cover any fees associated with these treatments and that I am ultimately financially responsible for payment. I freely give my consent to receive any of these treatments when recommended and requested. I also consent for my record to be used anonymously for the purpose of advancing clinical knowledge and for research and scientific purposes.

Date

Patient Name_____

Signature_____

Witness_____

Parent or Guardia Name_____

Alpine Clinic
1175 East 3200 North, Lehi UT 84043 Tel: (801) 407-3000 Fax: (801) 407-3001

revised Aug 2012

ARBITRATION AGREEMENT

Article 1 Dispute Resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any Claim for your 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 waving 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 "Patient" or "you" means:
(1) you and any personal 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 using 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 Arbitrators. 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 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 inital 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 hearby 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 / Recission / 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. Recission 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 recission notice will be the date the recission 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 tine, 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 Acknowledgment 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 9 Receipt of Copy I have received a copy of this document.

Provider

Alpine Clinic
Name of Physician, Group, or Clinic

By: _____
Signature of Physician or Authorized Agent

_____
Name of Patient (Print)

_____
Signature of Patient or Patient's Representative (Date)