Olympus Family Medicine

4624 Holladay Blvd.
Holladay, UT 84117
801-277-2682

Today's Date:	**Account Number:**

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)				Name Normally Used (Nickname)
Address (Number) (Street) (Apt. No.)				
City	State	Zip	Home Phone	Cell Phone
Date of Birth	Age	Sex	Marital Status	Occupation

Employer Name	Employer Street Address	City	State	Zip
Business Phone (Including Extension)		Patient's Driver's License No.	State	
Email Address				
Race	Ethnicity	Language		

SPOUSE'S OR RESPONSIBLE PARTY'S INFORMATION

Full Legal Name (First) (Middle) (Last)				Occupation
Address (If Different From Above)	City	State	Zip	Preferred Phone

Employer Name	Street Address	City	State	Zip	Business Phone (Ext)

INSURANCE INFORMATION

Primary Insurance Company Name	Group No.	ID/Certificate No.
Subscriber Name and Date of Birth	Where to Send Claim	
Secondary Insurance Company Name	Group No.	ID/Certificate No.
Subscriber Name and Date of Birth		
Other Insurance Information		

EMERGENCY INFORMATION

Person to Notify in Case of Emergency		Relationship
Address (Number) (Street) (Apt. No.)		

City	State	Zip	Home Phone

INFORMATION FOR THE PATIENT

1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.
2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc.) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.
3. If you have any questions we will, of course, be happy to assist you.

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Notice of Privacy Policy

This notice describes how medical information about you may be used and disclosed and how you may access this information. Please review it carefully before signing.

How we may use and disclose your personal health information:

- For treatment, payment, and health care operations of Olympus Clinic
- We will obtain your written authorization for purposes *other* than treating you, obtaining payment for your care, or our own health care operations
- We are permitted and required to use and disclose your personal health information in the following situations:
    - To business associates who work in our behalf
    - If we are required by law
    - For public health needs
    - Victims of abuse, neglect, or domestic violence
    - Health oversight needs
    - Judicial and administrative proceedings
    - Law enforcement
    - Coroners, medical examiners, and funeral directors
    - Research
    - Limited government functions
    - Health and Safety
    - Worker's Compensation

You have the right to:

- Receive a copy of this notice
- Inspect and copy your health information
- Amend your health information
- Request additional restrictions on uses and disclosures of your health information
- Request an accounting of disclosures
- Request confidentiality in certain communications
- File a Complaint

For further information about this privacy notice, to obtain a copy of this summary notice, or to obtain a detailed policy statement of Olympus Clinic's privacy notice, please contact us or visit our website at www.olympusclinic.com.

My signature acknowledges receipt of the summary privacy notice and I have been informed as to how to receive a more detailed privacy notice and how to authorize release of my confidential healthcare information.

Patient Name: _____ Date: _____

_____ Relation to Patient: _____

Signature of Responsible Party

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AUTHORIZATION TO LEAVE PERSONAL HEALTH & BILLING INFORMATION BY ALTERNATE MEANS

Date: _____

We want to stay in touch with you regarding your account, concerning your medical information as well as your billing information. By signing this form you are authorizing us to contact you through the following selected communication options:

(Please check all that apply)

☐ May leave detailed message on voicemail at home phone #: (_____)_____

☐ May leave detailed message on voicemail at work phone #: (_____)_____

☐ May leave detailed message on voicemail at cell phone #: (_____)_____

☐ May leave information with spouse: _____
Spouse's Name

☐ May leave information with other family member:

_____
Family Member's Name Relationship to Patient

With my signature below, I acknowledge and understand that this form will be kept in my medical record and the above parameter will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Patient Name: _____ Date: _____

_____ Relation to Patient: _____
Signature of Responsible Party

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Financial Responsibility

Patient Name: _____ Date of Birth: _____

Olympus Family Medicine appreciates the confidence you have shown in choosing us to be your healthcare provider. As a courtesy, we will bill your insurance carrier on your behalf. However, your policy is a contract between you and your insurance carrier. You are responsible for knowing what your insurance covers and which providers are covered in your network. Any services provided, but not covered by your insurance will be your responsibility to pay. In order to facilitate claims processing, you must provide all insurance policy information and any changes to our office immediately. Your bill is your responsibility whether your insurance carrier pays or not. If your insurance carrier has not paid within 90 days, you may be responsible to pay outstanding balance.

- **Co-Pays and Deductibles -** Some health insurances require a co-pay for services rendered. It is expected to be paid on the date of service, however, on rare occasions where you need to be billed for it there will be a $10.00 fee charged. With the increase of high deductible plan, we are asking for a $50.00 payment on the date of service.

- **Cancellations -** We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours prior to cancelling your appointment. You may be charged a $35.00 fee for office visits or a $50.00 fee for missed physicals.

- **Payment Plans -** Payment plans may be set up for balances over $100.00. Payment plans are to be paid in full with a minimum of $50.00 a month and will not exceed (6) installments. We do require a credit card on file for all payment plans. If you are unable to pay your balance within the allotted (6) installments, please contact our billing department to determine Special Financial Consideration.

- **Self-Pay -** A $96.00 minimum payment is due on the date of service for all self-pay patients. The discount of $96.00 is only available if it is paid on the date of service, if not you will be responsible for the full amount. We will then bill you for any remaining charges that were incurred i.e. labs, x-rays, etc. We will only send one bill with the new charges and if they are not paid within 30 days a discount will not be applied.

- **Returned Checks –** A $35.00 charge will be applied to all returned checks. Checks will no longer be accepted after two returned checks.

- **Auto Insurance and Workman's Comp Claims –** If your injuries were sustained in an auto accident or at work it is your responsibility to provide us with your insurance information as well as claim/policy numbers. If we do not receive this at the time of service, we will do one courtesy call to try and get this information. If we do not get it within three weeks, the balance will be moved to patient responsibility.

- **Collections -** By signing below, I agree to the above terms and I agree to pay any collection costs and/or reasonable attorney's fees, if a delinquent balance is placed with a collection agency and/or attorney for collection, or suit. A minimum collection fee of 40% of the principal amount(s) owing, as allowed by Utah Code Annotated, sec. 12-1-11, will be added to the account. If your account is sent to collections, you may be terminated from receiving services at our office. We will allow you to be seen for (30) days after your termination letter, however this will only be on an emergent basis. We will be unable to schedule physicals, medication checks etc. Once your account is in collections and you have been terminated from our office we will require proof of payment before we can schedule any future appointments.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Printed Name of Patient or Responsible Party Relationship

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Arbitration Agreement

Article 1: Dispute Resolution: By signing this 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:

The term "we", "parties" or "us" means you, (the patient), and the provider.

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.

The term "provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.

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:

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 any or all these methods to resolve your Claim.

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.

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:

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 it this Agreement.

Arbitrators: Within 30 days of receiving this 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 by the state or federal courts of Utah. If the arbitrators cannot agree upon 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.

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.

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.

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:

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 wither party notifies the other in writing of a decision to terminate it.

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)).

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: Acknowledgment 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 costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can refuse 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.

Name of Patient (Print)	Date
Signature of Physician or Authorized Agent	Signature of Responsible Party