

Jordan Landing Family Medicine
7478 S. Campus View Dr. - West Jordan, Utah 84088
Phone (801) 280-7774 - Fax (801) 748-2790

BRENT PUGH

DENNIS HAMP

PATIENT INFORMATION

PLEASE PRINT CLEARLY

Name _____
Last First Initial
Address _____
Street City State Zip
SS # _____ Sex: M F Birth Date _____ Age _____
Occupation _____ Employer _____
Home Phone (____) _____ Bus. Phone (____) _____ Ext. _____
Marital Status S M D W Cell Phone (____) _____

RESPONSIBLE PARTY

Name _____
Last First Initial
Relationship to Patient _____
Address _____
Street City State Zip
SS # _____ Sex M F Birth Date _____ Age _____
Occupation _____ Employer _____
Home Phone (____) _____ Bus. Phone (____) _____ Ext. _____

INSURANCE INFORMATION

Primary Company _____ Address _____ Effective Date _____
Policy Number _____ Group # _____ Phone _____
Insured _____ Relationship to insured _____
Employer _____ Date of Birth _____
Secondary Company _____ Address _____ Effective Date _____
Policy Number _____ Group # _____ Phone _____
Insured _____ Relationship to Insured _____
Employer _____ Date of Birth _____

OTHER INFORMATION

In Case of Emergency _____ Relationship _____ Phone _____
Referred to this Office by Yellow Pages Friend M.D. _____
 Insurance Carrier Other _____

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your health care provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing a provider.

1. Each patient is responsible for their own bill.
2. Payment of all insurance co-payments and deductibles are required all the time medical services are rendered.
3. Patients who have no insurance are required to pay 100% of services rendered each visit. If this is impossible, you will need to make payment arrangements with our billing office prior to any medical evaluation or treatment. We accept cash, checks and Visa/MasterCard.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, you will be responsible to pay.
6. If your insurance company has not paid your full account within 60 days, the outstanding balance must be paid by you without further delay.
7. Monthly payments are required on all accounts with outstanding balances. A monthly finance charge of 1-3/4% per month (21% annual rate) will be charged to the amount not paid after 60 days, with a minimum charge of \$.50 per month. By signing below, you acknowledge receipt of this Financial Policy and Agreement. If collection is made by suit or otherwise, patient and/or responsible party agrees to pay interest until paid, collection costs of 40% of the remaining balance, all attorneys fees and court cost.
8. A \$25.00 fee will be charged on all return checks.
9. Patients who fail to appear for their scheduled appointments may be charged a fee of \$25.00, unless the patient cancels the appointment at least 24 hours before the scheduled appointment time.

USUAL AND CUSTOMARY RATES

Our rates for medical services reflect the usual and customary rates in the community. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any).

AUTHORIZATION TO PAY BENEFITS

I further and direct said agency, attorney or insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that signing of this form does not prohibit customary monthly billings.

X _____ Date _____
Signature of Responsible Party

WRITTEN EXPLANATION OF BINDING ARBITRATION

A binding arbitration agreement requires a patient to submit all future medical malpractice claims to arbitration instead of having the claim heard in court by a judge or jury.

An arbitrator is a person chosen to resolve disputes after hearing the information presented by both sides. You select an arbitrator, your doctor selects one, and you and the doctor agree on a third arbitrator. In the event we cannot agree, the third arbitrator will be selected by the other two arbitrators from a court-issued list of arbitrators.

You pay for the fees and expenses of your arbitrator, the doctor pays for his or her arbitrator, and the fees and expenses of the third arbitrator are shared equally.

You have the right, at your expense, to be represented in arbitration by an attorney.

By choosing arbitration, you may also have the right to require mediation. Mediation occurs before arbitration. Mediation is a process by which a neutral person tries to help the parties reach a mutually agreeable resolution of their dispute. The cost of mediation is shared equally.

You have the right to decline to enter into the agreement and still receive health care.

You have the right to rescind the agreement within ten (10) days of signing the agreement.

The arbitration agreement is renewed each year unless it has been canceled in writing before the renewal date.

You have the right to have all of your questions about arbitration answered.



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:
 - (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 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 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 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.

Provider

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)

JORDAN LANDING CLINIC PATIENT HISTORY

Dr. Brent Pugh

Patient Name _____

What brings you here today?

Medical Problems you are being treated for now or in the past:

What surgeries have you had?

What have you been in the hospital for?

When?

What medications do you take?

Name:	Dose:	How Often:	When started:

What medications are you allergic to?

What happened?

Are you allergic to anything else?

Patient Name _____

What medical problems run in your family?

	Father	Mother	Siblings	Grandparents
Asthma				
Bleeding Disorder				
Cancer (which type?)				
Diabetes				
Heart Problems				
High Blood Pressure				
Kidney Disease				
Mental Illness				
Migraine Headaches				
Stroke				
Thyroid Disease				
Other				

Social History

Marital Status/Kids?	
Occupation?	
Education?	
Tobacco?	
Alcohol?	
Illicit Drugs?	
Exercise Regularly?	

Have you recently been bothered by any of the following?

	Yes	No		Yes	No		Yes	No
Fever or chills			Nausea			Skin Rashes		
Night sweats			Vomiting			Itching		
Weight change			Heartburn			Headaches		
Insomnia			Abdominal			Numbness		
Vision Changes			Diarrhea			Weakness		
Cold Symptoms			Constipation			Depression		
Nasal drainage			Black stools			Anxiety		
Chest pain			Blood in stools			Fatigue		
Palpitations			Pain with urination			Excessive thirst		
Swelling of legs			Urine incontinence			Heat/Cold intolerant		
Shortness of breath			Joint swelling			Swollen glands		
Cough			Joint Pain			Easy bruising		

Females

Last PAP Smear:	Last menstrual cycle:	Periods regular?
Last mammogram:	Vaginal discharge?	Other gyn problems?

Males

Poor urine stream?	Difficulty with erection?	Prostate problem?
--------------------	---------------------------	-------------------

JORDAN LANDING FAMILY MEDICINE & LASER AESTHETICS
NOTICE OF PRIVACY ACKNOWLEDGEMENT

NOTICE OF RECEIPT

By signing this form, you acknowledge having received the
"Notice of Privacy Practices" for **JORDAN LANDING FAMILY
MEDICINE & LASER AESTHETICS**

Patient Name _____

Patient/Guardian Signature _____

Date: _____

I hereby authorize **JORDAN LANDING FAMILY MEDICINE & LASER
AESTHETICS** to release my medical information to the following individuals:

I give my permission to **JORDAN LANDING FAMILY MEDICINE & LASER
AESTHETICS** to leave a detailed message on my voice mail, or with a family
member _____ (Initials)

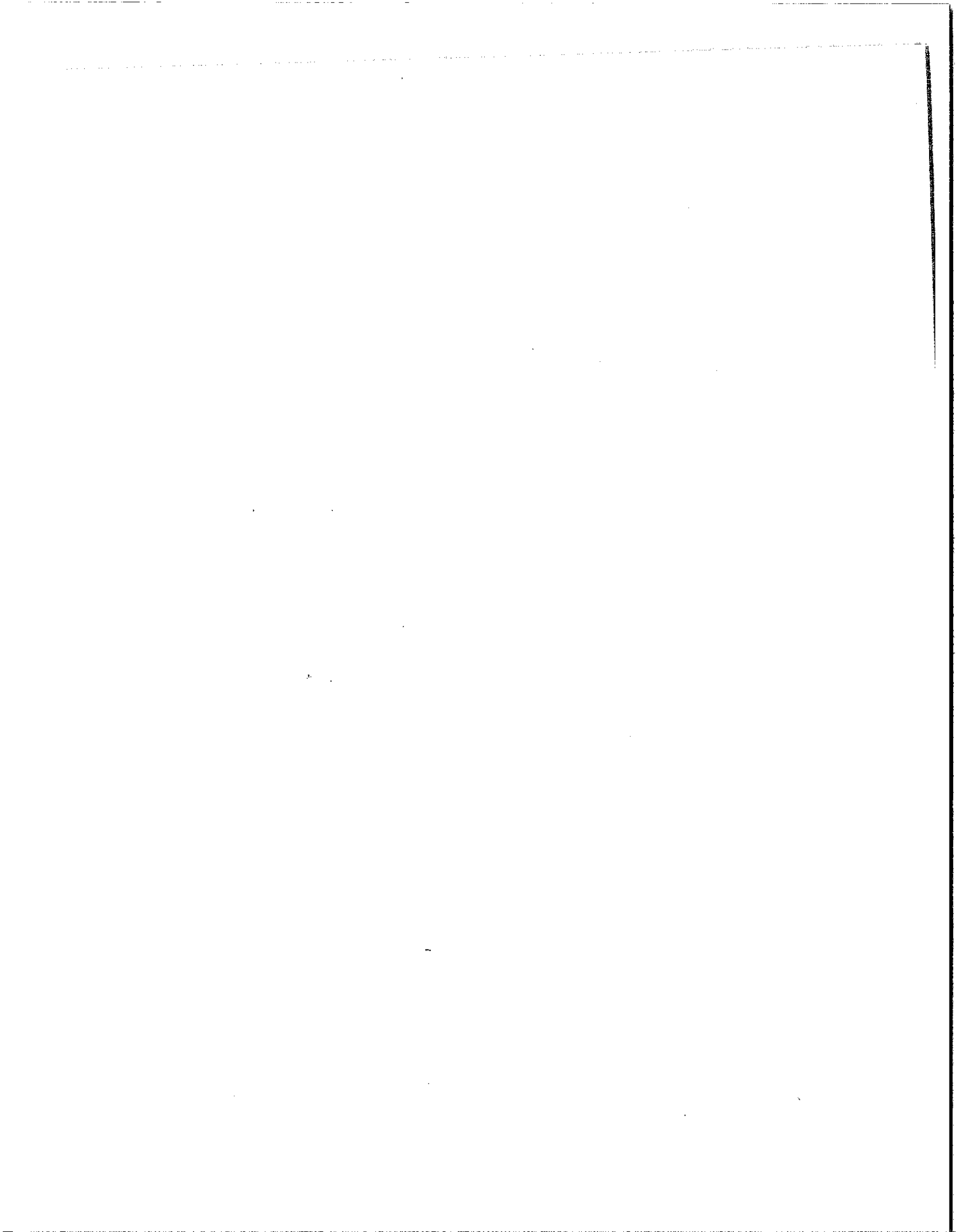
Permission to Transmit Newsletter Via Email

The undersigned does hereby give consent for a designated employee of Jordan Landing Clinic and Laser Aesthetics to transmit their newsletter to my email address. This permission will be effective immediately. I understand Jordan Landing Clinic and Laser Aesthetics will follow all privacy protocols that can be applied to the transmission of email information, but I also realize that no method of communication is without possible interception, including emails. I will hold blameless the doctors and employees of Jordan Landing Clinic and Laser Aesthetics if in transmitting their newsletter information is intercepted in any manner by a third party.

Signed this _____ day of _____, 200__

Patient's signature or Person Legally
Responsible for Patient, if a minor.

E-mail Address



Jordan Landing Family Medicine

Notice of Privacy Practices Effective March 27, 2003

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.

If you have any questions about this notice, please contact our Privacy Officer at
(801) 280-7774

Who will follow this notice?

This notice describes Jordan Landing Family Medicine's practices and that of:

- Any health care professional authorized to enter information into your medical record.
- All departments and units of this facility/organization.
- Any member of a volunteer group we allow to help you while you are in this facility.
- All employees, staff and other clinical personnel.
- Any other location directly affiliated and operated by Jordan Landing Family Medicine.

Our pledge regarding medical information:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and service you receive in our clinic. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by **Jordan Landing Family Medicine** whether made by ancillary staff or your personal physician.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

- We are required by law to:
- Make sure that medical information that identifies you is kept private;

- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

How may we use and disclose medical information about you?

The following categories describe different ways that we use and disclose medical information. All of the ways we are permitted to use and disclose information will fall within one of these categories.

- ✓ **For Treatment** – We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other ancillary personnel who are involved in your medical care.
- ✓ **For Payment** – We may use and disclose medical information about you so that the treatment and services you receive from our physician(s) and clinic may be billed to and payment may be collected from you, an insurance company or third party.
- ✓ **For Health Care Operations** – We may use and disclose medical information about you for clinical operations. These uses and disclosures are necessary to run the administrative portion of our business and to assure all of our patients a high quality of care.
- ✓ **Treatment Alternatives** – We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- ✓ **Health-Related Benefits and Services** – We may use and disclose medical information to tell you about health-related benefits or services that may be of interest to you.
- ✓ **To Avert a Serious Threat to Health or Safety** – We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
- ✓ **Workers' Compensation** – We may release medical information about you for Workers'

Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect circumstances to report a crime.

✓ **Coroners, Medical Examiners and Funeral Directors** – We may release medical information to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death.

✓ **National Security and Intelligence Activities** – We may release medical information about you to federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

✓ **Inmates** – If you are an inmate of a correctional institution or under the custody of law enforcement officials, we may release medical information about you to the correctional institution or law enforcement official.

Your rights regarding medical information about you

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy – You have the right to inspect and copy medical information that may be used to make a decision about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

To inspect and copy medical information that may be used to make decisions about you, you must submit a request in writing to the **Business Office** or obtain a copy of a Release of Information form from our medical record department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care

Professional chosen by **Jordan Landing Family Medicine** will review your request and the denial. The person conducting the review will not be the person who denied your original request. We will comply with the outcome of the review.

- ✓ **Right to Amend** – If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by of for **Jordan Landing Family Medicine**.

To request an amendment, your request must be made in writing and submitted to **Business Office**. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the clinic; is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

- ✓ **Right to an Accounting of Disclosures** – You have the right to request an "Accounting of Disclosures." This is a list of the disclosures made of medical information about you that were not made for treatment, payment for health care operations.

To request this list or "Accounting of Disclosures", you must submit your request in writing to **Business Office**. Your request must state a time period that must not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 1-year period will be free of charge. For additional list, we may charge you for the cost of providing this list.

- ✓ **Right to Request Restrictions** – You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the

payment of your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to **Business Office**. Your request must include the 1) information you want to limit; 2) whether you want to limit our use, disclosure or both; and 3) to whom you want the limits to apply.

- ✓ **Right to Confidential Communications** – You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.

- ✓ **Right to a Paper Copy of this Notice** – You have the right to a paper copy of this "Notice of Privacy Practices." You may ask us to give you a copy at any time.

Changes to this notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post of current copy in the waiting area(s) of our clinic. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you present for treatment or health care services, we will offer you a copy of the current notice.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the **Business Office**, 280-7774 or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to use will be made only with your written permission. If you provide us permission to use or disclose medical

information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosure we have already made with your permission, and that we are required to retain our records of the care that we provided to you.