FAMILY FIRST MEDICAL

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PATIENT INFORMATION

Date:_____

Patient Name: _____
Last First M.I.

Sex: _____ Age:_____ DOB:_____

Address:_____ _____ _____ _____
Street City State Zip code

Phone number: _____Cell:_____

Best time to be reached:_____

Email:_____

Marital status: married single widowed other

Ethnicity: Hispanic Non-Hispanic

Race: White Native American Asian African American Pacific Islander Other

Spouse:_____DOB:_____

IN CASE OF EMERGENCY

Name:_____

Relationship:_____

Phone Number:_____

CONSENT OF TREATMENT

I hereby consent to the medical treatment, diagnostic and laboratory tests, and other procedures, which the physician(s) may deem advisable in treatment of my case (or as legal guardian for patient). Family First Medical will determine the proper disposition of any tissues, parts, or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.
Patient/Responsible Party Signature:

_____Date:_____

Primary Insurance Company:

_____

Claims Address: _____

City _____ State _____ Zip _____

_

Group No. _____ID No._____

Relationship of Patient to Insured: (Circle One) Self Spouse Child Other

Policy Holder:

_____

Date of Birth: _____/_____/_____
(Mo.) (Day) (Year)

Mailing Address: _____ Apt# _____

City _____ State _____ Zip _____

Preferred Phone:( )_____

Date of Birth ____/_____/____ Social Sec. No:_____

Employer: _____

_

Employer Phone: ( ) _____

Secondary Insurance
Company:_____

Claims Address: _____

City _____ State _____ Zip _____

Group No. _____ ID No._____

Relationship of Patient to Insured: (Circle One) Self Spouse Child Other

Policy Holder: _____ Date of Birth: _____/_____/_____

I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier. I agree to pay a service charge of $25.00 for each check returned to this facility.

It is understood and agreed that if I fail to pay this account in accordance with policy, then I will pay all reasonable attorney fees and other costs incurred for collection of this account.

_____ _____

Patient Signature Date

FAMILY FIRST MEDICAL

Patient Health History

Patient Name:_____Todays Date:_____

Age:_____DOB:_____Last Physical Exam:_____

Symptoms: check (X) if you currently have or have had in the past year

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Urine frequency
- ☐ Painful Urination

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

GASTROINTESTINAL

- ☐ Poor appetite
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Hemorrhoids
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Bleeding

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular Heart Beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Ankle swelling
- ☐ Varicose Veins

EYES/EARS/NOSE/THROAT

- ☐ Bleeding gums
- ☐ Crossed vision
- ☐ Blurred vision
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision- flashes
- ☐ Vision- halos

MEN ONLY

- ☐ Lump in testicles
- ☐ Erection difficulties
- ☐ Penis discharge
- ☐ Sores on penis

WOMEN ONLY

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Menstruation cramps
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge

Last pap smear_____

Last Mammogram_____

Are you pregnant: Yes No

Number of pregnancies_____

Number of live children_____

List your prescribed medications, over-the-counter drugs, and vitamins:

MEIDCATION NAME	STENGTH	FREQUENCY TAKEN

Do you smoke? No Yes, for how long?_____How many packs day_____

Do you drink alcohol? No Yes, how much?_____

Surgeries/hospitalizations:_____
_____
_____

Allergies to Medications:_____

Does anyone in your family have a history of: **Relationship to Patient?**

- ☐ Cancer If yes, what type?_____ _____
- ☐ Diabetes _____
- ☐ High blood pressure _____
- ☐ Heart disease _____
- ☐ Other:_____

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,

(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 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 your Provider(s) will then jointly appoint an Arbitrator (the "Jointly-Selected Arbitrator"). If you or 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 by the state of 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 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 hearing will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the pre litigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 Term/ Rescission/ Termination

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.
B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from 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. 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 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 FAMILY FIRST MEDICAL

_____ _____

Name of Physican, Group, Clinic Name of Patient (Print)

By:_____ _____

Signature of Physician or Authorized Agent Signature of Patient or Patients Representative (Date)