PATIENT REGISTRATION FORM **Guarantor**_____

(In Office Use Only)

Biological/Adoptive Parents/Legal Guardian/Information

This document may only be completed by the biological/adoptive mother or father of your child(ren) unless you have legal documentation stating you have legal responsibility for the following child(ren). If you are a Step-Parent or Other, please stop now and see a receptionist.

Are parents: ❑Married ❑Separated ❑Divorced ❑Widowed/Widower ❑Single

Who is bringing the child in today:

- ❑ Biological Parent
- ❑ Adoptive Parent
- ❑ Legal Guardian (Please provide legal documentation)
- ❑ Foster Parent

Biological/Adoptive Parent/Legal Guardian

1: Last Name: _____ **First Name:** _____ **Middle Name:** _____

Sex: ❑Male ❑Female

Street Address: _____Apt No. _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____Driver's License # _____

Home Phone #: _____ Cell Phone #_____ Email: _____

Employer: _____ Business Phone: _____

Employer Address: _____ State: _____ Zip: _____

Biological /Adoptive Parent/Legal Guardian

2: Last Name: _____ **First Name:** _____ **Middle Name:** _____

Sex: ❑Male ❑Female

Street Address: _____Apt No. _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____Driver's License # _____

Home Phone Number: _____ Cell Phone Number: _____ Email: _____

Employer: _____ Business Phone: _____

Employer Address: _____ State: _____ Zip: _____

Authorization to treat in absence of a parent: **Guarantor** _____

(In Office Use Only)

Persons Authorized to Accompany and Provide Consent for Treatment Other than the Biological Parent, Adoptive Parent, or Legal Guardian.

(Example: Step-Parent, grandparent, aunt, uncle, baby-sitter, neighbor, or anyone who will bring your child to our office etc.)

I consent for the following person(s) to authorize evaluation and treatment for the patient(s) identified in the "Child(ren) Information section of this contract. This authorizes the following person(s) to consent to medical and surgical procedures and immunizations for the patient(s) listed above. If my child is 16 years of age or older, I agree that they can come in without a parent/legal guardian. I agree to be financially responsible for the cost of such care. The duration of this consent is indefinite and continues until revoked in writing by myself.

Name: _____ Phone Number: _____ Relationship: _____ Date of Birth: _____

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Name: _____ Phone Number: _____ Relationship: _____ Date of Birth: _____

Name: _____ Phone Number: _____ Relationship: _____ Date of Birth: _____

Name: _____ Phone Number: _____ Relationship: _____ Date of Birth: _____

Biological/Adoptive Parent
Legal Guardian Name (please print): _____

Biological/Adoptive Parent
Legal Guardian Signature: _____ Date: _____

Emergency Contact Information

Emergency Contact: (These persons should live in the same state, but not in the same household)

Name: _____ Phone Number: _____ Relationship: _____

Name: _____ Phone Number: _____ Relationship: _____

Immunization Policy

Alpine Pediatrics, PC follows the current immunization guidelines established by the American Academy of Pediatrics (AAP) and the Center for Disease Control's Advisory Committee on Immunization Practices (ACIP). Any desire to follow a modified schedule must be discussed with a provider.

Biological/Adoptive Parent
Legal Guardian Name (please print):_____

Biological/Adoptive Parent
Legal Guardian Signature:_____Date:_____

Child(ren) Information

Guarantor ______________________________
(In Office Use Only)

Alpine Pediatrics participates with several State and Federal programs that require race and ethnicity for each patient. Please complete the following information for each patient.

Consent for Treatment

I hereby authorize employees of Alpine Pediatrics, PC (including physicians, physician assistants, nurse practioners and other employees and staff members) to render medical evaluations and care to me or my child(ren) that I have listed below. The duration of this consent is indefinite and continues until I revoke in writing. ***I understand that by not signing this consent, my child(ren) will not be provided medical care except in case of emergency.***

Biological/Adoptive Parent
Legal Guardian Name (please print): ______________________________

Biological/Adoptive Parent
Legal Guardian Signature: ______________________________ Date: ______________

Child's Last Name: ______________ **First Name:** ______________ **Middle Name:** ______________
Preferred name child goes by: ______________ **Date of Birth:** ______________ **Sex:** ❑Male ❑Female
Race: ❑*American Indian/Alaska Native* ❑*Asian* ❑*Black/African American* ❑*Hispanic* ❑*Native Hawaiian/Pacific Islander* ❑*White*
Ethnicity: ❑*Hispanic/Latino* ❑*Non-Hispanic/Latino* ❑*Decline*

Child's Last Name: ______________ **First Name:** ______________ **Middle Name:** ______________
Preferred name child goes by: ______________ **Date of Birth:** ______________ **Sex:** ❑Male ❑Female
Race: ❑*American Indian/Alaska Native* ❑*Asian* ❑*Black/African American* ❑*Hispanic* ❑*Native Hawaiian/Pacific Islander* ❑*White*
Ethnicity: ❑*Hispanic/Latino* ❑*Non-Hispanic/Latino* ❑*Decline*

Child's Last Name: ______________ **First Name:** ______________ **Middle Name:** ______________
Preferred name child goes by: ______________ **Date of Birth:** ______________ **Sex:** ❑Male ❑Female
Race: ❑*American Indian/Alaska Native* ❑*Asian* ❑*Black/African American* ❑*Hispanic* ❑*Native Hawaiian/Pacific Islander* ❑*White*
Ethnicity: ❑*Hispanic/Latino* ❑*Non-Hispanic/Latino* ❑*Decline*

Child's Last Name: ______________ **First Name:** ______________ **Middle Name:** ______________
Preferred name child goes by: ______________ **Date of Birth:** ______________ **Sex:** ❑Male ❑Female
Race: ❑*American Indian/Alaska Native* ❑*Asian* ❑*Black/African American* ❑*Hispanic* ❑*Native Hawaiian/Pacific Islander* ❑*White*
Ethnicity: ❑*Hispanic/Latino* ❑*Non-Hispanic/Latino* ❑*Decline*

Child's Last Name: ______________ **First Name:** ______________ **Middle Name:** ______________
Preferred name child goes by: ______________ **Date of Birth:** ______________ **Sex:** ❑Male ❑Female
Race: ❑*American Indian/Alaska Native* ❑*Asian* ❑*Black/African American* ❑*Hispanic* ❑*Native Hawaiian/Pacific Islander* ❑*White*
Ethnicity: ❑*Hispanic/Latino* ❑*Non-Hispanic/Latino* ❑*Decline*

Child's Last Name: ______________ **First Name:** ______________ **Middle Name:** ______________
Preferred name child goes by: ______________ **Date of Birth:** ______________ **Sex:** ❑Male ❑Female
Race: ❑*American Indian/Alaska Native* ❑*Asian* ❑*Black/African American* ❑*Hispanic* ❑*Native Hawaiian/Pacific Islander* ❑*White*
Ethnicity: ❑*Hispanic/Latino* ❑*Non-Hispanic/Latino* ❑*Decline*

Financial Responsibility

Guarantor _____

(In Office Use Only)

I hereby authorize payment of medical benefits directly to Alpine Pediatrics PC and/or the attending provider for services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim.

I understand and agree that I am financially responsible for the total charges for services rendered which may include services not covered by the patient's insurance plan.

I understand and agree that I will be responsible for all charges accrued by my child(ren) who have turned 18 until such time as I notify Alpine Pediatrics in writing prior to services being provided, that I no longer accept financial responsibility.

I understand and agree that all patient balances and costs are due in full upon request.

I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me below for any reason, including to contact me about my account balance or to provide notices to me as required by law or otherwise. I agree to notify Alpine Pediatrics if any telephone number or address listed below ceases to be my number or address and to provide a replacement number or address to Alpine Pediatrics. I understand and agree that such calls may be initiated by Alpine Pediatrics or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages-some or all of which may result in data charges. I also consent to receiving e-mails at any e-mail address provided by me or anyone associated with me or acting on my behalf.

Utah law requires Alpine Pediatrics to provide the biological/adoptive parent(s) or other responsible parties with notice, by certified/priority letter or text message, 45 days prior to placing any delinquent balance with a collection agency or reporting any delinquent balance to any credit bureau, which actions may negatively impact my credit score. I understand I will be charged a fee of $10.00 if any such notice is sent to me by certified/priority letter.

I understand and agree that should my account become delinquent, and it is referred to an outside collection agency, I shall pay an additional collection fee of up to 40% of the amount owing as allowed by Utah Code Annotated, sec. 12-1-11. I also agree to pay reasonable attorney fees incurred by Alpine Pediatrics in connection with enforcement or collection of this agreement.

Returned checks are automatically forwarded to a collection agency for immediate collections and I may be charged a $20.00 return check fee on all returned checks. If the returned check amount is not resolved, additional charges may be applied as per Utah Law.

I understand and agree to arrive to my scheduled appointment on time. If I am 20 minutes late for my scheduled appointment, I may be asked to reschedule.

I understand and agree to give 24 hours cancellation notice of any pre-scheduled or confirmed appointments and at least 1 hour cancellation notice for same day appointments. I understand and agree that I will be charged a fee of $25.00 for each appointment that I fail to give proper notice of cancellation.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, Alpine Pediatrics cannot bill my insurance and I am responsible for payment of services in full on the date of service. This is applicable for all of my children listed in this contract.

Biological/Adoptive Parent
Legal Guardian Signature: _____ Date: _____

Printed Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile Phone: _____

Other Phone: _____ Email: _____

Arbitration Agreement

Guarantor _____

(In Office Use Only)

I acknowledge that I have been provided a copy of the Arbitration Agreement of Alpine Pediatrics, PC regarding all patients on the other side of this form.

Biological/Adoptive Parent
Legal Guardian Signature: _____ Date: _____

Acknowledgement of the Receipt of HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.

Alpine Pediatrics PC is furnishing you with the attached notice, which provides information about how Alpine Pediatrics PC may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law, regarding all patients on the other side of this form.

By signing this form, you acknowledge that you have received a copy of Alpine Pediatrics PC Notice of Health Information Practices.

Biological/Adoptive Parent
Legal Guardian Signature: _____ Date: _____

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:

Alpine Pediatrics
Name of Physician, Group, or Clinic

By: _____
Signature of Physician or Authorized Agent

Patient(s) Names:

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

_____ _____ _____

_____ _____ _____