Salson Clinics, LLC
1745 West 7800 South • West Jordan, Utah 84088
(801) 666-8640 • www.salsonclinics.com

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 the 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 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 the 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 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.

(!) 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, 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 the 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 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. 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. I have had the right to ask 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 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 healthcare. 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.

Salson Clinics, LLC

Name of Clinic

_____

Printed Name of Patient

_____

Signature of Patient or Patient's Representative

Date: _____

_____

Signature of Physician or Authorized Agent

Last Name _____ **First Name**_____**Middle Initial**_____

What is the ***main*** reason for your visit today?_____

Do you smoke? Yes No **Do you use Alcohol?** Yes No

Briefly describe your medical history:

What surgeries have you had?

Symptoms: ***Please check all that apply to you.***

- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Unexplained fatigue
- ☐ Fever
- ☐ Chills
- ☐ Trouble sleeping
- ☐ Sore throat
- ☐ Sinus pain
- ☐ Nasal Congestion
- ☐ Ear pain
- ☐ Cough
- ☐ Wheezing
- ☐ Feel short of breath
- ☐ Snoring
- ☐ Chest pains
- ☐ Rapid heart beat
- ☐ Hot flashes
- ☐ Low Libido
- ☐ Skin rash
- ☐ Itchiness
- ☐ Unusual hair growth
- ☐ Hair loss
- ☐ Achiness
- ☐ Joint pain
- ☐ Urinating frequently
- ☐ Urine pain or burn
- ☐ Blood in urine
- ☐ Urine incontinence
- ☐ Diarrhea
- ☐ Unexplained bruising
- ☐ Swelling
- ☐ Lump in breast
- ☐ Nipple discharge
- ☐ Women: PMS
- ☐ Women:Abnormal Menses
- ☐ Women: Cramping
- ☐ Constipation
- ☐ Headaches
- ☐ Dizziness
- ☐ Numbness/tingling
- ☐ Feel faint
- ☐ Seizures
- ☐ Anxiety
- ☐ Depression
- ☐ Feel irritable

Other symptoms:

Family History: (List relative and associated conditions)

Have you had a Colonoscopy? Yes No **Cholesterol Screen?** Yes No

Women: Last mammogram: _____ **Last Pap smear:** _____

Do you use Marijuana or recreational drugs? Yes No **Do use needles to inject?** Yes No

Are you sexually active? Yes No **With:** (Circle) Male Female

Birth control: (circle) None needed Condom Pill Diaphragm Vasectomy Other

Allergies: (List medication & Reaction)

List Medications: (Dosage & how many times per day)

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Insurance Assignment and Release

I certify that I have insurance coverage with _____.

- I assign directly to Salson Clinics, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. Initial _____

- In the event that my insurance company refuses payment for services rendered, I will be responsible for payment in full. A denial from my insurance company does not release me from my financial obligations to Salson Clinics, LLC. Payments on accounts billed are expected within 30 days and delinquent accounts will be charged interest in accordance with Utah collection statutes. Initial _____

- I recognize that **filing claims with my insurance carrier is done at an additional expense to Salson Clinic, LLC and is a courtesy, not an obligation,** as is procuring prior authorizations for prescription coverage. Initial _____

- I understand that payments not covered by insurance, as well as copays are to be paid at the time of service. Initial _____

- I understand that in the event legal action is taken to collect my account, or if my account is referred to a collection agency, there will be an additional fee added to the amount sent to collections to pay for these services in accordance with Utah collection statutes. Initial _____

- In order for Salson Clinics, LLC or an assigned billing company to contact me regarding my past due account, including any collection status it may have, I expressly authorize contact to be made by telephone, by text message or email using any number or email I have listed. I acknowledge that such contact could result in charges to me by my telephone carrier. Methods of contact may include the use of pre-recorded messages or the use of an automatic phone dialing system, as applicable. I acknowledge that such contact could result in charges to me by my phone carrier. I acknowledge and agree that this authorization shall extend to any billing or collection company that may be assigned to my account.
  Yes, I authorize this (initial) _____ No, I do not authorize this (initial) _____

- I authorize the use of my signature on all insurance submissions. Salson Clinics, LLC may use my health care information and may disclose such information to the afore named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below. Initial ____

Anti-Kickback Law: Due to policy provisions in your contract with your insurance carrier, we are obligated to collect all patient responsibility balances. If your insurance policy has provisions such as deductibles, co-insurances or co-payments, note that these are provisions that have been agreed to between you and your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. If a portion of your fees are applied to an annual out of pocket maximum and we do not collect that fee, your out of pocket maximum has not been correctly calculated.

Additionally, for Medicare patients that have any medical services that are eligible under Medicare, we are legally obligated to collect the patient's responsibility for co-insurance, co-payment or deductible under the terms of the anti-kickback law.

We sincerely regret if any of these regulatory provisions cause you any inconvenience, but we are bound by all provisions of insurance policy and federal law. If you have questions about coverage for your visit, **contact your insurance company.** We are more than happy to assist you as well.

Please feel free to contact us with any questions you may have or any assistance you may require to fully understand these provisions.

Print Patient Name: _____

Patient (Parent / Guardian) Signature: _____

Witness: _____ Date: _____

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Last Name: _____First Name: _____Middle: _____

Circle One: Male Female

Date of Birth: _____ Social Sec. #: _____

Phone: _____ Other Phone: _____

Email Address: _____

Street Address: _____ Apt./ Unit #: _____

City: _____ Zip: _____

Circle One: Own Rent

Circle One: White Black / African American Asian Hispanic

American Indian Pacific Islander Other: _____

Language Preference: _____

Next of Kin or Emergency Contact: _____

Relationship: _____ Phone: _____

If you would like others to be able to talk with us, please sign a HIPAA Release.

If you would like other family members or other facilities to communicate with our office about you, your appointments, your payments, your history or your on-going treatment, please list those people or facilities here. We will provide you with the proper document.

Spouse: _____Phone: _____

Child: : _____Phone: _____

Facility: _____Phone: _____

Parole Officer: _____Phone: _____

Other: _____Phone: _____

Circle the yes or no column below based on your personal and family history of cancer. Leave blank what you do not know

Relatives to consider: Parents siblings, half-siblings, children, grandparents, grandchildren, aunts, uncles, nieces and nephews on both sides of the family.

- **Breast, ovarian or pancreatic cancer** diagnosed at any age? Yes No
- **Colorectal or uterine cancer** diagnosed at age 64 or younger? Yes No
- Do you have a family history of **breast cancer** diagnosed at age 49 or younger? Yes No
- Do you have a family history of **ovarian cancer** diagnosed at any age? Yes No
- Do you have a family history of **pancreatic cancer** diagnosed at any age? Yes No
- Do you have a family history of **uterine cancer** diagnosed at age 49 or younger? Yes No
- Do you have a family history of **colon cancer** diagnosed at age 49 or younger? Yes No
- Do you have a family history of **3 or more breast cancers** diagnosed at any age in family members on the same side? Yes No
- Do you have a family history of **3 or more colon and / or uterine cancers** diagnosed at any age in family members on the same side? Yes No

Note: If you have answered YES to any of the questions above, you prequalify for a cancer prevention program.

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We are able to send patient appointment reminders and messaging via SMS mobile texting or voice telephone calls in addition to the email appointment reminders.
To enable this feature, you must first confirm and record your consent to receive such as a part of the
Telephone Consumer Protection Act (TCPA).

Name: _____
(Print)

I agree to receive automated SMS mobile text messaging and / or email reminders and messages.

_____
Phone Number

_____
Email Address

Signed: _____ Date: _____

Witness: _____

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HIPAA NOTIFICATION / ACKNOWLEDGEMENT OF PRIVACY PRACTICES REGARDING PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides detailed information about how we may use and disclose protected health information about you. As a patient you have a right to a copy of that notice. You may obtain a copy from our office. We reserve the right to change the notice and if we do, you may obtain a copy of the revised notice from the same office. Please acknowledge your receipt of the notification by signing below and returning it to the receptionist.

Signature: _____ Date: _____

TREATMENT CONSENT

I hereby consent and give my permission to the doctor, assistants or designated replacement to administer and perform such procedures upon me, as the provider deems necessary.

Signature: _____ Date: _____

MEDICARE / MEDIGAP / MEDICAID AUTHORIZATION

I request that payment of authorized benefits be made either to me, or on my behalf, to Salson Clinics, LLC. for any services furnished to me by them. To the extent permitted by law, I authorize any holder of medical or other information about me to be released to the centers for Medicare and Medicaid Services, my insurer and their agents regarding any information needed to determine their benefits for related services.

Signature: _____ Date: _____