PATIENT REGISTRATION

Date: _____

Patient Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security #: _____

Home Address: _____
(Street & House #) (City) (State) (Zip Code)

Primary Phone #: _____ Alternate Phone #: _____

Employer: _____ Work Phone #: _____

Occupation: _____ E-Mail Address: _____

Relationship to Responsible Party (circle one): Self Spouse Child Other: _____

Emergency Contact Name: _____ Relationship: _____ Emergency Phone: _____

Contact Address: _____
(Street & House #) (City) (State) (Zip Code)

Responsible (insured) Party Information

Name: _____
(Last) (First) (Middle)

Date of Birth: _____ Social Security #: _____

Home Address: _____
(Street & House #) (City) (State) (Zip Code)

Primary Phone #: _____ Alternate Phone #: _____

Employer: _____ Phone #: _____

City: _____ Supervisor #: _____

Insurance Information

Primary Insurance: _____ Address#: _____

Contact (ID) #: _____ Phone #: _____

Group Name: _____ Group #: _____

Co Pay $: _____ Subscribers Name: _____

Date of Birth: _____ Social Security #: _____

Please Circle: Male Female

Patient Relationship to Insurance Subscriber (circle one): Self Spouse Child

Financial Agreement

Thank you for choosing The Alpine Clinic as your health care provider. It is our goal to make medical care accessible and affordable. Please understand that payment of your bill is necessary for us to continue to provide high quality health care. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. In the event that we are not participating with your insurance company, payment is expected at the time of service. We will be happy to provide you with any necessary information for you to submit your claim and pursue reimbursement from your insurance carrier. If we are a participating provider with your insurance plan, we agree to the assigned insurance benefits from that plan. However, it is the patient's responsibility to make sure that their insurance has paid the claim in a timely fashion. We allow 60 days for the claim to be paid by your insurance, after which time the balance due is your responsibility. Generally, you are responsible to collect payment from your secondary insurance company. We will gladly supply you with the necessary documentation to bill your secondary plan after the primary insurance has paid. **All co-payments and deductibles are due prior to treatment.** A billing fee of $5.00 will be assessed to all co-payments and deductibles that are not paid at the time services are rendered. **It is also your responsibility to inform our office in a timely manner of any changes in insurance coverage.** Often insurance will deny a claim because of changes in coverage, and there is no time left within the allowed submission period to re bill it correctly. Under these circumstances, the patient will be held responsible for payment in full for services rendered, regardless of our status with the insurance carrier. A minimum of $2.00 per month, or 18% APR. will be charged as a billing charge for all unpaid balances over 30 days. All collections and legal fees associated with a bad debt will be the responsibility of the patient. In addition, due to the difficulties associated with missed appointments, we reserve the right to bill a service charge for appointments that are not canceled within 24 hours of the appointment. If complete payment cannot be made at the time of service, definite arrangements for payments must be made at that time. We cannot extend a line of credit through our office; however, we will try to be as helpful as possible in determining the most convenient payment option for you.

*******Important:* **Some of the services offered at The Alpine Clinic may not be covered by or billable to your insurance and are therefore the responsibility of the patient.****

I have read, understood and agree to the provisions of the financial policy :

Patient/Parent (guardian): _____ Date: _____

I have received a copy of the form entitled "notice of privacy practices" for the Alpine Clinic:

Patient/Parent (guardian): _____ Date: _____

NON STANDARD CARE CONSENT

In addition to standard medical treatments, the Alpine Clinic offers several treatment options that are considered non-standard, or alternative care. These modalities are offered for patients for a variety of medical indications. However, these treatments are considered by many physicians and insurance companies to be alternative and many have not been tested through prevailing double-blind methods of medical research. In addition, they are often not covered by insurance and are usually the financial responsibility of patients. If you have questions about whether treatment options are covered by your plan, please consult with your insurance company for more information. These include the following specific modalities.

Homeopathy/ Nutritional Counseling
Homeopathy and natural medicine are distinct, specialized medical services apart from conventional allopathic medical practice. Benefits from this treatment are unique and can be an important complement to conventional techniques. There are no risks or side effects associated with this care. The homeopathic examination and interview requires an extensive office visit that is not recognized or reimbursed by health insurance. Patients are responsible for the full payment of fees associated with this treatment.

Electrodermal Analysis
This is designed to help identify particular patterns of stress throughout the body. This is a totally non-invasive procedure where a metal probe is touched to the skin to measure electrical conductivity at responsive points, typically on hands and feet. Remedies that bring abnormal electrical patterns into balance are then recommended. This procedure is extremely safe. There may be mild discomfort associated with the pressure of the probe on the skin. While there are no documented risks associated with remedies or recommended substances, please report any concerns to your practitioner.

Microcurrent (Electrical Stimulation)
Healing effects are produced by using specific frequencies of microamperage current to treat specific tissues. This therapy is useful for trauma, overuse injuries, fibromyalgia and other chronic pain syndromes.
Side effects may include a post-detoxification reaction, including nausea, mild aching and fatigue. This is usually preventable by good hydration before treatment.

Manipulation
Manual traction and pressure on muscles and connective tissue to relieve imbalances in opposing muscle groups and bring the muscles into balance. We do not use chiropractic adjustment techniques. No side effects have been identified from this gentle technique.

Trigger-point injections
Injection of local anesthetic, homeopathics and possibly low dose steroids into precise loci of pain to break cycles of myo-fascial pain and speed healing. Side effects are those of any injection: pain at injection site, possible bruising, risk of infection or rare allergic reaction.

I have been informed of these alternative treatment options with their accompanying benefits and risks. I acknowledge that I have had and will have the opportunity to ask questions about treatment and to have my questions answered to my full satisfaction. I acknowledge and accept these therapies when requested as an adjunct therapy to the standard drug therapies. I acknowledge that no guarantees or claims have been made to me regarding the efficacy or results of any of the above therapies. I have been informed that my insurance company is not likely to cover any fees associated with these treatments and that I am ultimately financially responsible for payment. I freely give my consent to receive any of these treatments when recommended and requested. I also consent for my record to be used anonymously for the purpose of advancing clinical knowledge and for research and scientific purposes.

Date_____ Patient Name_____

Signature_____

Witness_____

Parent or Guardia Name_____

Alpine Clinic
1175 East 3200 North, Lehi UT 84043 Tel: (801) 407-3000 Fax: (801) 407-3001

revised Aug 2012

ALPINE CLINIC PATIENT AUTHORIZATION FORM
RELEASE OF RECORDS AND INFORMATION

SECTION A:

I, _____, authorize Alpine Clinic to release the use and/or disclosure of my confidential protected health information covering the period of health care from

Please choose one:

_____ to _____ or ☐ All past, present and future periods

Name and relationship of those to whom my information may be disclosed:

_____ _____

_____ _____

SECTION B

B. Right to Revoke: I understand that I may revoke this authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this authorization will continue until I revoke this authorization.

SECTION C

C. Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions in Section A. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions.

I,_____, have read the contents of this authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

_____ _____
Your Signature Date

_____ _____
Signature of Witness Date

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ALPINE CLINIC REVIEW OF SYSTEM

Name: _____ **Date** _____

FEMALE

Hot flashes	O **Yes**	O **No**
Persistent vaginal itching or dryness	O **Yes**	O **No**
Perform monthly breast exam	O **Yes**	O **No**
Get annual pelvic exam	O **Yes**	O **No**
Menstrual cycle	O **Yes**	O **No**
Heavy bleeding/clots	O **Yes**	O **No**
Irregular menstrual cycles	O **Yes**	O **No**
Painful menstrual cramps	O **Yes**	O **No**
Breast tenderness	O **Yes**	O **No**
Breast changes/concerns	O **Yes**	O **No**
Abnormal PAP	O **Yes**	O **No**
Other	O **Yes**	O **No**

MALE

Rupture or swelling of the groin	O **Yes**	O **No**
Nodule in testicle growing larger	O **Yes**	O **No**
Pain/tenderness in groin	O **Yes**	O **No**
Perform monthly self testicular exam	O **Yes**	O **No**
Penile Discharge	O **Yes**	O **No**
Enlarged or infected prostate	O **Yes**	O **No**
Other	O **Yes**	O **No**

GENITOURINARY

Blood in Urine	O **Yes**	O **No**
Kidney Stones	O **Yes**	O **No**
Pain/burning with urination	O **Yes**	O **No**
Urination at night more than twice	O **Yes**	O **No**
Urinary urgency	O **Yes**	O **No**
Previous UTIs	O **Yes**	O **No**
Kidney or flank pain	O **Yes**	O **No**
Sexually transmitted diseases	O **Yes**	O **No**
Problems/questions re: sexual function	O **Yes**	O **No**

DERMATOLOGY

Rash	O **Yes**	O **No**
Dry or sensitive skin	O **Yes**	O **No**
Warts	O **Yes**	O **No**
Psoriasis	O **Yes**	O **No**
Eczema	O **Yes**	O **No**
Skin discoloration	O **Yes**	O **No**
Skin cancer	O **Yes**	O **No**
Significant hair loss	O **Yes**	O **No**
Acne	O **Yes**	O **No**
Moles/color, shape or texture	O **Yes**	O **No**

CARDIOVASCULAR

Fainting	O **Yes**	O **No**
Chest Pain	O **Yes**	O **No**
Palpitations	O **Yes**	O **No**
Rapid heart rate	O **Yes**	O **No**
Angina	O **Yes**	O **No**
History of rheumatic fever	O **Yes**	O **No**
Swollen feet or ankles	O **Yes**	O **No**
Heart attack	O **Yes**	O **No**

HEAD, EYES, EARS, NOSE, THROAT

Thrush	O **Yes**	O **No**
Chronic sore throat	O **Yes**	O **No**
Blurring of vision	O **Yes**	O **No**
Persistent pain in either eye	O **Yes**	O **No**
Chronic sinus infection	O **Yes**	O **No**
Bloody nose	O **Yes**	O **No**
Mouth sores	O **Yes**	O **No**
Loss/change in sense of taste	O **Yes**	O **No**

HEMATOLOGY/LYMPH

Swollen glands/lymph nodes	O **Yes**	O **No**
History of anemia	O **Yes**	O **No**
Abnormal bleeding	O **Yes**	O **No**

PULMONARY

Any breathing problems	O **Yes**	O **No**
Shortness of breath on exertion	O **Yes**	O **No**
Shortness of breath at rest	O **Yes**	O **No**
Sudden shortness of breath at night	O **Yes**	O **No**
Asthma	O **Yes**	O **No**
Chronic cough	O **Yes**	O **No**
Coughing up blood	O **Yes**	O **No**

ENDOCRINE

Change in voice	O **Yes**	O **No**
Heat intolerance	O **Yes**	O **No**
Excessive thirst	O **Yes**	O **No**
Skin/hair changes	O **Yes**	O **No**
Cold intolerance	O **Yes**	O **No**
History of thyroid problems	O **Yes**	O **No**

GASTROENTEROLOGY

Abdominal pain	O **Yes**	O **No**
Abnormal colonoscopy	O **Yes**	O **No**
Constipation	O **Yes**	O **No**
Nausea	O **Yes**	O **No**
Vomiting	O **Yes**	O **No**
History of jaundice	O **Yes**	O **No**
Dark/bloody stool	O **Yes**	O **No**
Diarrhea	O **Yes**	O **No**

CENTRAL NERVOUS SYSTEM

Loss of coordination	O **Yes**	O **No**
Tingling in any part of the body	O **Yes**	O **No**
Mood swings	O **Yes**	O **No**
Changes in ability to concentrate	O **Yes**	O **No**
Dizziness	O **Yes**	O **No**
Changes in memory	O **Yes**	O **No**
Sleeping disturbance	O **Yes**	O No
Unusual emotional changes	O **Yes**	O **No**
Headaches	O **Yes**	O **No**

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

Effective April 14, 2003

As a patient of Alpine Clinic, you are entitled to receive notice about our privacy practices and how we may use and disclose your personal health information in different circumstances. This notice explains how we use and disclose your personal information, the choices and rights you have about how your information may be used and disclosed and our obligations to protect the privacy of your personal health information.

Our Duties: ALPINE CLINIC is required by law to maintain the privacy of your personal health information. We are required to comply with the terms of this notice which is currently in effect, but we reserve the right to change our privacy practices and to make such changes apply to all the protected health information we maintain. In the event that our notice changes, we will provide you with the revised notice the first time you visit us after the change or otherwise upon your request.

How we use and disclose your protected health information.

We may disclose your personal health information for such purposes in the following ways:

1. For treatment: to plan, provide, and coordinate your health care services.
2. To obtain payment for health care services we have provided for you.
3. For our health care operations.
4. To our business associates to provide the service we have contracted them to do in your behalf. We require all business associates to also safeguard your information in accordance with the law.
5. To the extent that we are required by law to do so.
6. In compliance with applicable laws for the purpose of controlling disease, injury or disability or to a public authority authorized to receive reports of child abuse or neglect, to report information about products or services under the jurisdiction of the U.S. FDA. Or to alert authorities of persons who may have been exposed to communicable disease or who may otherwise be at risk of contracting or spreading a disease or condition, and to your employer for certain work-related illness or injuries.
7. To government authorities of individuals whom we have reason to believe are victims of abuse, neglect, exploitation, or domestic violence.
8. To a health oversight agency charged with overseeing the health care system as authorized by law.
9. In the course of any judicial or administrative hearing or in response to a subpoena where we receive satisfactory assurance that you have been notified of the request.
10. For law enforcement purpose, to law enforcement officials in compliance with and as limited by applicable law.
11. To a coroner or medical examiner to identify a deceased person, determine a cause of death or for other duties as authorized by law.
12. To organ procurement organizations for organ, eye, or tissue donation purposes.
13. For research purposes when such research has been approved by an institutional review board that has reviewed the research to ensure the privacy of your personal health information, or as otherwise allowed by law. (Without your authorization.)
14. To certain government agencies charged with special government functions as limited by applicable law.
15. To prevent or lessen a serious threat to any person's or the public's health or safety. In all cases, disclosures will only be made in accordance with applicable law.
16. To judicial or administrative proceedings in response to orders regarding workman's comp.
17. With your authorization, for purposes other than treating you or receiving payment for your care, we will obtain your written permission prior to disclosing your information. (Unless otherwise permitted by law.)
18. Unless you object, we may contact you to provide appointment reminders or information about treatment, health benefits or services that may interest you. Before we send marketing materials, we may obtain your authorization. We may also use your information to notify a family member, close friend, or another person responsible for your care, provided that you have the opportunity to object. If you are unable to object, we may disclose this information as necessary if we determine it is in your best interest based upon our professional judgment.

Alpine Clinic

You have the following rights with regard to your to your personal health information.

Right to:

- Upon request to receive a paper copy of this notice. Please ask the receptionist for a copy.
- Upon request, to access and obtain a copy of your health information maintained by us.
- Request in writing that we amend your health information which we maintain. We will comply with your request in the event that we determine the information that you are asking us to amend is false, inaccurate or misleading.
- Request in writing that we place additional restrictions on how we use or disclose your personal health information. While we consider your request, we are not required to agree to your request.
- Request an accounting of the disclosures we make of your personal health information. For such discloser, the accounting will include the date it was made, a brief description of the information disclosed, the name and address (if known) of the person or entity that received the disclosure and a brief statement of the reason for the disclosure.
- To ask that we communicate with you by alternate means or at alternate locations. We will accommodate any reasonable written request.
- Receive further information about our privacy practices, your privacy rights, or if you disagree with a decision we make about your personal health information, or if you believe that your privacy rights have been violated.
- If you feel your rights have been violated, you may file a formal complaint with our Privacy Officer. You may also file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you the address to file your complaint. Under no circumstances will we retaliate against you for filing a complaint.

To contact our Privacy Officer, please write or call:

Alpine Clinic
Attn: Privacy Officer
1175 E 3200 N.
Lehi, UT 84043
(801) 407-3000

Alpine Clinic