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

Alpine Clinic

1175 East 3200 North, Lehi UT 84043 Tel: (801) 407-3000 Fax: (801) 407-3001 revised Nov 2012

ALPINE CLINIC REVIEW OF SYSTEM

Name: _____ **Date** _____

FEMALE

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

MALE

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

GENITOURINARY

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

DERMATOLOGY

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

CARDIOVASCULAR

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

HEAD, EYES, EARS, NOSE, THROAT

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

HEMATOLOGY/LYMPH

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

PULMONARY

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

ENDOCRINE

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

GASTROENTEROLOGY

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

CENTRAL NERVOUS SYSTEM

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

Alpine Clinic

1175 East 3200 North, Lehi UT 84043 Tel: (801) 407-3000 Fax: (801) 407-3001 revised Nov 2012

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

Cancer Family History Questionnaire

Patient Name: _____ **Date of Birth:** _____ **Age:** ____

Today's Date: _____ **Health Care Provider:** _____

Complete the section below with information on cancers in your family. Include yourself and all 1st and 2nd degree male and female blood relatives from both your mother's and father's families. Estimate the ages of diagnosis to the best of your ability. **1st degree relatives:** Parents, siblings, & children. **2nd degree relatives:** Grandparents, aunts/uncles, nieces/nephews, and half-siblings

YOUR FAMILY'S Cancer History (Please be thorough and accurate)

CANCER		YOU (age)	PARENTS / SIBLINGS / CHILDREN	AGE	MOTHER'S SIDE	AGE	FATHER'S SIDE	AGE
☑Y ☑N	*EXAMPLE: BREAST CANCER*		*Sister*	*41*	*Aunt* *Cousin*	*45* *61*	*Grandmother*	*53*
☑Y ☑N	BREAST CANCER (Female or male)							
☑Y ☑N	OVARIAN CANCER							
☑Y ☑N	PANCREATIC CANCER							
☑Y ☑N	ENDOMETRIAL CANCER							
☑Y ☑N	COLON/RECTAL CANCER							
☑Y ☑N	10 or MORE COLON POLYPS							
☑Y ☑N	OTHER CANCER(S) (SPECIFY):							

☐Y ☐N Are you of Ashkenazi Jewish descent?

☐Y ☐N Have you or anyone in your family had genetic testing for a hereditary cancer syndrome?
If yes, please explain and include a copy of the result:

Testing Criteria (For medical office use only)

Hereditary Breast and Ovarian Cancer Syndrome

- ☐ Breast cancer diagnosed at or under age 50*
- ☐ A personal history of breast cancer at any age
- ☐ Ovarian cancer at any age*
- ☐ Pancreatic cancer at any age*
- ☐ Personal history of prostate (Gleason score 7 or higher) and at least one close relative with breast, ovarian, pancreatic, or prostate
- ☐ Two primary breast cancers in the same person with one diagnosed at or under age 50*
- ☐ Two relatives on the same side of the family with breast cancer, one diagnosed at or under age 50
- ☐ Three relatives on the same side of the family with breast and/or ovarian cancer at any age
- ☐ Triple negative breast cancer at or under the age of 60 (receptor status negative for ER, PR and HER2)
- ☐ Male breast cancer
- ☐ Three or more relatives on the same side of the family with any of the following cancers: breast, ovarian, pancreatic, prostate at any age
- ☐ Ashkenazi Jewish ancestry with an HBOC-associated cancer**

Lynch Syndrome

- ☑ A personal history of colon/rectal cancer diagnosed at or under age 64
- ☐ A personal history of endometrial cancer diagnosed at or under age 64
- ☐ A personal history of two or more Lynch syndrome cancers***
- ☐ Two or more relatives with a Lynch syndrome cancer***, one before the age of 50
- ☐ Three or more relatives with a Lynch syndrome cancer*** at any age
- ☐ Ten or more cumulative colorectal adenomatous polyp(s)

☐ A previously identified cancer gene mutation in the family

*** In self, first or second degree family members**
****HBOC associated cancer includes: *Breast, ovarian, pancreatic and melanoma***
*****Lynch-associated cancers include: *colon, endometrial, gastric, ovarian, ureter/renal pelvis, biliary tract, small bowel, pancreas, brain and sebaceous adenomas.***

Cancer Risk Assessment Review

Patient's Signature: _____ Date: _____

Health Care Provider's Signature: _____ Date: _____

For Office Use Only:

Follow-up appointment scheduled: ☐ YES ☐ NO Date of Appointment: _____

Patient offered hereditary cancer genetic testing? ☐ YES ☐ NO ☐ ACCEPTED ☐ DECLINED

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 Clinic	
Name of Physician, Group or Clinic	Name of Patient (Print)
By: 	
Signature of Physician or Authorized Agent	Signature of Patient or Patient's Representative (Date)

(06/2011)