PATIENT HISTORY FORM

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT

Your Name: _____ Date of Birth:_____ Today's Date:_____

Primary Care Physician:_____

What type of complaint or disease is the reason for requesting this visit?_____

_____

MEDICATIONS:

List all medications your are currently taking which have been ordered by a doctor (including inhalers)

Prescription Medications	Strength	Frequency	**Reason for taking this medication**

NON-PRESCRIPTION / HERBAL PREPARATIONS: (over-the-counter medications) such as aspirin, ibuprofen, vitamins, laxatives, etc.

Over-the-counter medications	Strength	Frequency	**Reason for taking this medication**

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of drug reaction

_____

_____

O Food O Animals O Latex O Tape O Pollen O Iodine O Other:_____

MEDICAL HISTORY: Please check illnesses which apply to you currently or in the past

O Anemia
O Asthma
O Arthritis
O Bleeding/Blood Disorder
O Breast Cancer
O Cancer(s) _____
O Cataracts
O Colitis
O Depression
O Diabetes Type_____
O Emotional/Mental Illness
O Emphysema
O Epilepsy/seizure
O Glaucoma
O Hay Fever
O Heart Problems _____
O Hepatitis/Jaundice
O High blood pressure
O HIV/AIDS
O Others: _____
O Kidney Disease
O Kidney Stones
O Liver Disease
O Osteoporosis
O Rheumatic Fever
O Stroke
O Thyroid Disease
O Tuberculosis/TB
O Ulcers

Name:_____

SURGERIES

Surgeries:	Date/Reason
Tonsils removed	
Appendix removed	
Gall Bladder removed	
Wisdom Teeth removed	
Hysterectomy	

Other Surgeries:	Date/Reason

Please list any **hospitalizations** you had in the past:_____

_____

Trauma/Broken Bones/Serious Accident:_____

Are you adopted: O yes O no

FAMILY HISTORY: Place an 'X' in appropriate boxes to identify all illnesses/conditions in your blood relatives

Illness/Condition	Family Member							
	Mother's Mom / Dad	Father's Mom / Dad	Father	Mother	Brother	Sister	Son(s)	Daughter(s)
Other cancer - What type?								
Colon or rectal cancer								
Chronic Ulcerative Colitis								
Crohn's Disease								
Depression/psychiatric illness								
Diabetes								
Genetic disorder (inherited)								
Heart Disease								
High blood pressure								
Polyps								
Other								

TELL US ABOUT YOURSELF:

Please list number of children and year of birth:
Number of Son(s):_____ Year(s) of Birth:_____
Number of Daughter(s):_____ Year(s) of Birth:_____

Do you use tobacco? O Never O Current O Past If yes, how many packs per day?_____
Year that you quit?_____ Number of years that you used tobacco?_____ How many packs per day?_____
Indicate type: O Smokeless O E-Cigarette O Cigarette O Cigar O Pipe

Do you use alcohol? O No O Yes If yes, how often do you drink?_____
If you have quit, how long ago?_____

Have you ever used recreational drugs?_____

Are you at risk for AIDS/HIV? O Yes O Unknown O No

(homosexual, bisexual, multiple sex partners, needle drug use other than insulin)

Home situation: O Single O Married O Divorced O Widowed O Domestic partnership (Male/Female)

Name:_____

Employment:

Status: O full-time O part-time O retired O disabled O homemaker

Occupation/type of work/jobs:_____

Anything Else?

O Are you experiencing an unusually stressful situation?

O Are there any specific personal issues you would like to bring up at the time of your visit?

SYSTEM REVIEW: Please check any problems or symptoms you are experiencing now or have had in the past.

General

- O depression
- O poor sleep
- O chills
- O fever
- O weight gain of 10+ lbs during last 6 months
- O weight loss of 10+ lbs during last 6 months
- O headache

Eyes, ears, nose, throat

- O history of glaucoma
- O history of cataracts
- O other change in vision
- O blurred vision
- O loss of hearing
- O sinus problems
- O hoarseness
- O ringing in ears

Endocrine

- O history of thyroid disease
- O history of diabetes
- O cold intolerance
- O excessive thirst
- O hot intolerance

Gastrointestinal

- O when was your last colonoscopy?_____
- O indigestion
- O history of liver disease
- O abnormal liver tests
- O abdominal pain
- O blood in stools
- O change in bowel habits
- O constipation
- O poor appetite
- O diarrhea
- O difficulty swallowing
- O nausea
- O rectal bleeding
- O vomiting

Pulmonary/lungs

- O shortness of breath
- O persistent cough
- O asthma
- O coughing up blood
- O wheezing
- O stop breathing during sleep

Cardiovascular

- O chest pain/tightness
- O history of high blood pressure
- O history of angina
- O heart attack
- O history of poor circulation
- O leg edema/swelling
- O congestive heart failure
- O pacemaker
- O history of irregular heart beat

Women only

- O abnormal pap smear
  date of last mammogram_____
- O bleeding between periods
- O # times pregnant_____ deliveries_____
- O # miscarriages/abortion_____
- O are you pregnant?
- O are you breastfeeding?

Men only

- O PSA have you had test done O Yes O No

Genitourinary

- O blood in urine
- O frequent urination
- O painful urination
- O urinary incontinence

Muscle/joint/bone

- O numbness
- O peripheral neuropathy
- O weakness

Skin

- O easy bruising
- O change in moles
- O itching

Neurologic

- O history of stroke
- O blackouts
- O loss of consciousness
- O forgetfulness/confusion

Patient Name	Date of Birth Age	Social Security #
Address	City	State, Zip
Home Phone	Cell Phone	Work Phone
Employer	Employer Address	City, State, Zip
Spouse/Significant Other/Parent	Date of Birth	Social Security #
Employer	Employer Address	Employer's Phone
Relative/Friend	Relationship	Phone
Emergency Contact	Relationship	Phone
Primary Care Physician	Phone	Address
Referring Physician	Phone	Address

Do you have an email address that we can use to contact you?_____

Would you like access to our web portal? O Yes O No

May we text message you on your cell phone? O Yes O No Voice mail cell / home? O Yes O No

Race: O American Indian O Asian O Native Hawaiian or Other Pacific Islander O Black or African American
O White O Hispanic O other race_____ O unreported or refused to answer

Ethnicity: O Hispanic or Latino O Not Hispanic or Latino O unreported or refused to answer

What is your primary language: O English O Spanish O Russian O Other_____

What is your Pharmacy:_____ Address:_____

Insurance Information: Please present your insurance card(s) to be copied. Thank you!

Primary Insurance	Phone Number	Group Number	Policy/Member Number
Insured's Name	Date of Birth	Relationship to you	
Secondary Insurance	Phone Number	Group Number	Policy/Member Number
Insured's Name	Date of Birth	Relationship to you	

Treatment and Consent

Consent to Treat and Disclose Protected Health Information: I authorize the physician(s) in charge of the care of the above named patient to administer anesthetics and/or medications and to perform such operations and/or diagnostic procedures as may be deemed necessary by the physician for the diagnosis and treatment of this patient.

The practices written Privacy Notice provides detailed information on how we may use and disclose protected health information. By signing this consent form, you acknowledge that you have received a copy of the Written Privacy Notice and are in agreement with our use and disclosure of protected health information for treatment, payment, and healthcare operations. I have read and understand the above statements. Affixing my signature to this form represents my receipt of the Written Privacy Notice, my consent to treatment, and the above use of protected health information.

_____ _____

Signature of patient or responsible party Date

FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your healthcare provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement, which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing a provider.

1. Each patient is responsible for his or her own bill.
2. Payment of all insurance co-payments and deductibles is required at the time medical services are rendered. Patients who have no insurance are required to pay 100% of services rendered at each visit. If this is impossible you will need to make payment arrangements with our billing office prior to any medical evaluation for treatment. We accept cash, checks and major credit cards.
3. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
4. You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. Any service provided, but not covered by your insurance company, will be your responsibility to pay.
5. If your insurance company has not paid your full account within 60 days, you must pay the outstanding balance without further delay.
6. Monthly payments are required on all accounts with outstanding balances. A monthly finance charge of 1¾% per month (21% annual rate) will be charged to the amount not paid after 60 days, with a minimum charge of $0.50 per month. By signing below, you agree to pay collection costs up to 40% with or without suit and/or reasonable attorney's fees on any delinquent balance, if referred to an agency or attorney for collection or suit.
7. A $35.00 fee will be charged on all returned checks.
8. Patients who fail to appear for their scheduled appointments may be charged a fee of $50.00 unless the patient cancels the appointment at least 24 hours before the scheduled appointment time.

USUAL AND CUSTOMARY RATES

Our rates for medical services reflect the usual and customary rates in the community. Unless we have accepted an alternate fee schedule from your insurance, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates for medical services.

AUTHORIZATION TO PAY BENEFITS

I further authorize and direct set agency, attorney or insurance company to pay from the proceeds of benefits of any recovery of insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

_____ _____

Signature of Patient or Responsible Party Date

_____

Printed Name

ASSOCIATES IN COLON AND RECTAL SURGERY

DR MICHELLE E MURDAY
DR JILL E WALDRON
DR ABBY CRUME

PATIENT DISCLOSURE INSTRUCTIONS

I wish to be contacted with results in the following manner (check all that apply)

- ☐ Home/Cell Phone_____
  - o OK to leave messages with detailed information
  - o Leave message with call-back number only
- ☐ Work Phone_____
  - o OK to leave messages with detailed information
  - o Leave message with call-back number only
- ☐ Written Communication
  - o OK to mail to my home address
  - o OK to mail to my work/office address
  - o OK to fax to number indicated:_____

I allow you to give my clinical information to or answer questions from (check all that apply and provide name and phone number)

- ☐ Spouse/Partner: _____
- ☐ Parent: _____
- ☐ Child: _____
- ☐ Other: _____
- ☐ None

Patient Printed Name: _____

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. 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

_____	_____
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)

(05/03/04)