Patient Name:_____

Past Medical History — Have you ever had any of the following:

Heart Attack	O Yes O No	Heart Surgery	O Yes O No	Hypertension	O Yes O No
High Cholesterol	O Yes O No	Angina	O Yes O No	Heart Murmur	O Yes O No
Stroke	O Yes O No	Blood Clots	O Yes O No	COPD	O Yes O No
Asthma	O Yes O No	Emphysema	O Yes O No	Pneumonia	O Yes O No
GERD/Reflux	O Yes O No	Ulcers	O Yes O No	Diverticulosis	O Yes O No
Diabetes	O Yes O No	Thyroid Disease	O Yes O No	Kidney Disease	O Yes O No
Kidney Stones	O Yes O No	Frequent UTI	O Yes O No	Liver Disease	O Yes O No
Hepatitis B	O Yes O No	Hepatitis C	O Yes O No	Cancer	O Yes O No
Seizures	O Yes O No	Migraines	O Yes O No	Anemia	O Yes O No
Depression	O Yes O No	Anxiety	O Yes O No	Eczema	O Yes O No
Arthritis	O Yes O No	Gallbladder Surgery	O Yes O No	Tonsillectomy	O Yes O No
Hysterectomy	O Yes O No	Appendectomy	O Yes O No	Hernia Repair	O Yes O No
Sleep Apnea	O Yes O No	Obesity	O Yes O No		

Family History — Has anyone in your family ever had health problems?

Sister	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased
Brother	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased
Father	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased
Mother	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased
Paternal Grand Father	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased
Paternal Grand Mother	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased
Maternal Grand Father	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased
Maternal Grand Mother	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased
Paternal Uncle	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased
Paternal Aunt	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased
Maternal Uncle	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased
Maternal Aunt	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased
Children	O Diabetes	O Hypertension	O Heart Disease	O Stroke	O Cancer	O Deceased

Social History

Smoking O Nonsmoker O Current # packs _____# years _____O Former When did you quit? _____
Alcohol O Yes O No type _____ frequency _____ When did you quit? _____
Drug use O Yes O No type _____
Caffeine O Yes O No # cups/day _____
Marital Status O Single O Married O Partner O Divorced O Widowed
Children O Yes O No O NA How many? _____
Employed O Yes O No
Exercise O Yes O No

Email: _____

Providing your email will give you access to the Patient Portal, which enables our patients to communicate with our doctors, nurses, and staff members easily, safely, and securely *via* the Internet. Through the Portal, you are able to ask questions from your provider, request prescription refills and referrals, set up appointments, and view your personal health record… all from the comfort of your home, whenever it is convenient for you!

Patient Name:_____

(Symptoms within past 6 months)

CONSTITUTIONAL

Weight Gain	O Yes O No	Weight Loss	O Yes O No
Fatigue	O Yes O No	Chills	O Yes O No
Night Sweats	O Yes O No	Fever	O Yes O No

ENT

Nose Bleed	O Yes O No	Ear Pain	O Yes O No
Swollen Lymph Nodes	O Yes O No	Sinus Pain	O Yes O No
Sore Throat	O Yes O No	Hearing Loss	O Yes O No

CARDIOLOGY

Chest Pain	O Yes O No	Leg Edema	O Yes O No
Shortness of Breath	O Yes O No	Irregular Heart Beat	O Yes O No

RESPIRATORY

Persistent Cough	O Yes O No	Chest Congestion	O Yes O No
Diff breathing w/laying down	O Yes O No	Wheezing	O Yes O No
Cough up blood	O Yes O No		

ALLERGY

Nasal Congestion	O Yes O No	Ear Symptoms	O Yes O No
Sneezing	O Yes O No	Post-nasal Drip	O Yes O No

GASTROENTEROLOGY

Nausea	O Yes O No	Vomiting	O Yes O No
Diarrhea	O Yes O No	Blood in Stool	O Yes O No
Heartburn	O Yes O No	Abdominal Pain	O Yes O No

MUSCULOSKELETAL

Joint Stiffness	O Yes O No	Joint Swelling	O Yes O No
Back Pain	O Yes O No	Muscle Aches	O Yes O No

UROLOGY

Blood in Urine	O Yes O No	Urinary Frequency	O Yes O No
Urinary Incontinence	O Yes O No	Urinary Urgency	O Yes O No
Excessive Nighttime Urination	O Yes O No		

NEUROLOGY

Tingling/Numbness	O Yes O No	Sleep Problems	O Yes O No
Imbalance	O Yes O No		

ENDOCRINOLOGY

Excessive Urine	O Yes O No	Excessive Thirst	O Yes O No
Hair Changes	O Yes O No	Bowel Changes	O Yes O No

DERMATOLOGY

Rash	O Yes O No	Eczema	O Yes O No

PSYCHOLOGY

Depression	O Yes O No	Anxiety	O Yes O No
Sleep Disturbances	O Yes O No	Hallucinations	O Yes O No

DIXIE PRIMARY CARE

INFORMATION SHEET AND CONSENT FORM

Date: _____

Patient Name: _____ (Last / First / Middle) **Date of Birth:** _____
Gender: M F

Mailing Address: _____ (PO Box Street / City / State / Zip) **Primary Phone:** _____
Alternate Phone: _____

Email: _____

Street Address: _____ (If different than above) (Street / City / State / Zip) **Marital Status:** M S D W (Circle your selection)

Preferred Language: English -- Spanish -- Philipino -- Other _____ (Circle your selection) **SS#:** _____

Employer: _____ (Name / City / State)

Address: _____ (Street / City / State / Zip) **Work Phone:** _____

Employment Status *(Circle one)*: Full time -- Part time **Student Status** *(Circle one)*: Full time -- Part time

Race *(Circle one)*: White -- Hispanic -- Asian -- Native Hawaiian/Other Pacific Islander -- Black/African American -- American Indian/Alaskan Native -- Other Race _____

Ethnicity *(Circle one)*: Are you of Hispanic descent? Yes -- No -- Prefer Not to Say

Emergency Contact: _____ (Name / Phone / Relationship)

Pharmacy: _____ (Name / City / State)

RESPONSIBLE OR INSURED PARTY IF DIFFERENT THAN ABOVE

Insured Party Name: _____ (Last / First / Middle) **Date of Birth:** _____

Mailing Address: _____ (PO Box Street / City / State / Zip) **Primary Phone:** _____
Alternate Phone: _____

SS#: _____/_____/_____ **Employer Name:** _____ **Work Phone:** _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS
(Important – Please read carefully before signing)

I understand that payment of all medical care is due at time of service. I understand that it is my responsibility to pay any deductible, co-insurance, or any other balance NOT PAID by my insurance company. I understand that I am responsible for any costs incurred in the collection of patient accounts in case of default, including reasonable attorney fees and court costs.

I hereby grant permission to Grace Paradela, MD PC and Dixie Primary Care to release any pertinent information to my insurance company upon request, and I also assign and authorize payment directly to Grace Paradela, MD PC and Dixie Primary Care. I permit a copy of this authorization to be used in place of the original.

Signature: _____ **Date:** _____ **Relationship:** _____

DIXIE PRIMARY CARE

FINANCIAL RESPONSIBILITY POLICY

Co-payments, Fees, and Accepted Forms of Payment

Our policy is to collect payment at the time of service, as we do not employ a billing company. Please arrive for your appointment with adequate funds for any co-payment, co-insurance, or deductible that your insurance requires. If payment for the above is not received in full at the time of service, a $25 billing fee may be assessed in addition to any amount owed. Insurance companies do not cover this fee.

- The undersigned specifically agrees to pay all reasonable attorney fees and court cost in the event legal action is taken to collect on the account. The undersigned further agrees to pay an additional amount representing up to 50% of the principal balance if the account is referred to a collection agency or attorney for collections. This additional amount is in recognition of the cost associated with said collection action processing.
- Returned checks will assume a $30 fee in addition to the above billing fees.
- We accept cash, personal checks, and credit/debit cards as forms of payment.
- Any patient who fails to show up to an appointment, and has not notified our office, will be considered a No Show, and ***charged a $20 fee.*** The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**

Insurance Billing

As a courtesy to you, your insurance will be billed for the cost of services. If for any reason your insurance company denies payment for services rendered, you will become responsible for the charges. The most common reasons for insurance payment denials are:

1. Incorrect or outdated insurance information. We will ask you to verify that our system has your most recent insurance data prior to any services. (We are happy to receive calls to update addresses and new insurance information.)
2. I am not listed as a network provider with your insurance.
3. Receiving care for services not covered by your specific insurance plan. A common example is annual preventive exams. (Most health plans will pay for one such exam in any 12 month period.) ***It is your responsibility to learn your plan's policy prior to your appointment.***
4. Your insurance company deems the visit or procedure not medically necessary.
5. You have a pre-existing condition.
6. Your visit is related to an auto accident or employment.

The above list includes only a few examples of the many ways physicians are denied payment.

By signing this agreement, you understand that health care services are being provided to you and ultimately, you are responsible for payment of these services. Thank you for the opportunity to participate in your healthcare.

I, _____, the guarantor of this account have read, understand, and agree with the above financial policy agreement between Dixie Primary Care and myself.

Signature: _____ **Date:** _____

DIXIE PRIMARY CARE

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, spouse, children, parents or legal representative, 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 you 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 limitation 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 s ingle 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 selects an individual from the list 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 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 expense of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.

D. Final and Binding Decisions. 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. The party electing the second panel will pay all costs associated with that second panel. 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 pre-litigation 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 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 rights 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 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.

Provider:

DIXIE PRIMARY CARE
Name of Physician, Group, or Clinic

Signature of Physician or Authorized Agent

Patient:

Name of Patient (Print)

Signature of Patient or Patient's Representative

DIXIE PRIMARY CARE

REQUEST FOR RELEASE OF MEDICAL RECORDS

HIPAA COMPLIANT AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT INFORMATION

NAME:	BIRTH DATE:

I hereby authorize:

Physician's Name/Clinic

Phone

Fax

To Release To:

DIXIE PRIMARY CARE
292 S 1470 E, Ste 200
St. George, UT 84790
Phone – (435) 688-0759
Fax – (435) 656-0491

I request and authorize the above named health care provider to release the information specified below to the organized agency, or individual names on this request. I understand that this authorization is voluntary and is not a condition of treatment.

INFORMATION TO BE RELEASED:

- ☐ Complete Health Record (Last 3-5 years)
- ☐ Further Medical Treatment
- ☐ Diagnostic Testing (Lab/Radiology)
- ☐ Progress Notes
- ☐ Treatment Reports
- ☐ Medication List
- ☐ Other _____

PURPOSE FOR DISCLOSURE:

- ☐ Continuity of Care
- ☐ Moving/Relocation
- ☐ Attorney/Court Case
- ☐ Change Physicians
- ☐ Personal Request of Individual
- ☐ Other _____

EXTENT OF AUTHORIZATION:

☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

☐ I authorize the release of my complete health record with the exception of the following information:

- Mental Health Records
- Communicable Diseases (including HIV and AIDS)
- Alcohol/Drug Abuse treatment

This authorization is subject to revocation in writing at any time except to the extent that action has been taken and expires as soon as the purpose for which it is given can reasonably be effectuated and in no event later than one year from the date signed. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure, in which case it may no longer be protected by federal privacy regulations.

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MY MEDICAL RECORDS.

Patient Signature _____ Date _____