CALLAHAN CLINIC, P.C.

PERSONAL INFORMATION

Full name: _____
Last First M I

Address: _____
Street Address City State Zip Code

Home Phone: _____ Cell phone: _____

Preferred Contact : _____ Can we leave voice mail messages: YES ☐ NO☐

Social Security Number: _____ Preferred Language: _____

Birthdate: _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

E-mail address: _____ Race: _____ Ethnicity: _____

Spouse's Name: _____ Spouse's Phone Number: _____

OTHER INFORMATION

Currently Employed? ☐ Yes ☐ Unemployed ☐ Retired ☐ Student ☐ Disabaled ☐ Homemaker

Number of Children: _____ Preferred Pharmacy: _____

How did you hear out about our clinic? _____

INSURANCE INFORMATION

Ins. Name: _____ Member ID: _____ Group # : _____

Insurance Address: _____ Copay: _____
Claims Address

_____
City State Zip Code

Secondary Insurance: _____ Member ID: _____

EMERGENCY CONTACT INFORMATION (Not living in Household)

Full Name: _____
Last First M I.

Relationship: _____ Home Phone: _____ Cell Phone: _____

GUARANTOR INFORMATION

Full Name: _____
Last First M.I.

Address: _____
Street Address City State Zip

Home Phone: _____ Cell Phone: _____ Date of Birth: _____

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 emploees, 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 you heirs, your spouse, children, parens or legal representatives, AND
(2) your unborn child or newborn child youfor 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 you **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 you 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 statue of limitations during the dispute resolution process described in the 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 and arbitrator of the 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 and individual from the lists described above. Each party will pay their own fees and costs in such and 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 Youwill 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 eith the Utah Uniform Arbitration Act.

E. All Claims May be Joined. Any person or entity that could be approriately 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 issuers 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 parites 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, 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 intities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remian if 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

Our Financial Policy

We are dedicated to providing the best possible care for you and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance by your carrier. We accept *Visa and Mastercard.*

2. **Keep in mind that your insurance policy is basically a contract between** you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangement with many insurance companies and other health plans to accept and assignment of benefits. We will bill them, and you are required to pay a copayment at the time of visit.

4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office.

6. We will bill your insurance company for all services provided in the hospital. You are responsible for any balance due.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree the such terms may be amended by the practice from time to time.

_____ _____

Signature of patient (or reponsible party, if minor) Please print name of patient

Date_____

CALLAHAN CLINIC, P.C.

CONSENT AND CONDITIONS OF SERVICE

Patient Name _____ Date of Birth _____

As either the Patient or the legally authorized representative of the Patient, the following consents, understandings, and agreements are make on my own behalf of the Patient in partial consideration of the health care services to be provided to the Patient in the Facility:

Consent for Treatment: On behalf of the Patient, consent is hereby given to the Facility, its contractors, medical staff, and employees to provide health care services to patient and to administer physician orders for the benefit of the Patient for this visit and any subsequent visits, and it is understood that this consent may be revoked in writing at any time. It is understood that ther is a risk of substantial and serious harm involved in such health care services, and such risk is accepted in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made, it being undersoon and accepted that there is some uncertainty involved in the outcome of health care services for which this consent is given. It is understood that physicians are separately responsible to explain what they do and, in some cases, to obtain serparate consent for some of the services they perform.

Release of Information: The law requires health care providers to make and keep records of your medical treatment, and C.C. Safeguards those records. Access to medical records is limited to persons who are providing, coordinating, evaluating, or improving health care, subject to applicable law. By receiving services at C.C. You agree to the release of medical record information for the uses spefied above. You also agree to release claims related information to insurance companies or other third parties to assist in paying you health care costs. Permission is given for the Facility, its contrators, medical staff, and employees to release medical and other information about the Patient to insurance companies, to other third party payors who are or may be responsible to pay for all or any part of the health care services rendered to Patient, and to the agents or representatives of such companies or payors. Such information may be released with further authorization for the purpose of making, completing, and verifying claims and the receipt of services, and in connection with prospective, concurrent, or retrospective review related to such health care services and the payment of such services.

Assignment of Benefits: Any and all benefits from insurance companies and other third party payors that are payable to Patient or on behalf of Patient for health care services and related payments for services rendered or provided to Patient are hereby transferred and assigned to Facility for the exclusive purpose of paying for charges associated with health care services provided to Patient in the Facility. It is understood and intended that all insurance companies and other third party payors will pay benefits directly to Facility in payment of Facility's charges and the charges or any other health care providers for whom Facility is authorized to bill in connection with health care services provided to Patient.

Financial Responsibility: Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all the health care services rendered to Patient in the Facility including but not limited to any amounts not paid by any insurance company or other third party payor. Patient and the undersigned, if other than the Patient, remains responsible for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payor. It is understood and agreed that charges not paid in a timely fashion may be placed with a collection agency or attorney for purposes of collection. It is further understood and agreed by the Patient and the undersigned that any amounts not paid within 30 days of the date of the Facility's bill or statement for payment may be charged a delayed payment fee at the rate of 1 1/2% per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed with a collection agency or attorney for collection, Patien and the undersigned, if other than the Patient, each jointly and severally agree to pay costs and reasonable attorney's fees in connection with the collection process. A service charge may be collected in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid to the Facility.

Medicare/Medicaid Patient's Certification: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act if correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers for the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the Facility for its charges and for any charges for physicians or other providers for whom the Facility is authorized to bill in connection with its service.

CHAMPUS/CHAMPVA Authorization: I request payment of authorized benefits to the Facility on my behalf for any services furnished me by the Facility, including physician's services. I authorize any holder of medical or other information about me to release to CHAMPUS/CHAMPVA and its agents any information needed to determine these benefits or benefits for any relatede services.

The undersigned signs this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have reviewed the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding to what I am agreeing to by signing below. I understand that I am entitled to request and obtain a copy of this document. My consent for treatment will remain in effect unless revoked in writing.

Signature : _____ Relationship to patient : _____

Witness To Signature : _____ Date : _____

CALLAHAN CLINIC, P.C.

Original Date:

Dates Revised:

HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.)*: ☐ M ☐ F | **DOB:**

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Previous or referring doctor: | **Date of last physical exam:**

PERSONAL HEALTH HISTORY

Childhood illness: ☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio

Immunizations and dates:		
	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR *Measles, Mumps, Rubella*

List any medical problems that other doctors have diagnosed

Surgeries

Year	Reason	Hospital

Other hospitalizations

Year	Reason	Hospital

Have you ever had a blood transfusion? ☐ Yes ☐ No

Please turn to next page

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name the Drug	Strength	Frequency Taken

Allergies to medications

Name the Drug	Reaction You Had

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ Hi	☐ Med	☐ Low		
	Rank fat intake	☐ Hi	☐ Med	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola		
	# of cups/cans per day?					
Alcohol	Do you drink alcohol?				☐ Yes	☐ No
	If yes, what kind?					
	How many drinks per week?					
	Are you concerned about the amount you drink?				☐ Yes	☐ No
	Have you considered stopping?				☐ Yes	☐ No
	Have you ever experienced blackouts?				☐ Yes	☐ No
	Are you prone to "binge" drinking?				☐ Yes	☐ No
	Do you drive after drinking?				☐ Yes	☐ No
Tobacco	Do you use tobacco?				☐ Yes	☐ No
	☐ Cigarettes – pks./day	☐ Chew - #/day	☐ Pipe - #/day	☐ Cigars - #/day		
	☐ # of years	☐ Or year quit				
Drugs	Do you currently use recreational or street drugs?				☐ Yes	☐ No
	Have you ever given yourself street drugs with a needle?				☐ Yes	☐ No
Sex	Are you sexually active?				☐ Yes	☐ No
	If yes, are you trying for a pregnancy?				☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:					
	Any discomfort with intercourse?				☐ Yes	☐ No

		Illness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness?	☐ Yes	☐ No
Personal	**Safety**	Do you live alone?	☐ Yes	☐ No
		Do you have frequent falls?	☐ Yes	☐ No
		Do you have vision or hearing loss?	☐ Yes	☐ No
		Do you have an Advance Directive or Living Will?	☐ Yes	☐ No
		Would you like information on the preparation of these?	☐ Yes	☐ No
		Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F		**Grandfather** *Paternal*		

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Have you ever attempted suicide?	☐ Yes	☐ No
Have you ever seriously thought about hurting yourself?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever been to a counselor?	☐ Yes	☐ No

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		

MEN ONLY

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Date of last prostate and rectal exam?	☐ Yes	☐ No

OTHER PROBLEMS

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

Preventative Health	Have you ever had a Colonoscopy?	☐ Yes	☐ No	If yes, when?
	Have you ever received the pneumonia vaccine?	☐ Yes	☐ No	If yes, when?
	Have you received the flu vaccination this year?	☐ Yes	☐ No	If yes, when?
	Date of last Eye Exam:		Date of last Foot Exam:	

CALLAHAN CLINIC
1240 E 100 S SUITE 15-A
ST GEORGE, UT 84790
435-656-5323
435-656-5127 FAX

Due to HIPPA (privacy) laws, we can not discuss any information about you to ANYONE (except other medical professionals) without your permission. Please list the names below and the relationship, that you would allow information given to.

_____

_____

_____

_____
Patient signature

_____
Witness signature

_____
Patient Name
PLEASE PRINT

_____
Date

_____
Date

CALLAHAN CLINIC, P.C.

Thomas Dee Callahan, M.D., F.A.A.F.P.
Douglas Dee Callahan, D.O., P.C.
Amanda Turner, FNP-BC

Children • Adults • OB • Minor Surgery

1240 East 100 South Suite 15-A • St. George, Utah 84790 • (435) 656-5323

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

***** THERE MAY BE A FEE FOR MEDICAL RECORDS*****

This authorization complies with all state and federal regulations and MUST BE COMPLETED IN ITS ENTIRETY to be valid. To ensure added security we DO NOT FAX medical records.

PATIENT NAME _____ DATE OF BIRTH (MONTH/ DAY/ YEAR) ___/___/___

ADDRESS _____ PHONE NUMBER _____

CITY _____ STATE, _____ ZIP CODE _____

RELEASE MEDICAL RECORDS FROM:

NAME OF CLINIC/ DOCTOR _____

ADDRESS _____

CITY _____ STATE/ ZIP CODE _____

PHONE _____ FAX# _____

RELEASE MEDICAL RECORDS TO:

NAME OF COMPANY/ AGENCY/ FACILITY/ PERSON _____

ADDRESS _____

CITY _____ STATE,/ZIP CODE _____

PHONE _____ FAX# _____

INFORMATION TO BE RELEASED: HIPAA laws prohibit disclosure of other facility records including: hospital records, other clinic records, and medical records sent to us by other physicians on your behalf.

☐ LABS ☐ X-RAY ☐ PROGRESS NOTES ☐ ALL ☐ OTHER: _____ (SPECIFY)

DATE(S) OF TREATMENT(S) TO DISCLOSE _____ PURPOSE OF DISCLOSURE (e.g. Continuing Care, School, Legal, Insurance, other) _____

☐ I consent to the release of information which may relate to: Alcohol/Drug Abuse, or contain: psychiatric information, HIV or Sexually Transmitted Disease testing results or AIDS information. INITIALS: _____

This authorization is valid for 1 year from the date of signing, and may be revoked at any time by sending a written request to the facility releasing your personal health information. Revocation of this authorization shall not affect Releases made prior to the revocation.
I understand that signing this release is voluntary, and that I need not sign this document in order to assume medical treatment by my provider. I further understand that the disclosure of this carries with it the potential for unauthorized re-disclosure and the information may no longer be protected by federal confidentially rules.

PATIENT SIGNATURE (If over 18) _____ DATE: ___/___/___ (MONTH/ DAY/ YEAR)

If patient is under 18, or unable to sign for themselves, please have parent, legal guardian or representative fill out the below section:

SIGNATURE _____ PRINTED NAME _____ RELATIONSHIP TO PATIENT _____

PLEASE NOTE: A fee will be charged to the patient when they request their records be sent to a third party requestor. (e.g.: attorneys or insurance) However, no fee will be charged if sent to another continuing care provider. (e.g.: other physician, hospital or clinic)

*****PROOF OF ID REQUIRED TO RELEASE MEDICAL RECORDS***** ☐ ID COPIED AND ATTACHED TO THIS RELEASE FORM