

**MOAB FAMILY MEDICINE**

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**PATIENT INFORMATION**

Date \_\_\_\_\_

Social Security Number \_\_\_\_\_

Legal Name \_\_\_\_\_  
Last Name

\_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone (\_\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_\_) \_\_\_\_\_

Email \_\_\_\_\_

Gender  Male  Female Age \_\_\_\_\_

Birthdate \_\_\_\_\_

Married  Single  Widowed  
 Separated  Divorced  Minor

Employer/School \_\_\_\_\_

Employer/School Address \_\_\_\_\_

Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_

Spouse's Name \_\_\_\_\_

SSN \_\_\_\_\_

Birthdate \_\_\_\_\_

Spouse's Employer \_\_\_\_\_

Spouse's Occupation \_\_\_\_\_

Whom may we thank for referring you to our office?  
 \_\_\_\_\_

**INSURANCE INFORMATION**

*\*\*Please note: We will re-verify benefits and file your insurance as a courtesy to you. It is your responsibility to know your coverage, eligibility and, if you need a referral, and to obtain this prior to your visit.*

Policy Holder's Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Insurance Company \_\_\_\_\_

Medical Claims Address \_\_\_\_\_

Policy (subscriber) # \_\_\_\_\_

Group Name \_\_\_\_\_ Group # \_\_\_\_\_

Customer Service Phone # (\_\_\_\_\_) \_\_\_\_\_

Is Patient covered by additional insurance?  Yes  No

Insurance Company \_\_\_\_\_

Policy (subscriber) # \_\_\_\_\_

PLEASE PROVIDE ALL INSURANCE CARDS AT TIME OF VISIT

**Medicare Status Questionnaire**

**Employment:**

1. Are you currently employed and covered by a group health plan  Yes  No

2. Are you covered by any active group health plan through your spouse or family member?  Yes  No

**Accidents:**

3. Is your visit today associated with a work injury or illness, either past or present?  Yes  No

4. Is your visit today associated with a motor vehicle accident?  Yes  No

5. Is your visit today associated with accident, other than vehicle?  Yes  No

**Entitlements:**

6. Are you entitled to Black Lung or Energy Employee benefits?  Yes  No

7. Are you entitled to Medicare solely because of SSA Disability?  Yes  No

8. Are you entitled to Medicare solely because of End Stage Renal Disease?  Yes  No

9. Are you enrolled in the VA Fee Basis Program?  Yes  No

**PHONE NUMBERS**

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Best time and place to reach you \_\_\_\_\_

**IN CASE OF EMERGENCY, PLEASE CONTACT:**

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

**ACCIDENT INFORMATION**

Is condition due to an accident?  Yes  No

Date \_\_\_\_\_

Type of accident  Auto  Work  
 Home  Other: \_\_\_\_\_

To who have you made a report of your accident?

Auto Insurance  Employer  
 Worker's Comp.  Other: \_\_\_\_\_

Attorney's Name (if applicable) \_\_\_\_\_

**MEDICATIONS**

**ALLERGIES**

**VITAMINS/HERBS/MINERALS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Pharmacy Name \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_



# HEALTH HISTORY

Chief Complaint: \_\_\_\_\_  
 History of Present Illness: \_\_\_\_\_  
 Location: \_\_\_\_\_ (Where is the pain/problem?)      Quality: \_\_\_\_\_ (Example: normal versus abnormal color, activity, etc.)  
 Severity: \_\_\_\_\_ (How severe is the pain/problem on a scale of 1-5 with 5 being the most severe?)      Duration: \_\_\_\_\_ (How long have you had this pain/problem?, or, When did it start?)  
 Timing: \_\_\_\_\_ (Does the pain/problem occur at a specific time?)      Context: \_\_\_\_\_ (Where were you at the onset of this pain/problem?)  
 Associated signs/symptoms \_\_\_\_\_ (What other associated problems have you been having?)      Modifying factors: \_\_\_\_\_ (What makes the pain/problem worse or better? Or, have you had previous episodes?)

## PAST MEDICAL HISTORY

Have you ever had the following: (leave blank if uncertain)

Measles <input type="checkbox"/>	Rheumatic Fever <input type="checkbox"/>	Tuberculosis <input type="checkbox"/>	Back Trouble <input type="checkbox"/>	Ulcer <input type="checkbox"/>
Mumps <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Diabetes <input type="checkbox"/>	High Blood Pressure <input type="checkbox"/>	Kidney Disease <input type="checkbox"/>
Chickenpox <input type="checkbox"/>	Arthritis <input type="checkbox"/>	Cancer <input type="checkbox"/>	Low Blood Pressure <input type="checkbox"/>	Thyroid Disease <input type="checkbox"/>
Whooping Cough <input type="checkbox"/>	Venereal Disease <input type="checkbox"/>	Polio <input type="checkbox"/>	Hemorrhoids <input type="checkbox"/>	Bleeding Tendency <input type="checkbox"/>
Scarlet Fever <input type="checkbox"/>	Anemia <input type="checkbox"/>	Glaucoma <input type="checkbox"/>	Asthma <input type="checkbox"/>	Date of last chest x-ray _____
Diphtheria <input type="checkbox"/>	Bladder Infections <input type="checkbox"/>	Hernia <input type="checkbox"/>	Hives or Eczema <input type="checkbox"/>	Any other disease <input type="checkbox"/>
Smallpox <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Blood or Plasma Transfusions <input type="checkbox"/>	AIDS OR HIV+ <input type="checkbox"/>	(please list) _____
Pneumonia <input type="checkbox"/>	Migraine Headaches <input type="checkbox"/>	Stroke <input type="checkbox"/>	Infectious Mono <input type="checkbox"/>	_____
Bronchitis <input type="checkbox"/>	Mitral Valve Prolapse <input type="checkbox"/>		Hepatitis <input type="checkbox"/>	_____

Have you ever taken Fen-Phen/Redux?

## PATIENT SOCIAL HISTORY:

Marital Status:  Single  Married  Separated  Divorced  Widowed  
 Use of Alcohol:  Never  Social only  Regular \_\_\_\_\_ Day / Week / Month  
 Use of Tobacco:  Never  Smoke Previously, but quit \_\_\_\_\_ Days / Months / Years  Smoke: \_\_\_\_\_/day  Chew: \_\_\_\_\_/day  
 Use of Drugs:  Never  Use: \_\_\_\_\_  Stopped use: \_\_\_\_\_  
 Excessive exposure at home / work to:  Fumes  Dust  Solvents  Air-borne particles  Noise  
 Highest Level Education Completed:  Elementary  Middle  High School  College  Graduate  Doctorate  Specialty School  Other

## PREVIOUS HOSPITALIZATIONS/SURGERIES/SERIOUS ILLNESSES

## WHEN?

## HOSPITAL, CITY STATE

_____	_____	_____
_____	_____	_____
_____	_____	_____

## FAMILY MEDICAL HISTORY

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

## CONSTITUTIONAL SYMPTOMS

- Good general health lately
- Recent weight change
- Fever
- Fatigue
- Headaches

## EYES

- Eye disease or injury
- Wear glasses/contact lenses
- Blurred or double vision

## EARS / NOSE / MOUTH / THROAT

- Hearing loss or ringing
- Earaches or drainage
- Chronic sinus problem or rhinitis
- Nose bleeds
- Mouth sores
- Bleeding gums
- Bad breath or bad taste
- Sore throat or voice change
- Swollen glands in neck

## CARDIOVASCULAR

- Heart trouble
- Chest pain or angina pectoris
- Palpitation
- Shortness of breath w/ walking or lying flat
- Swelling of feet, ankles or hands

## RESPIRATORY

- Chronic/frequent coughs
- Spitting up blood
- Shortness of breath
- Wheezing

## GASTROINTESTINAL

- Loss of appetite
- Change in bowel movements
- Nausea or vomiting
- Frequent diarrhea
- Painful bowel movements or constipation
- Rectal bleeding or blood in stool
- Abdominal pain

## GENITOURINARY

- Frequent urination
- Burning or painful urination
- Blood in urine
- Change in force of strain when urinating
- Incontinence or dribbling
- Kidney stones
- Sexual difficulty
- Male – testicle pain
- Female – pain with periods
- Irregular periods
- Vaginal discharge
- # of pregnancies \_\_\_\_\_
- # of miscarriages \_\_\_\_\_
- Date of last Pap smear \_\_\_\_\_

## MUSCULOSKELETAL

- Joint pain
- Joint stiffness or swelling
- Weakness of muscles or joints
- Muscle pain or cramps
- Back pain
- Cold extremities
- Difficulty in walking

## INTEGUMENTARY (Skin, breast)

- Rash or itching
- Change in skin color
- Change in hair or nails
- Varicose veins
- Breast pain
- Breast lump
- Breast discharge

## NEUROLOGICAL

- Frequent recurring headaches
- Light headed or dizzy
- Convulsions or seizures
- Numbness/tingling sensations
- Tremors
- Paralysis
- Head Injury

## PSYCHIATRIC

- Memory loss or confusion
- Nervousness
- Depression
- Insomnia

## ENDOCRINE

- Glandular or hormone problem
- Excessive thirst or urination
- Heat or cold intolerance
- Skin becoming dryer
- Change in hat or glove size

## HEMATOLOGIC / LYMPHATIC

- Slow to heal after cuts
- Bleeding or bruising tendency
- Anemia
- Phlebitis
- Past transfusion
- Enlarged glands

## ALLERGIC / IMMUNOLOGIC

- History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics
  - Morphine, Demerol, other Narcotics
  - Novocain or other anesthetics
  - Aspirin or other pain remedies
  - Tetanus or other serums
  - Iodine or other antiseptic
- Other drugs / medications : \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_



# ACKNOWLEDGEMENTS, AGREEMENTS AND CONSENTS

## Acknowledge and Consent to Treatment

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I may need.

## Financial Responsibility and Payment Policy

**Insurance:** Knowing your insurance benefits are your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. We will as a courtesy bill and pre-authorize benefits and claims with your insurance company. However, it is important for you to understand that health and/or accident insurance policies are an arrangement between the insurance carrier and you.

**Co-Payments and Deductibles:** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance Company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

**Non-covered services:** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

**Proof of insurance:** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current and valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

**Claims submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

**Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Please notify us of all family members' names and birth dates that require changes. Failure to provide this information in a timely manner may cause you to be responsible for the balance of the claim. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

**Non-payment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. If my account becomes delinquent or is placed with an attorney I agree to pay all attorney and collection fees. I also understand that if I suspend or terminate my care or treatment, any fees for professional services rendered me will be immediately due and payable.

**Missed appointments:** Missed appointments not canceled within a reasonable amount of time will be tracked. More than two missed appointments may result in you being discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. Please help us to serve you better by keeping your regularly scheduled appointment.

*We are committed to providing you with quality and affordable health care. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns. A copy will be provided to you upon request.*

## Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- ❖ A basis for planning my care and treatment.
- ❖ A means of communication among the many health professionals who contribute to my care.
- ❖ A source of information for applying my diagnosis and surgical information to my bill.
- ❖ A means by which a third-party payer can verify that services billed were actually provided.
- ❖ And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.
- ❖ Your records may be released in response to a subpoena, to the practice attorney, and/or the practice insurance carrier in the event of legal proceedings.

**If you want to restrict the use of your healthcare information, please describe below. Moab Family Medicine reserves the right to refuse to abide by certain restrictions as described above:** \_\_\_\_\_

### I wish to be contacted in the following manner (check all that apply):

- |  |  |   |
|--|--|---|
| <b>Home telephone</b> _____  | <b>Work Telephone</b> _____  | <b>Written Communication</b>                                    |
| <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O.K. to leave message with detailed information | <input type="checkbox"/> O.K. to mail to my home address        |
| <input type="checkbox"/> Leave message with call back number only.       | <input type="checkbox"/> Leave message with call back number only        | <input type="checkbox"/> O.K. to mail to my work/office address |
|  |  | <input type="checkbox"/> O.K. to fax to this number _____       |

*In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual.*

**Note: Uses and disclosures for TPO may be permitted without prior consent in the event of an emergency.**

**Health care entities must keep records of PHI disclosures. Information provided below, if completed properly, will constitute as an adequate record.**

Date	Disclosed w/ whom Address or Fax number	Description of Disclosure Purpose of Disclosure	By Whom Disclosed

**I certify that I have read this form and understand its contents. I certify that I have received a copy(s) of the document(s) titled "Notice of Health Information Practices", "Moab Family Medicine Payment Policy" or that I was offered a copy and declined to take it.**

\_\_\_\_\_  
(Patient or Other Legally Authorized Person and relationship if necessary)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Witness)

\_\_\_\_\_  
(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 the 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 selects 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 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.

\_\_\_\_\_  
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)