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 Definition

A. The term "we," "parties" or "us" means you, (the Patient), and the Provider.
B. The term "Claim" means on e 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 the 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 on-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 of using non-binding mediation does not resolve your Claim, we agree that your Claim will be resolved through binding arbitration. We bot5h 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 you Claim (the "Notice"). If the Notice is sent tot the Provider by certified mail it will suspend (toll) the applicable statute 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 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 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 of 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 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 tot the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 Terms/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 the 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 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 the Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement and I have been verbally encouraged to read it and this Agreement. I have had the right to ask questions, I have been verbally encouraged to ask any questions, and I have had all my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement with in 10 days of signing it.

Article 10 Receipt of Copy I have received a copy of this document.

Utah Vein Specialist, PC
Name of Physician, Group or Clinic

_____
Signature of Patient or Patient's Representative

By: _____
Signature of Physician Date
Or Authorized Representative

Utah Vein Specialists

Veins matter.

Confidential Health History

Patient Name: _____ **DOB:**_____

Who is your primary care physician? _____

Please check the symptoms you are currently experiencing. (Please Circle)

☐	Varicose Veins, Spider Veins, Purple (Reticular) Veins at the Ankles	Left	Right
☐	Leg Pain: Aching, Tired, Heavy Legs, Tender Varicosities, Painful Calves	Left	Right
☐	Leg Cramps: Night Cramps, "Charley Horses", Nocturnal Cramping	Left	Right
☐	Swollen Ankles: Swelling at day's end or when traveling (w/o CHF, renal ssues)	Left	Right
☐	Skin Changes: Red/Brown Discoloration, Ulceration, Eczema, Itching & Burning	Left	Right
☐	'Secondary' Restless leg syndrome	Left	Right

Please check any methods you have used to relieve your leg discomfort:

__Warm Soak __Exercise __Pain Meds __Wrap __Compression Stockings __Leg Elevation

__Cold Packs __Aspirin __Walking __Tylenol __Ibuprofen __Flexion/Extension of your feet

Other Method: _____

Many insurance companies require conservative treatment of Compression Stockings before they will consider coverage for any veinous treatment. Have you previously worn Compression Stockings? If so, for how long?
_____Years _____ Months

Do you have a history of serious skin, staph or bacterial infections? Yes No
Please Explain:

Does walking/exercise relieve your discomfort? Yes No **Which?** Walking / Exercise

Have you ever been treated for your veins before? Yes No **When?**_____

What Method:

__Cosmetic Injection __Ultrasound-Guided Injections __Radiofrequency Closure __Ambulatory Phlebectomy

__Ligation __Stripping __Laser for Spider Veins __Laser Catheter Ablation

__Other_____ **What were your results?** _____

How do your vein symptoms effect your daily life? _____

ALLERGIES:

Do you have any allergies or sensitivities to medicines or tape? Yes No

Please list:

MEDICATION LIST: (Prescription, Non-Prescription, Vitamins and Herbal)

PAST MEDICAL HISTORY: (Please check all that apply to your PAST Medical History)

__ Kidney/Bladder Disease
__ Diabetes: Insulin Dependent
__ Peripheral Vascular Disease
__ Atherosclerosis
__ Coronary Heart Disease
__ Heart Valve Problems
__ Anemia
__ Pulmonary Embolism
__ High Blood Pressure
__ Liver Disease
__ Thyroid Disease
__ Stroke or TIA
__ Bleeding Disorder
__ Deep Vein Thrombosis
__ Excessive Bleeding/Easy Bruising
__ Carotid Disease
__ Trauma to your Legs
__ Intolerant of NSAIDS

PAST SURGICAL HISTORY & HOSPITALIZATIONS: (Please include childbirths & pregnancies) **YEAR**

FAMILY HISTORY:

Family History of spider or varicose veins? Yes No Mother/Father/Grandparent

Please describe: _____

Family History of deep blood clot, stroke, or clotting disorder? Yes No Mother/Father/Grandparent

Please describe: _____

SOCIAL HISTORY:

Do you smoke? Yes No How much?_____

D o you consume alcohol? Yes No How much?_____

OCCUPATION: _____

Are you being treated for any current medical conditions? Yes No

Please list:

CURRENT MEDICAL - REVIEW OF SYSTEMS: (Please check all that apply to your CURRENT health)

__ Weight Loss	__ Weight Gain	__ Fever	__ Chills
__Night Sweats	__ Fatique	__ Dizziness	__ Chest Pain
__ Heart Palpitations	__ Tachycardia	__ Shortness of Breath	__ Cough
__ Wheezing	__ Vision Loss	__ Loss of Taste	__Loss of Balance
__ Bleeding Disorder	__ Cough of blood/sputum	__ Headaches	__ Painful Respiration
__ Blood in urine	__ Blood in Stool/Tarry Stool	__Frequent Fainting	

Patient Signature _____ Date _____

Patient Registration Form

Patient Information

Name_____ _____/_____/_____ _____
Last First Middle Initial Date of Birth Age

_____ Gender: ☐ Male ☐ Female _____/_____/_____
Address City, State Zip Social Security #

( ) _____-_____ ( ) _____-_____ **Marital Status** ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Cellular Telephone Home Telephone

☐ Check here if messages can be left on an answering machine

Email address: _____

Emergency Contact _____ ( ) _____-_____ _____
Last First Telephone Relationship to Patient

Primary Care Physician: _____ Telephone Number: _____

Who may we thank for referring you? _____

Primary Insurance

Insurance Company _____ ( ) _____-_____ Effective Date _____
Telephone

_____ Policy # _____ Group #_____
Claim Address City, State Zip

Policy Holder Name _____ Relationship to Patient _____

_____ _____/_____/_____ Gender □ **Male** □ **Female**
Address City, State Zip Date of Birth

Additional Insurance

Insurance Company _____ ( ) _____-_____ Effective Date _____
Telephone

_____ Policy # _____ Group #_____
Claim Address City, State Zip

Policy Holder Name _____ Relationship to Patient _____

_____ _____/_____/_____ Gender □ **Male** □ **Female**
Address City, State Zip Date of Birth

Patient Service Agreement

Consent for Services

By signing this agreement I give consent to the physicians, medical staff and employees of Utah Vein Specialists to provide health care services to _____, _____(Date of Birth).
Patient Name

Financial Responsibility and Assignment of Benefits

I agree that all benefits from insurance companies or any other third party payer will be paid directly to Utah Vein Specialists for services rendered by the health care providers employed by Utah Vein Specialists. I authorize the use of my signature and any records pertaining to my services to all insurance companies, or third party payers to secure payment.

I understand that I am financially responsible for all charges whether or not paid by insurance or any other third party payer. I agree to pay all co-payments at the time of service, all deductibles, co-insurance, and all non-covered services regardless of the amount paid by my insurance or any other third party payer. I agree to pay all attorney fees, court costs, filing fees, including charges or commissions that may be assessed by any collection agency retained to pursue collection on outstanding balances, with or without suit. The cost of collection is 25% of the total balance owed. I further agree to pay interest fees at the rate of 1 ½% per month (18% annually) for any outstanding balance.

I agree to pay a return processing fee of $20.00 for any check, or other payment method, that is returned unpaid to Utah Vein Specialists.

Release of Information and Privacy Notice

The law requires Utah Vein Specialists to make and keep records of the patient's medical treatment. Utah Vein Specialists safeguards those records and it uses and discloses such records and any information they contain only in accordance with Utah State and Federal privacy laws. Such uses and disclosures are described in detail in the Notice of Privacy Practices. The Notice of Privacy Practices is available for the patient to review at anytime.

Acknowledgement

I acknowledge I have received or been offered the Notice of Privacy Practices by Utah Vein Specialists. As the patient, or the representative of the patient, I have read the above information and give consent and agree to the terms. All of my questions regarding privacy and this agreement have been answered and a copy has been offered.

Date _____

Patient or Legal Representative Signature: _____

0r Legal Representative Name: _____

Witness Signature: _____
Utah Vein Specialists

Utah Vein Specialists

Veins matter.

Photograph Consent

I agree to have Dr. Jensen or his assistants take photographs of my legs and my face for medical records purposes. These photographs will be held in confidentiality according to HIPPA regulations. Photographs of my name and face will only be used for purpose of my chart at Utah Vein Specialists, Inc. in order for the staff to better recognize each patient and to confirm correct patient when they arrive in the office. I do consent to the future use of my leg photographs, both before and after proposed procedures, at Dr. Jensen's discretion for the purpose of insurance authorization, and patient and physician education.

By: _____

Patient or Patient's Representative Signature

Utah Vein Specialists

By: _____

Signature of Physician Or Authorized Representative