IVC® INTERVENTIONAL VASCULAR & VEIN CENTER

Thank you for choosing IVC Interventional Vascular & Vein Center. We are very interested in consulting with you as a patient. Before you come in for your visit, we would like you to fill out the enclosed forms. **Some of the forms have information on the front and back.** We would ask you to be thorough in filling in your information. This will make your time and our staff's time run more efficiently. Please read over and sign all forms and policies. If you have questions about the forms and policies, please feel free to call us.

New Patient Consultation Form: It is very important all applicable fields be filled out on the New Patient Consultation form and Activities of Daily Living form. The scales should be filled out at the **worst** the symptoms have been. The pain scale and activities of daily living scale do get submitted to the insurance to help prove medical necessity for insurance coverage and authorizations. Also, please circle **all** of the referrals sources that may be applicable to you on the new patient form. You may circle more than one. If you were referred by a physician, please write their name in the space provided. If you were referred through an event or community fair, please write down which one.

Please bring:

- Insurance card(s)
- Photo ID (required by law)
- Means of payment for co-payment & self-pay
- Parent or guardian if you are under 18

Please be Prepared by:

- Coming well hydrated to this appointment, as it will help us to more easily document vessel sizes.
- Walking at least 5 minutes, prior to your appointment time. Do not wear your compression socks 2 days before your appointment.
- Recommend only one other person attend appointment with you. (Please make other arrangements for childcare)

We ask that you arrive a few minutes early for the staff to complete your chart. **If you are more than 15 minutes late or you do not have your paperwork filled out for your appointment, it is an automatic reschedule and you may be charged a cancellation fee.** We reserve the right to charge for appointments cancelled or broken without 48 hours advance notice.

Your visit will consist of:

- Ultrasound on one or both lower extremities.
- Consultation with the Advanced Practice Provider
- Insurance requirements explained and financial information provided
- **Plan on your visit being approximately 2 hours**. With the visit being timely and our waiting room being small, we ask that children be left with a family member or a friend if at all possible. We will be performing an ultrasound on your legs. You will be asked to change from the waist down. Disposable shorts will be provided for you to change into at your appointment. You will be asked to turn off cell phones while in the office.
- Your insurance **will** be billed for this initial consultation and ultrasound visit.

  Single Leg Examination: $700
  Bilateral Leg Examination: $865
  (Add'tl amount for pelvic and scrotal ultrasound add-ons)

A portion, or all, of the amount given above may be applied to your deductible. All other treatment costs will be explained to you during your consultation.

Mark S. Asay, MD
Carl M. Black, MD
S. Doug Brown, MD
Cody Jarrett, PA-C
John S. Collins, MD
Daniel J. Hatch, MD
Jonathan H. Harrison, MD
Jason Henrie, APRN
Ryan B. Nielsen, MD
Matthew E. Nokes, MD
Brandon Hermansen, PA-C
Kelly Thorpe, APRN

Map and Driving Directions:

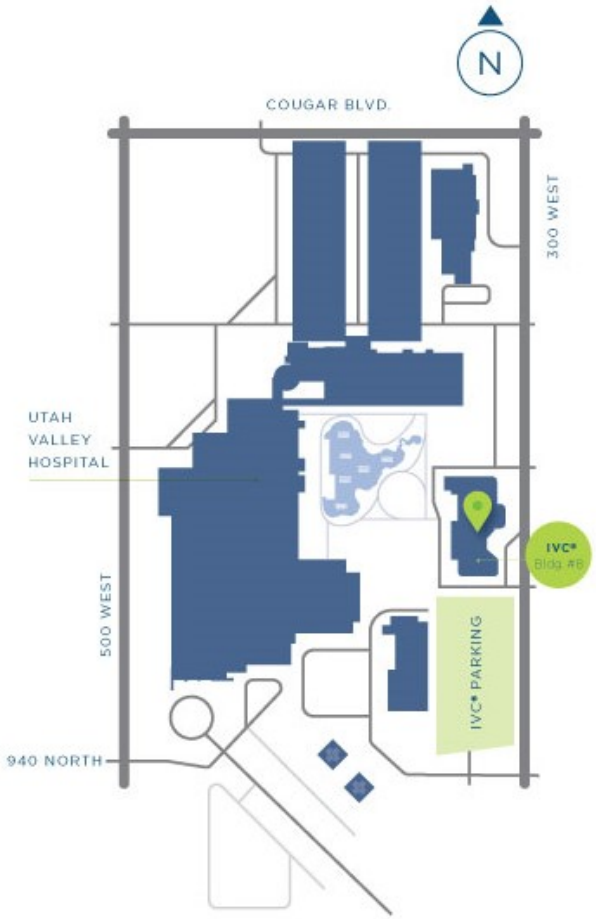
IVC® Interventional Vascular & Vein Center
1055 N 300 W Suite 104
Provo, UT 84604

From the North:

From I-15, take University Parkway Exit (Exit 269). Turn left (east) off of exit and travel approximately 2 miles. Turn south on State Street, approximately 2 miles towards Utah Valley Regional Medical Center. At the bottom of the hill, turn left (east) onto Cougar Boulevard. At the second light, turn right, (south) onto 300 W. IVC® is located in the Physicians Plaza on the right (west) side of the road in Suite 104. Parking is available at the south end of the Physicians Plaza.

From the South:

From I-15, take Center St. Exit (Exit 265). Turn right (east) off of exit and travel approximately ½ mile. Turn left (north) onto 500 W and travel approximately 1 mile. Turn right (east) onto Cougar Boulevard. At the second light, turn right (south) onto 300 W. IVC® is located in the Physicians Plaza on the right (west) side of the road in Suite 104. Parking is available at the south end of the Physicians Plaza.



The Physician Plaza is a brown brick building with black windows and a #8 on the building.

Questions? Call us at: 801.379.6700 for IVC

IVC® INTERVENTIONAL VASCULAR & VEIN CENTER

Patient Information *(Please Print)* Today's Date_____

Name_____
Last First M.I. Preferred
Mailing Address _____

Street Address (if different from mailing)_____
City State Zip
Home Phone (_____)_____ Cell/Work Phone(_____)_____SS# _____

Date of Birth ____ / ____ / ____ Age _____ Sex _____ Marital Status _____

Language_____ Race_____ Ethnicity_____

E-mail Address (for appt. reminders)_____

PRIMARY INSURANCE POLICY HOLDER (if different from patient)

Name_____
Last First M.I.
Mailing Address _____
City State Zip
Home Phone _____ Cell/Work Phone _____SS#_____
Area Code Area Code
Date of Birth ____ / ____ / ____ Sex _____ Marital Status _____

INSURANCE INFORMATION (*Please present insurance card at time of check in.*)

Primary Insurance Name _____
Insured's ID# _____
Relationship of patient to the insured _____

Secondary Insurance Name _____
Insured's ID# _____
Relationship of patient to the insured _____

PHARMACY OF CHOICE _____ Location/City _____

In case of Emergency, who should be notified? _____Phone _____

Primary Care Physician: _____

Referral Source (Please select all that apply): ☐Physician: _____

☐TV ☐Radio ☐Friend ☐Internet ☐Billboard ☐Magazine ☐Other: _____

Other family members that are patients: _____

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf, or my dependents.

Patient Signature: _____ Date ____ / ____ / ____

Personal Health History

Confidential

Patient Name _____ Today's Date _____

Check all conditions that apply to you

General

- □ Fatigue, tiredness
- □ Weakness
- □ Chills
- □ Fever
- □ Night Sweats
- □ Appetite Change
- □ Lived in a foreign country
- □ Unexplained Weight Loss
- □ Unexplained Weight Gain
- □ Generalized pain
- □ Unable to tolerate heat
- □ Unable to tolerate cold
- □ Sedentary lifestyle
- □ Active lifestyle
- □ Other _____

Neurological

- □ Fainting spells
- □ Seizures
- □ Paralysis
- □ Dizziness
- □ Tremor
- □ Chronic headaches
- □ Poor balance
- □ Fractured back or neck
- □ Numbness of face/arm/leg
- □ Peripheral Neuropathy
- □ Stroke or Mini-stroke
- □ Other _____

Psychiatric

- □ Depression
- □ Anxiety (abnormal)
- □ Panic attacks
- □ Alzheimer's
- □ Confusion (abnormal)
- □ Hospitalized for nervousness
- □ Substance Abuse
- □ Anorexia
- □ Other _____

Respiratory

- □ Chronic Obstructive Disease
- □ Wheezing
- □ Chronic cough
- □ Coughing up blood
- □ Asthma
- □ Shortness of breath
- □ TB
- □ Lung cancer
- □ Emphysema
- □ Chronic bronchitis
- □ Pneumonia
- □ Fluid in lungs
- □ Need to sleep sitting up
- □ Other _____

Cardiac

- □ Angina (chest pain)
- □ Rapid Heartbeat
- □ Past heart attacks
- □ Heart murmur
- □ Congestive Heart Failure
- □ Pacemaker
- □ High Blood Pressure
- □ Aortic aneurysm
- □ Other heart problem
- □ Other _____

Vascular

- □ Leg pain walking over 1 block
- □ Leg pain walking < 1 block
- □ Pain in legs while at rest.
- □ Blood clots in legs
  - □ Deep □ Superficial
- □ Cold feet or hands
- □ Amputation of toes
- □ Amputation of feet or legs
- □ Peripheral vascular disease
- □ Ulcers of lower legs
- □ Varicose veins
- □ Aneurysm of arteries
- □ Other _____

Gastrointestinal

- □ Diarrhea
- □ Constipation
- □ Stool Changes
- □ Bowel Habits Changed
- □ Hemorrhoids
- □ Indigestion
- □ Ulcers
- □ Irritable Bowel
- □ Colon Polyps
- □ Cramps/Pain
- □ Cancer of stomach or bowel
- □ Diverticulitis
- □ Other _____

Genitourinary

- □ Hesitancy/urgency of urine
- □ Need to urinate often at night
- □ Loss of bladder control
- □ Difficult urination
- □ Renal Failure
- □ Impotence
- □ Current Dialysis
- □ Renal Transplant
- □ Prostate Enlargement
- □ Cancer of bladder, kidneys
- □ Other _____

Blood & Lymph System

- □ Anemia
- □ Blood Disease
- □ Transfusions
- □ Leukemia
- □ Bone Marrow tests
- □ Long term Coumadin use
- □ Blood clotting problems
- □ Other _____

Eye, Ear, Nose, Throat

- □ Pain
- □ Hearing Loss
- □ Polyps
- □ Vertigo
- □ Ringing in ears (tinnitus)
- □ Sinus infections
- □ Deafness
- □ Other _____

Musculoskeletal

- □ Arthritis
- □ Joint Swelling
- □ Joint Stiffness
- □ Muscle Aches
- □ Muscle Weakness
- □ Leg Cramps
- □ Other _____

Skin

- □ Rashes
- □ Tumors
- □ Sensitivity to Sunlight
- □ Malignant Melanoma
- □ Squamous cell carcinoma
- □ Basal cell carcinoma
- □ Easy bruising
- □ Fungal infection
- □ Non-healing sores
- □ Excessive rough or dry skin
- □ Other _____

Endocrine

- □ Thyroid problems
- □ Diabetes – Type 1
- □ Diabetes – Type 2

Abdominal Organs

- □ Hepatitis (Type: _____)
- □ Cirrhosis (liver)
- □ Gallbladder Disease

Height:_____

Weight:_____

Pregnancies _____

Births _____

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1055 North 300 West # 104, Provo, UT 84604
801.357.6700

See other side...

Occupational

Check if your work exposes you to the following:

☐ Prolonged Sitting ☐ Heavy Lifting

☐ Prolonged Standing ☐ Hazardous Material

What is/ was your occupation?_____

Surgeries

Year	Surgery	If hospitalized, name of hospital

Check if your blood relatives have had any of the following.

	Disease	Relationship to you
	Arthritis, gout	
	Asthma	
	Cancer	
	Stroke	
	Diabetes	
	Heart Disease	
	High Blood Pressure	
	Kidney Disease	
	Varicose veins	
	Other vein disease	

Medications

List all medications AND dosage you are currently taking (i.e. Ibuprofen 800 mg)

Medication	Dose
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Health Habits:

Check substances you use and describe how much you use:

☐ Tobacco

- ☐ Current use # packs per day _____
- ☐ Past use _____ # of years
- ☐ Year quit _____
- ☐ # of packs per day _____

☐ Drugs (please indicate drug(s), not prescription)

☐ Alcohol (i.e. beer, wine, etc.)

Number of drinks: 1 2 3 4 4+

Frequency: Daily Weekly Monthly

Allergies to Medications

List all drug allergies and the reaction you have:

_____

_____

_____

_____

_____

I certify that the above information is correct to the best of my knowledge. I will not hold my health care provider or members of their staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature_____ Date_____

Name: _____ Date of Birth: _____

IADL Questionnaire

To help facilitate treatment and approval from you insurance company, we need to know how your symptoms affect your Instrumental Activities of Daily Living (ADL's) on a personal level. IADL's refer to your ability to do tasks such as housework, shopping, working etc. Please describe how your symptoms (i.e. heaviness, achiness, throbbing) impact your ability to do these daily tasks, whatever they may be.

*** In complete sentences**, please describe how your symptoms affect your ability to **sleep** at night?

With 10 being the worst, circle your level of discomfort while sleeping at night. 0 1 2 3 4 5 6 7 8 9 10

*** In complete sentences**, please describe how your symptoms affect you when **sitting for long periods of time**, such as driving or riding in a car, at work or in general?

With 10 being the worst, circle your level of discomfort while sitting for long periods of time. 0 1 2 3 4 5 6 7 8 9 10

*** In complete sentences**, please describe how your symptoms affect you when **standing for long periods of time**, such as at work or in general?

With 10 being the worst, circle your level of discomfort while standing for long periods. 0 1 2 3 4 5 6 7 8 9 10

*** In complete sentences**, please describe how your symptoms **affect your ability** when you are on your feet for long periods of time, such as shopping, chores, dishes, laundry and cleaning?

With 10 being the worst, circle your level of discomfort when on your feet for a long time. 0 1 2 3 4 5 6 7 8 9 10

Name_____

For Female Patients Only:

Some females suffer from pelvic varicose veins, as well. The answers to these questions below will help us determine if this diagnosis may or may not apply to you.

Pelvic Pain Scale

Do you have labial varices?	Y	N
Do you experience pelvic pain?	Y	N
Do you have the urge to urinate more frequently than usual?	Y	N
Do you take pain medication on a regular basis?	Y	N

Please answer the following questions on a scale from 0 to 10, 10 being the highest level of pain.

How intense is your overall pelvic pain?	0	1	2	3	4	5	6	7	8	9	10
How intense is your pelvic pain while lying down?	0	1	2	3	4	5	6	7	8	9	10
How intense is your pelvic pain while standing?	0	1	2	3	4	5	6	7	8	9	10
How intense is pain in your leg(s) while lying down?	0	1	2	3	4	5	6	7	8	9	10
How intense is the pain in your leg(s) while standing?	0	1	2	3	4	5	6	7	8	9	10
How intense is the pain in your leg(s) during menstruation?	0	1	2	3	4	5	6	7	8	9	10
How intense is your pain during or after intercourse?	0	1	2	3	4	5	6	7	8	9	10

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Name:_____ Date: _____

Date of birth: _____ Age: _____ Sex: M F

Symptoms:	Left	Right	N/A		Left	Right	N/A
Unsightly veins	□	□	□	Pigmentation	□	□	□
Ankle edema	□	□	□	Itching	□	□	□
Bleeding from vein	□	□	□	Leg pain while resting	□	□	□
Ulceration (open sore)	□	□	□	Night cramps	□	□	□
Leg pain while standing	□	□	□	Dermatitis (rash)	□	□	□
Induration (redness)	□	□	□	Bruise easily	□	□	□
Daily pain	□	□	□	Restless legs	□	□	□
Heavy/tired legs	□	□	□	Developing new veins	□	□	□

History:	Left	Right	N/A
SVT (superficial vein blood clot) ___ (# episodes)	□	□	□
DVT (deep vein blood clot) _____(# episodes)	□	□	□
Spider vein treatment	□	□	□
Sclerotherapy	□	□	□
Local excision	□	□	□
Ligation/stripping	□	□	□
Thermal ablation	□	□	□
PE (blood clot in lung)	Yes	No	
Patent foramen ovale (PFO)	Yes	No	
Stroke	Yes	No	
Migraines	Yes	No	
Hemorrhoids	Yes	No	

Worn prescription compression stocking? **Y N**
□ Longer than 3 mo □ Longer than 6 mo □ Longer than 12 mo

Have you taken NSAIDs (i.e. ibuprofen, naproxen) for your leg pain? **Y N**
*NSAID:_____ *How often do you take it? _____
If yes, was the NSAID a prescription? **Y N**
If yes, please provide the RX# from your prescription:_____

Do you have an intolerance to anti-inflammatories? **Y N**

If you cannot take NSAIDs, what medication do you take for leg pain?
*Drug:_____ *How often do you take it? _____

How long have you had the problem with your legs that brings you in today? _____

Referral source (please circle):

Billboard Radio Insurance Internet TV Self Phonebook Word of Mouth Magazine Newspaper

Physician: _____ Event: _____

(Physician's name) (Event name or date)

HIPAA

PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, research, training or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

I acknowledge that I can request from the Group a copy of a separate document, entitled, "Notice of Privacy Practices" which sets forth this Group's privacy practices and my rights regarding privacy of my protected health information.

_____ _____

Printed Name - Patient or Representative Signature

Today's Date ___/___/___

_____ _____ ___/___/___

Relationship to Patient (if other than patient) *Signature* *Date*

*For Office Use Only

INTERVENTIONAL, VASCULAR & VEIN CENTER
Name of Physician, Group, Clinic

*_____ *_____ ___ / ___ / ____

Printed Name – Practice Representative Signature Date

Financial/Cancellation Policy

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office, scheduling, and notifying the office if you are unable to make your scheduled appointment.

FINANCIAL POLICY

1. Insurance Patients: As a courtesy to you, we will file a claim with your primary and secondary plans. When each has paid their portion of the charge, the remainder becomes your balance and is indicated on the statement you will receive from the office. While our billing professionals will do all they can to help you in communicating/negotiating with your insurance plan, we must remind you that you are responsible for all charges until they are fully paid.

At the time of visit, we will collect co-payments, co-insurance amounts as well as charges for non-covered or cosmetic services prior to meeting with the physician/nurse practitioner.

Should a surgical procedure be necessary, we will help you communicate with your insurance for pre-notification or pre-authorization. We will collect 100% of the estimated patient responsibility prior to the surgery. This can be paid on the day of the surgery or any day before. We expect that if any remaining balances are due they will be paid upon receipt of the statement, or at your next visit. If financial arrangements are needed, we go through CareCredit. Please ask the receptionist or insurance specialist for more information.

If we do not have a contractual relationship with your insurance carrier, we will bill your primary and secondary insurance for services rendered. If we do not receive payment from either insurance, you will be billed for the entire amount. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. The entire balance remaining after your primary carrier has paid will be billed to you. Payment or payment arrangements must be made 10 days after receipt of the statement.

2. Self-pay Patients: We expect payment at the time of treatment for patients who have no insurance coverage. We will do our best to give you an estimate of the charges prior to your visit. A 40% discount will be offered to those who pay 100% of the cost prior to the procedure being done (does not include cosmetic procedures). If financial arrangements are needed, we go through CareCredit. Please ask the receptionists or insurance specialists for more information.

3. Medicare Patients: We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of co-payments and charges for non-covered or cosmetic services. You will be asked to sign an Advance Beneficiary Notice (ABN) form in the event that a service is provided which we know is not covered by Medicare.

If you have Medicare as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 45 days after we file a claim, you will be sent a bill and will be responsible for the balance.

Most insurance companies generally will not give a specific amount that they will pay until a claim is submitted, but we will obtain insurance benefits before the patient's initial visit so that we may provide an estimate of what the patient responsibility will be. If you have any questions about this policy, please contact our office.

SCHEDULING / CANCELLATION POLICY

a) Scheduling Appointments: It is our office policy that appointments need to be made by the patient unless the patient is a minor or there are circumstances that necessitate assistance in making appointment arrangements. We understand it may be more convenient at times to have a friend, spouse or family member set up the appointment; however, to reduce mistakes and misunderstandings on our part we request for appointments to be made directly with the patient.

b) Holding Appointments: Due to the nature of our practice we are unable to hold appointment spots for new patient appointments, procedure appointments and/or follow up appointments.

c) Late Patients: Patients are required to be on time to their appointment. If possible, patients should arrive a few minutes early to check in and fill out any required paperwork. If a patient is more than 15 minutes late for an appointment, the appointment may be cancelled. It will be at the discretion of the provider and the office staff to determine if there will be enough time to see the patient without making other patients wait. A cancellation fee may be charged if your appointment has to be cancelled.

d) Cancellation / No Shows:
   a. Prior to an appointment our office will attempt to contact you as a reminder of the appointment. If the patient is unable to make the consultation/ultrasound or follow up/ultrasound, they are requested to give a 48-hour (2 day) notice. Our time is valuable and it is difficult to fill the cancelled appointment slot on such short notice. If this notice is not given in time, or not at all, then the patient will be charged $50.00.
   b. Prior to a procedure our office will attempt to contact you as a reminder of the procedure. If the patient is unable to make the procedure appointment, they are requested to give a 72-hour (3 day) notice. If this notice is not given in time, or not at all, then the patient will be charged for the cancelled / missed procedure. (Amounts can range from $100.00 - $400.00, depending on the procedure that was cancelled / missed.)

Your signature below signifies that you understand and agree to our financial policy, our cancellation policy, and your responsibility regarding charges incurred in this office.

⇨ _____ ⇨ _____/_____/_____

Patient or Responsible Party Signature Date

IVC® INTERVENTIONAL VASCULAR & VEIN CENTER

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. File 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, physical therapist, psycholgist, 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 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 aribtrator 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 Expeneses. 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 artibration 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.

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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 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 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 or have had the opportunity to obtain a copy of this document.

_____
Name of Patient

_____ _____
Signature of Patient or Patient's Representative Date

_____
Signature of Physician or Authorized Agent

Patient's Consent for Provider to Disclose PHI to Authorized Persons

1. **Authorization to Disclose PHI (Protected Health Information).** I hereby authorize you, my healthcare provider ("Provider"), to disclose any and all of my medical and protected health information ("PHI") to the persons indicated below.

2. **Persons to Whom Disclosure May be Made.** Provider may disclose my PHI to the following persons:

Name	**Relationship, If Any**
_____	_____
_____	_____
_____	_____

3. **Purpose of Disclosure**. The purpose of the disclosure is to allow these persons to participate in my care, participate in the payment of my medical bills, and/or to know the status of my health.

4. **Expiration of Authorization.** This authorization shall continue until I revoke this authorization in writing, which I may do at any time by sending a letter addressed to the Privacy Officer to any office where I am treated by Provider.

5. **Conditioning of Treatment**. Provider may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this consent.

6. **Redisclosure by Recipient.** I understand that once Provider discloses my PHI to the persons listed herein, my Provider has no control as to whether those persons may redisclose my PHI, which may no longer be protected by federal or state law.

7. **Acknowledgment and Receipt of Copy.** I have read, understood, and agreed to this authorization and received a copy of same.

_____ _____

Patient Name or Representative Date

If a Representative Signs, state the Representative's Authority:

_____

AUTHORIZATION FOR EMAIL & TEXT COMMUNICATION

You may give permission to Interventional, Vascular & Vein Center staff to communicate with you by email and text message (also known as SMS). This form provides information about the risks of these forms of communication, guidelines for email/text communication, and how we use email/text communication. It also will be used to document your consent for communication with you by email and text message.

How we will use email and text messaging: We use these methods to communicate only about your care with us. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Your email and text messages may be forwarded to our staff member as necessary for appropriate handling. We will not disclose your emails or text messages to outside parties. Please refer to our Notice of Privacy Practices for information as to permitted uses of your health information and your rights regarding privacy matters.

Risk of using email and text messages: The use of email and text message has a number of risks that you should consider. These risks include, but are not limited to, the following:

a. Emails and texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
b. Senders can easily misaddress an email or text and send the information to an undesired recipient.
c. Backup copies of emails and texts may exist even after the sender and/or the recipient has deleted his or her copy.
d. Employers and on-line services have a right to inspect emails and texts sent through their company systems.
e. Emails and texts can be intercepted, altered, forwarded or used without authorization or detection.
f. Emails and texts can be used as evidence in court.
g. Email and text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

Conditions for the use of email and text messages: IVC cannot guarantee but will use reasonable means to maintain security and confidentiality of email/text information sent and received. You must acknowledge and consent to the following conditions:

IN A MEDICAL EMERGENCY, DO NOT USE EMAIL, CALL 911. Do not email for urgent problems. If you have an urgent problem, please call 801.379.6700. Urgent messages or needs should be relayed to us by using regular telephone communication and may include text messages.

a. You should speak with our staff to discuss complex and/or sensitive situations rather than send email or text messages regarding such situations.
b. Email and text messages may be filed electronically into your medical record.
c. Clinical staff will not forward your identifiable email/texts to outside parties without your written consent, except as authorized by law.
e. You should use your best judgment when considering the use of email or text messages for communication of sensitive medical information. Clinical staff are not responsible for the content of messages.
f. IVC is not liable for breaches of confidentiality caused by you or any third party.

Withdrawal of consent: I understand that I may revoke this consent at any time by so advising IVC in writing. My revocation of consent will not affect my ability to obtain future health care nor will it cause the loss of any benefits to which I am otherwise entitled.

Client Acknowledgement and Agreement: I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the use of email and text messaging as a form of communication between IVC staff and me, and consent to the conditions and instructions outlined, as well as any other instructions that IVC may impose to communicate with me by email or text message.

_____ _____ __/__/__
Printed Name - Patient or Representative Signature Date

_____ _____ __/__/__
Relationship to Patient (if other than patient) *Signature* *Date*