



Patient Financial Responsibility Disclosure Statement

Your signature below forms a binding agreement between Cherry Tree Family Practice (CTFP –the provider of medical services) and the Patient who is receiving medical services or the Responsible Party for minor patients (those patients under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges for services rendered are due and payable at the time of service.

MEDICAL INSURANCE: we have contracts with many insurance companies, and we will bill them as a service to you. As the responsible party, you are responsible if your insurance company declines to pay for any reason.

The person signing on behalf of the Patient as the Responsible Party must:

- **Inform CTFP of the current address and phone number for the patient and the responsible party.**
- **Present all current insurance cards prior to each office visit.**
- **Verify at each visit that the information is current by signing the data sheet.**
- **Pay any required copay at the time of the visit**
- **Pay any additional amount owing 30 days of receiving a statement from our office. (When CTFP receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you).**

Returned Check Policy

If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the patient of the Patient’s Responsible Party will be responsible for the original check amount in addition to a \$25.00 Service Charge. Once notice is received of the returned check, CTFP will send out a letter to notify the Responsible Party of the returned check. If a response is not made within 15 days from the letter date by the Patient of the Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance- in addition to the \$25.00 Check Service Charge.

Non-Payment on Account

Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient’s Responsible Party, understands that CTFP has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The patient, or the patients Responsible Party, understand that they are responsible for all costs of collection including, but not limited to, interest due at 18% APR, all court costs and Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a patient who is receiving medical services or as the responsible party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patients Name (please print) _____

Patients Signature _____ Date _____

Responsible Party Name (please print) _____

Responsible Party Signature _____ 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 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 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 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 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 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.

Cherry Tree Family Practice

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) (01/01/2011)



Please Keep This Page For Reference

Welcome to *Cherry Tree Family Practice*. Our goal is to provide you with excellent medical care in a friendly, timely, and cost effective manner.

To accomplish our goal, we would like to explain our office policies:

- ☆ When you call for an appointment, please tell the receptionist **all the reasons for your visit** so that she can schedule the appropriate amount of time.
- ☆ **Please arrive early** for your appointment so you can be ready to be seen at the appointed time. If you are coming for a physical exam, you will need to come at least 20 minutes early, so that you can complete the necessary paper work, leave a urine sample, and be ready for your appointment time.
- ☆ Each time you come in, please **bring your current insurance card and update your contact information**.
- ☆ Please call to reschedule if you cannot come for your appointment, or if you will be late; so we can accommodate other patients with urgent problems.
- ☆ Health insurance is very complicated. Please let us know if you have a special insurance plan or a high deductible plan, so we can advise you. **Please get familiar with your coverage and benefits before you come for your visit. Note specific requirements such as required lab to use, hospital to use, etc.**
- ☆ We will bill your insurance company. Each insurance company has different plans with different deductibles, co-pays, and benefits. We deal with many insurance companies, so we cannot always tell you what your plan will cover. After your insurance company has paid us, you will be responsible for any remaining balance.
- ☆ **Co-payments are due at the time of service** and we collect them at check-in. Co-payments not paid on the day of service will be assessed a **\$15 billing fee**.
- ☆ **For those patients who do not have medical insurance**, we offer a **discounted cash price** for both services and lab tests. **However, this fee must be paid at the time of service** and no insurance company can be billed.
- ☆ If you would like our Notice of Privacy Practices, please ask for a copy.
- ☆ For prescription refill requests, and to contact us with non urgent problems; please send an email to ptrequest@ctfp.com. Please note that we do not refill controlled drugs without a follow-up visit.

We know that you have many options for medical care and we appreciate you choosing our office. We will do our best to serve your medical needs.