UTAH DEPARTMENT OF HEALTH

Health Clinics of Utah

Ogden Clinic
2540 Washington Blvd.
Suite 122
Ogden UT 84401
P (801) 395 6499
F (801) 334-9804

Salt Lake Clinic
168 N 1950 W
Suite 201
Salt Lake City, UT 84116
P (801) 715-3500
F (801) 715-3385

Provo Clinic
150 E Center Street
Suite 1100
Provo, UT 84606
P (801) 374-7011
F (801) 374-7009

NEW PATIENT PACKET

General Information

Name:		Drug Allergies:
Date of Birth:	SS#:	
Address:		
City:	Zip:	
Phone (home):	(other):	

Reason for Visit (briefly describe)

_____

_____

_____

Surgeries and Major Procedures

Date	Reason	Date	Reason

Medications

Are you currently taking medications from other physicians? (Yes / No)
If yes, please list the physician's names: _____ Date:_____ Initials _____

Citizenship Verification (If patient is under 18 years of age, skip this section)

	Yes	No
The patient is a lawful citizen/resident of the United States or holds a valid visa.		

If "YES" provide a photocopy of a valid identification document (ID) such as driver license, American passport, foreign passport with valid visa, green card or permanent resident card, etc. Ask in reception for other valid identification forms. This verification, along with a photocopy of the ID document obtained, will be on file for all patients.

Name – Please Print:

Signature:	Date:

Note: If you provide false information on this section, you will be subject to penalties of perjury.

Emergency Contact

Name:	Phone:
Relation to patient:	

I hereby authorize Health Clinics of Utah to disclose health information to the above-listed emergency contact if deemed medically necessary.

Signature of Patient/Authorized Representative Date

Important Screenings

Year of Last:		
	Colonoscopy _____	Dexa/Bone Scan _____
	Mammogram _____	Prostate Exam (Males) _____
	Pap Smear _____	Other: _____

Vaccination History

Year of Last:				
	Flu _____	Pneumonia _____	Tetanus _____	Other _____

Medical History (Check all that apply)

__Head Injuries
__Frequent Headaches
__Migraines
__Glaucoma
__Cataracts
__Macular Degeneration
__Serious Eye Injury
__Serious Eye Infection
__Hearing Loss
__Vertigo
__Chronic Sinusitis
__Nasal Polyps
__Frequent Nose Bleeds
__Recurrent Throat Infections
__Asthma
__COPD
__Emphysema
__Pulmonary Embolism
__Sleep Apnea

__Heart Attack
__Angioplasty
__Coronary Bypass Surgery
__Congestive Heart Failure
__Arrhythmia
__Stroke or TIA
__Carotid Plaque or Carotidendarterectomy
__Claudication or aortic aneurism
__Venous thrombosis
__Varicose Veins
__Esophageal Spasm __Esophagitis
__Acid Reflux
__Hiatal Hernia
__Ulcer (stomach or duodenal)

__Gastritis
__Liver cirrhosis
__Hepatitis (Type _____)
__Pancreatitis
__Irritable Bowel Diverticulosis
__Diverticulitis colitis
__Frequent Bladder Infection
__Urethritis
__Prostatitis
__Glomerulonephritis
__Nephrotic Syndrome
__Kidney Stones
__Vaginitis
__Candida Infections
__Renal Vascular Disease
__Sexual Dysfunction
__Seizures
__Multiple Sclerosis
__Peripheral Neuropathy
__Anemia
__Clotting Disorder
__Lymphoma
__Autoimmune Disease
Cancer (Circle type):
Breast Uterus
Lung Blood
Colon Melanoma
Prostate Skin
Cervix Other: ____
__High Cholesterol
__High Triglycerides
__Low HDL
__Diabetes
__Low Thyroid (Hypothyroidism)
__High Thyroid (Hyperthyroidism)

__Grave's Disease
__Gout
__Severely Overweight
__Cushing's Disease
__Pituitary Problems
__Low Back Pain
__Osteoarthritis
__Rheumatoid Arthritis
__Osteoporosis
__Systemic Lupus Erythematous
__Severe Acne
__Psoriasis
__Alopecia
__Severe Skin Infection
__Depression
__Anxiety
__Panic Attacks
__Manic Episodes
__Schizophrenia

Childhood Illnesses:
__Chickenpox
__Measles
__Mumps
__Rubella
__Other_____

Comments:

_____

_____

_____

Lifestyle Demographics

1. What is your current marital status?

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed

2. Race/Ethnicity (select all that apply):

- ☐ Hispanic/Latino
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native Hawaiian/Pacific Islander
- ☐ White
- ☐ Middle Eastern/North African
- ☐ Other _____

3. What is your primary language?

- ☐ English
- ☐ Spanish
- ☐ Other (specify) _____

4. Please select your average weekly exercise.

- ☐ Less than once a week
- ☐ 1-3 Times a week
- ☐ 4-7 Times a week
- ☐ More than 7 times a week
- ☐ Other: _____

5. Please indicate the types of exercise you do:

- ☐ Walking
- ☐ Running
- ☐ Biking
- ☐ Swimming
- ☐ Aerobics
- ☐ Weight Lifting
- ☐ Other: _____

6. Please describe your eating habits.

- ☐ Fairly Balanced
- ☐ Eat too much
- ☐ Lots of fast food
- ☐ I follow a diet program
- ☐ Other:_____

7. How many times have you been married?

_____

8. Have you or your partner had intimate contact with a: male homosexual, I.V. drug user, or someone with AIDS?

- ☐ No
- ☐ Yes
- ☐ I don't know

9. Have you ever been sexually abused?

- ☐ No
- ☐ Yes

10. Have you ever been physically abused?

- ☐ No
- ☐ Yes

☐

11. What is your current sleeping pattern?

- ☐ Irregular
- ☐ 2-3 Hours
- ☐ 4-6 Hours
- ☐ 6-8 Hours
- ☐ 9+ Hours

12. Do you drink alcohol?

- ☐ No
- ☐ Yes
- ☐ Former Drinker

13. Do you use tobacco?

- ☐ Current Every Day Smoker
- ☐ Current some day Smoker
- ☐ Former Smoker
- ☐ Never Smoked

14. Secondhand smoke exposure?

- ☐ No
- ☐ Yes

15. Do you use recreational drugs?

- ☐ No
- ☐ Yes
- ☐ Former Drug User

16. Do you need a doctor's help with drug addiction?

- ☐ No
- ☐ Yes

Females (Please Complete the following)

17. Have you ever been pregnant?

- ☐ No
- ☐ Yes

18. Have you ever had a Miscarriage?

- ☐ No
- ☐ Yes

19. Number of Live Births

_____

20. When was your last menstrual Period?

_____

21. What methods of birth control do you use?

_____

Family History

Are you adopted? (Yes / No)

Please indicate if any immediate family members have had any of the following conditions:

	Father	Mother	Brother	Sister	Children	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa
Substance abuse									
Alzheimer's Disease/Dementia									
Cancer: (if yes, please indicate what type of cancer).									
Diabetes									
Emotional/Mental Illness									
Suicide									
High Blood Pressure									
Heart Attack Prior to Age 55									
Heart Disease									
Thyroid Disease									
Osteoporosis									
Stroke									
Tuberculosis									
Kidney Disease									
Epilepsy / Convulsions									
Other non-accidental death prior to age 50									

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Patient Consent for the Use of Email and/or Text Message Communication

Health Clinics of Utah recognizes the benefits to the efficient exchange of information with our patients and employs safeguards and precautions to protect patient privacy. At the same time, we understand the inherent risks that email and text messaging present to the security of health information.

However, should you prefer that your Health Clinics of Utah provider communicate to you electronically such as through email or text messaging, please indicate such communication is acceptable to you by completing the Consent below. This consent may be revoked at any time should you change your mind.

You are not required to authorize the use of email and/or text messaging and a decision not to sign this consent will not affect your health care in any way. If you prefer not to authorize the use of email and/or text messaging we will continue to use U.S. Mail or telephone to communicate with you.

☐ I prefer to receive communication via email

Preferred Email Address:_____

☐ I prefer to receive communication via text messaging

Preferred Phone No.: _____

Name (Please Print) : _____

Alternate Phone No.: _____

Signature of Patient/Authorized Representative Date

PLEASE READ CAREFULLY BEFORE SIGNING

Authorization for Medical and/Or Surgical Treatment

I voluntarily consent to outpatient care and treatment performed by health care providers and staff at Health Clinics of Utah. This consent includes examinations, consultations, lab procedures, and medical treatments, which my provider may consider necessary or advisable. I am aware that the practice of medicine is not an exact science and I further acknowledge the results of any treatments, tests, or care cannot be guaranteed.

I understand I have the right to make informed decisions regarding all care and treatments, and that I should ask my health care provider to further clarify or explain anything I do not understand. I also acknowledge I have the right to refuse any drugs, treatment, or procedures to the extent permitted by law. I authorize treatment of any of my minor children herein listed.

Signature of Patient/Authorized Representative Date

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In accordance with Senate Bill 20, State Security Standards for Personal Information, passed by the Utah Legislature in the General Session, we are hereby informing you that if you are enrolled in Medicaid Insurance, the Health Clinics of Utah may share your information with the Medicaid Eligibility Database or Children's Health Insurance Program (CHIP).

Insurance Information

Patient Name:			SSN:
Address:			
Phone No.	DOB:	Age:	Sex:
Employer:		Relationship to insured:	

Primary Insurance

Insured's Name:			
SSN:			
Address:			
Phone No.	DOB:	Age:	Sex:
Employer:		Relationship to insured:	
Insurance Company:			Phone No.:
Address:			
ID:		Group No.:	

Secondary Insurance

Insured's Name:			
SSN:			
Address:			
Phone No.	DOB:	Age:	Sex:
Employer:		Relationship to insured:	
Insurance Company:			Phone No.:
Address:			
ID:		Group No.:	

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AGREEMENT AND ACCEPTANCE OF FINANCIAL RESPONSIBILITY

Financial Responsibility. I understand the services provided by Health Clinics of Utah, today or in the future, may or may not be services covered by my health insurance plan. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. I understand I am financially responsible for the payment of co-payments, co-insurance, and deductibles that may be required under the terms of my insurance plan, as well as any non-covered services under the terms of my insurance plan. If my insurance carrier denies any part of my claims, or if I do not have insurance that covers the services I receive, I understand I am financially responsible for any amount due.

I understand and agree any amounts not paid within 30 days of the date of service may accrue interest at the rate of 1.5% per month (18% per year) on any unpaid account balance. I understand there will be a charge of $20 for any returned checks.

Assignment of Benefits. In consideration of the services provided at Health Clinics of Utah, I hereby assign and transfer to Health Clinics of Utah any and all benefits payable to me, including Medicare and Medicaid payments, from insurance carriers or other third party. I understand I am financially responsible for any amount not covered or paid by my insurance benefits authorized by this assignment.

I understand it is my responsibility to provide Health Clinics of Utah with current and accurate insurance information, including any updates or changes in coverage.

I acknowledge that I have carefully read that above and hereby agree to the terms and conditions as set forth. I have had the opportunity to ask questions and if so, understand the answers.

(Signature of Patient/Authorized Representative) Date

Witness Date

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HEALTH CLINICS OF UTAH

NO SHOW POLICY

Health Clinics of Utah has a no show policy requiring patients to cancel their appointments **24 hours** in advance. Failure to do so will result in a penalty fee that must be paid prior to scheduling any future appointments.

If the clinic is closed, please leave a message on the answering machine. It will tell us when you called.

The no show fee charged will depend entirely upon appointment type and the amount of time that was scheduled. A fee of $5.00 is required for appointments scheduled less than 30 minutes. A fee of $10.00 is required for time scheduled 30 minutes or more and includes all appointments with chiropractors, specialists and/or volunteer physicians. A fee of $20.00 will be required for Form 20's and appointments scheduled one hour or more.

Thank you,
Administration

Signature of Patient / Authorized Representative Date

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Notice of Privacy Practices
FAMILY DENTAL PLAN (FDP) and HEALTH CLINICS OF UTAH (HCU)

This Notice describes how medical and health information about you or your child may be used and disclosed and how you can get access to the information. Please review it carefully.

PRIVACY PROMISE

FDP/HCU understands that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information. We use your health information (and allow others to access it) only as permitted by federal and state laws. These laws give you certain rights regarding your health information.

HOW WE USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

When you receive care from FDP/HCU, we may use your health information for treating you, billing for services, and conducting our normal business known as health care operations. Examples of how we use your child's information include:

1. **For Treatment** - We keep records of the care and services provided to you. Health care providers use these records to deliver and coordinate quality care to meet your needs. For example, your doctor may share your health information with a specialist who will assist you in your treatment. Some health records, including confidential communications with mental health professionals, substance abuse treatment records, and genetic test results, may have additional restrictions for use and disclosure under state and federal laws.

2. **For Payment** - We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to verify Medicaid or State Children's Health Insurance Program coverage through an inquiry to the State eligibility database, or to obtain payment from you, your insurance company, or another third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services that may need prior notice or approval. For example, we may disclose information about the services provided to you to claim and obtain payment from your insurance company.

3. **For Health Care Operations** - We use health information to improve the quality of care, train staff and medical students, provide customer service, arrange costs, conduct required business duties, and make plans to better serve our communities. For example, we may use your health information to evaluate the quality of treatment and services provided by our physicians, nurses, and other health care workers.

OTHER USES OF YOUR HEALTH INFORMATION

We may also use your health information to recommend treatment choices and tell you about services, community resources and family support that may benefit you. We may remind you of an appointment and share information with third parties who assist us with treatment, payment, and health care operations.

YOUR INDIVIDUAL RIGHTS

You have the following rights:

Right to Receive a Copy of this Notice. Upon request, you have the right to receive a paper copy of this Notice. Copies are available at any time, at any of our FDP or HCU clinics, or at our web site, health.utah.gov/clinics.

Right to Inform Us of How to Best Communicate with You. You can specify how we can best communicate with you using information such as a phone number, address or e-mail. You can decide if you do not want us to remind you of your upcoming appointments. When you make the appointment, let the scheduling staff know if you do not want these reminders. The staff will assist you in completing a written request.

Right to Inspect and Copy Your Health Information. Upon written request, you have the right to access and obtain a copy of your health information maintained by us. Please contact the DFP or HCU Privacy Officer (DFP: 801-273-6642; HCU: 801-395-6401) to request the information you need to access. In person: You will need to fill out a request form and present a picture ID. Our staff can assist you with completing this form. By mail or FAX: You will need to request and complete a request form and submit a copy of your picture ID.

Right to Amend Your Health Information. You have the right to request, in writing, that we amend health information maintained in your health record. We will comply with your request in the event that we determine the information that would be amended is false, inaccurate or misleading. Please contact our Privacy Officer (DFP: 801-273-6642; HCU: 801-395-6401), who can review the request and help you contact the correct provider being requested to amend the health information.

Right to Request Additional Restrictions on Uses and Disclosures of Your Health Information. You have the right to request in writing that we place additional restrictions on how we use or disclosure your personal health information. We will consider all requests for special restrictions carefully and implement those required by law and carefully consider other requests. We may not always be able to grant some requests. We are not required to agree to any restriction except where you have paid for the health care service in full. Please contact our Privacy Officer (DFP: 801-273-6642; HCU: 801-395-6401), who will help you complete a request form to request additional restrictions on how we may use and disclose your personal health. We will notify you in writing when a request cannot be granted.

Right to Request an Accounting of Disclosures. You have a right to request in writing an accounting of certain disclosures made by us of your personal health information. For each disclosure, the accounting will include the date the information was disclosed, to whom, the address of the person or entity that received the disclosure (if known), and a brief statement of the reason for the disclosure. Please contact our Privacy Officer (DFP: 801-273-6642; HCU: 801-395-6401) for information you need to request an accounting of disclosures.

OUR PRIVACY RESPONSIBILITIES

FDP/HCU is required by law to:

Maintain the privacy of your health information.

Provide this notice that describes the ways we may use and share your health information.

Notify you if your health information was affected by a breach.

Follow the terms of the notice currently in effect.

You may revoke your authorization to share your health information at any time. Simply notify in writing the FDP/HCU facility that has your authorization on file. Please understand that we may not be able to get back health information that was shared before you changed your mind.

FDP/HCU complies with federal laws that require extra protection for your health information if you receive treatment in an addiction treatment program, or from a psychotherapist.

SHARING YOUR HEALTH INFORMATION

There are limited situations when we are permitted or required to disclose health information without your signed authorization (permission). These situations include:

Business Associates. There are some services that we provide through contracts with our

business associates. In such situations, we may disclose your personal health information to our business associates so they can perform the job we asked them to do. We require all business associates to appropriately safeguard your information, in accordance with applicable law.

Notification of Family and Close Friends. We may use or disclose your personal health information to notify a family member, personal representative or another person responsible for your care, provided you have the opportunity to agree or object to the disclosure. If you are unable to agree or object, we may disclose this information as necessary if we determine that it is in your best interest based upon our professional judgment. In all cases, we will only disclose the health information that is directly relevant to that person's involvement with your health care.

Required by Law. We may use or disclose your personal health information to the extent that we are required by laws to do so. The use or disclosure will be made in full compliance with the applicable law governing the disclosure.

Public Health Activities. We may disclose your personal health information to a Public Health Authority authorized by law to collect such information for public health activities.

Health Oversight Activities. We may make disclosures of your personal health information to a health oversight agency charged with overseeing the health care industry. Disclosures will be made only for activities authorized by law.

Judicial and Administrative Proceedings. We may disclose your personal health information in the course of any judicial or administrative hearing in response to an order of a court of administrative tribunal, or in response to a subpoena, discovery request of other lawful process where we receive satisfactory assurance that appropriate precautions have been taken. In all cases, we will take reasonable steps to protect the confidentially of your health information.

Law Enforcement. We may disclose your personal health information for a law enforcement purpose to law enforcement officials in compliance with and as limited by applicable law.

Research. We may use or disclose your personal health information without your authorization for research purposes when such research has been approved by an institutional review board that has reviewed the research to ensure the privacy of your personal health information or as otherwise allowed by law. No identifiable information will be disclosed without prior consent from you.

Victims of Abuse, Neglect or Domestic Violence. We may disclose personal health information to a government authority regarding an individual whom we reasonably believe to be a victim of abuse, neglect or domestic violence, including a social service or protective service agency authorized by law to receive reports of child abuse, neglect or domestic violence. Any such disclosures will be made in accordance with and limited to the requirements of the law.

Limited Government Functions. We may disclose your personal health information to certain government agencies charged with special government functions, as limited by applicable law. For example, we may disclose your health information to authorized federal officials for the conduct of national security activities, as required by law.

Coroners, Medical Examiners and Funeral Directors. We may disclose personal health information to a coroner or medical examiner to identify a deceased person, determine a cause of death or for other duties as authorized by law. We may also disclose personal health information to funeral directors in accordance with applicable laws.

Health and Safety. We may disclose your personal health information to prevent or lessen a serious threat to a person's or the public's health and safety. In all cases, disclosures will only be made in accordance with applicable law and standards of ethical conduct.

To a medical device's manufacturer, as required by the FDA, to monitor the safety of a medical device.

Workers' Compensation. We may disclose your personal health information in accordance with workers' compensation laws.

OTHER INFORMATION ABOUT PROTECTING YOUR PERSONAL HEALTH INFORMATION

Any sharing of your health information other than as described in this notice requires your written authorization. For example, we **WILL NOT** use your health information unless you authorize us in writing to:

Share any of your psychotherapy notes, if they exist, with a third party;

Share any of your health information with marketing companies; or

Sell any of your health information.

We may change this privacy notice at any time and we may use new ways to protect your health information. Our current privacy notice is posted in our clinics and in the facilities we utilize and on our website at health.utah.gov/clinics.

This notice of privacy practice describes the practices of FDP/HCU and of FDP/HCU's employees and volunteers working at any or our facilities. This notice also describes the privacy practices of affiliated health care providers – who are not employees of FDP/HCU – while treating you in a FDP/HCU facility, unless they provide you with a notice of their own privacy practices. (For more information about the specific privacy practices of affiliated providers, please contact them directly.)

Our Privacy Officer can help you with any questions or concerns you may have about the privacy of your health information. They can also help you fill out any forms that are needed to exercise your privacy rights.

CONTACT US

If you are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your health information contact:

Juli Miller FDP Privacy Officer Office: 801.273.6642 Email: julimiller@utah.gon http://health.utah.gov/clinics	Lauri Valerio HCU Privacy Officer Office: 801.374.7010 Email: laurivalerio@utah.gov http://health.utah.gov/clinics

We will investigate all complaints and will not penalize or treat you any differently for filing a complaint. You may also file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you with the information needed to file your complaint.

By Signing below, I certify that I have had the Utah Department of Health HCU and FDP Notice of Privacy Practice made available to me:

_____

(Patient Name) Please Print Date of Birth

_____

(Signature of Patient / Authorized Representative) Date