Alpine Center Medical Services: Patient Information ***Referred by:_____***

Patient Information

Patient Name: Marital Status: Married Single

Home Address:

City: State: Zip:

Email Address: (only fill out if you want us to use it)

Home Phone: Cell Phone:

Date of Birth: Social Security Number: Sex: Male Female

Emergency Contact: Contact Phone Number:

Primary Physician: Physician Phone Number:

Primary Insurance Information: **MUST PRESENT INSURANCE CARD(s) AT TIME OF SERVICE**

Primary Insurance Company: Employer:

Policyholder Name: Insurance ID #:

Policyholder Date of Birth: Insurance Group #:

Policyholder Social Security #: Sex: Male Female

Secondary Insurance Information (If applicable)

Secondary Insurance Company: Employer:

Policyholder Name: Insurance ID #

Policyholder Date of Birth: Insurance Group #:

Policyholder Social Security #: Sex: Male Female

Responsible Party Information (Person responsible for paying patient portion of the bill)

Name: Date of Birth:

Street Address:

City: State: Zip:

Home Phone: Cell Phone:

Patient Signature: ***Date:***

If patient is a MINOR, parent or guardian MUST sign for the patient.

Alpine Center Medical Services Consent to Release/Exchange Personal Information

Name of Client:_____

Date of Birth: _____/_____/_____ Social Security Number: _____-_____-_____

I do herby authorize Alpine Center Medical Services to share/receive information with:_____

Phone number of person/organization receiving the Information:_____

The following information; (Please indicate items to be released by marking with an "X")

___Admissions to Treatment
___Social History
___Discharge Summary
___Physical Examination
___Psychological Evaluation
___Treatment Plan
___Progess Notes, status, attitude and progress letters
___Other(specify)

_____

_____

For the purpose of:

___To comply with court order
___To obtain records
___To aid in treatment
___Application for insurance
___For follow up care
___For discharge planning
___To update medical records
___To update treatment records
___Other (Specify)

_____

_____

I understand that I may revoke consent at any time. Otherwise, I understand that this consent will remain in effect until one year following a formal and effective termination from the services provided or authorized by Alpine Center Medical Services or revocation of my release from confinement, probation, parole, or other proceeding under which I was mandated into treatment. I understand that the date derived from my participation in my treatment may be used for reasearch purposes, so long as my anonymity is in accordance with federal, state and professional research standards.

I also understand that any disclosure made is bound by 42 CFR Part 2 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse client records, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164 and that recipients of this information may ***not*** be re-disclosed unless otherwise provided for in the regulations or in connection with their official duties.

This consent is valid until _____

(Date, event or condition upon which consent expires)

Signature:_____Date: _____

Signature of Witness or Guardian _____Date: _____

Financial Policy

Effective 09/01/11

Alpine Center Medical Services
5689 S Redwood Road Suite 30
Salt Lake City, UT 84123
PH: 801-268-1715 FX: 801-268-1783

We are committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

***ALL CLIENTS/PATIENTS MUST COMPLETE OUR INFORMATION FORMS BEFORE SEEING THE MEDICAL/PROFESSIONAL PROVIDER.**

***FULL PAYMENT IS DUE AT TIME OF SERVICE.**

If you have valid health insurance coverage, you will only be expected to pay the patient portion at the time of service, this could be deductible or copay depending on your benefits. A $20.00 late fee will be added to your copayment if not paid on the day of your visit.

***WE ACCEPT CASH AND MAJOR CREDIT CARDS.**

***WE DO NOT ACCEPT CHECKS**

If you have insurance, we will help you receive the maximum reimbursement allowable. If your insurance requires pre-authroization for your visits, you are responsible for getting that before seeing the provider.

If you have valid health insurance, we will bill the insurance company for their portion of the bill. However you must pay the patient portion of the total charge at the time of service (including deductible) If your insurance company has not paid the FULL BALANCE within 60 days, you will be expected to pay the balance within 15 days. If your insurance then picks up the balance owed, we will issue you a refund check.

Refund checks with amounts over $50.00 will be made out to the person who issued the original payment, NOT the patient, for example if a parent or friend pays the balance over $50.00 that person will need to be in person and with ID to request this check be sent out to them, then allow 10 days.

Insurance is a contract between you and your insurance company. We are NOT a party to this contract in most cases. We will call your insurance and check your coverage and benefits, you are encouraged to do the same, and it is your responsibility to check whether or not the provider is contracted with your insurance company. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company regarding deductibles, copayments, covered charges, secondary insurances, "usual and customary" charges, litigiation, etc. Other than to supply factual information as necessary. We do not consider possible or pending court settlements as a reason for non payment of an account. We will not hold our bills until cases are settled. You are responsible for the timely payment of your account.

Any balances that appear on your statement, as patient responsibility may be subjected to a 25% A.P.R. finance charge. This will take effect once balances are more than 30 days old. If this account is referred to a collection agency you may have to pay reasonable attorney fees, court costs and collection agency commissions (30% of the balance owing).

No Show/Cancellation Policy: You as the patient are responsible for all fees accumulated by appointments that are no showed or cancelled with less than 24 hours notice. These fees cannot be billed to insurance. Fees for no showed appointments are $50.00 and fees for late cancellations are $30.00.

If Crime Victims, Voc Rehab and/or other government funded programs are covering your fees, please discuss your payment situation with our staff PRIOR to your visit.

DRUG TESTING/U.A's: Billing and charges for all Drug Testing is done separate from Alpine Center and separate from the programs. All drug testing is done through Dominion Diagnostics. A collector from Dominion Diagnostics is on site (at Alpine Center) to collect and send UA's to the lab for results. You may receive a bill from Dominion Diagnostics: 211 Circuit Drive, North Kingston, KI 02852. 401-667-0800

Thank you for taking the time to review our Financial Policy. Please let us know if you have any questions or concerns.

I have read and understand the terms of the Financial Policy.

Patient (or gaurdian if patient is a minor) Signature: _____Date:_____

Patient Name (Please Print): _____

Alpine Center Medical Services

CONSENT FOR TREATMENT AND CONSUMER RIGHTS

-Alpine Center Medical Services uses it's own form of treatment accordingly may vary from standard treatment of other treatment facilities. Alpine Center Medical Services will treat all clients with dignity and will not discriminate.

-Alpine Center Medical Services has my permission to act in medical and psychiatric matters on my behalf, including and limited to, prescribing and conducting treatment and therapy.

- Alpine Center Medical Services has made no promises or guarantees to me whatsoever.

- I have been provided with fee collection policies, financial arrangments and costs have been discussed with me.

- I freely and voluntarily wish to receive treament at Alpine Center Medical Services.

- Any of the information I have given will not be released to anyone who is not part of the Alpine Center Medical Services program unless I give consent for this information to be released by signing a patient release of information form.

- I have received a copy of Alpine Center Medical Services HIPPA privacy practices.

-Consumers have the right to privacy of information of current and closed records.

- Reasons for involuntary termination: Non-compliance with acceptable consumer behaviors, Non-compliance in treatment recommendations as outlined in each consumers treatment plan and/or Non-payment for rendered services.

- Re-Admission Criteria: Consumers may be re-admitted to the program at the sole discretion of the clinical team. Consumers will not be considered for re-admission unless reasons for involuntary termination have been resolved.

- Consumers have the right to be free from potential harm or acts of violence.

- Consumers are responsible for following their treatment plan once they have agreed to do so.

- Consumers are responsible to be courteous of the rights of other consumers as well as staff.

- Consumers have the right to communicate by telephone or in writing with family, attorney, physician, clergyman, counsleor, or case managers, except when contradicted by the treatment plan and the assigned licensed clinical professional.

- Alpine Center is a non smoking facility in accordance with the Utah Clean Air Act.

- The maximum consequence any consumer shall be given is involuntary termination of services.

I have read, agree to and understand the above stated consumer rights and I consent to receive treatment from Alpine Center Medical Services.

Signature:_____Date:_____Employee:_____

Alpine Center's Collections Policy

Alpine Center for Personal Growth and Alpine Center Medical Services
5689 S Redwood Road Suite 30
Salt Lake City, UT 84123

Policy Effective 08/01/2013

At Alpine Centers, we have created a policy for when members have gone to collections, go to collections or are about to go to collections. The policy is shall be for both, Alpine Center for Personal Growth and Alpine Center Medical Services. If you are in collections on one side, you will be discharged from both clinics, and not able to schedule until the following steps have been taken;

-If you have been sent to collections, you will be blocked on our schedule system, and not be able to schedule until your balance is paid in full to the collections company or to Alpine directly. This balance will include a 30% collections fee, in which you agreed to on the financial statement. If you have been sent to collections you have received multiple statements, letters, and warnings regarding your bill. Our system automatically sends out statements, which let you know how old your balance is, as well as you will receive delinquent notices. In MOST cases, if we have a valid phone number, you will receive a phone call, as well as the front desk will have informed you of your balance.
-If you have been sent to collections in the past, and have cleared your bill and continue to schedule with Alpine Center, there will NEVER be an exception to payment at time of service, under no circumstance. All payment (copayment or cash payment) will be expected in full at time of service. NO EXCEPTIONS.
-If you have been sent to collections and have insurance, we will bill your insurance promptly and insurance will have 30 days from the time the claim was sent, to pay this balance. If payment is not received by your insurance company, you will need to pay off the balance, and when and if insurance DOES pay, Alpine will refund you the amount you paid. If your balance is not paid within 30 days, you will not be able to reschedule until your balance is paid in full.

Current clients on the verge of collections;
-You will be informed by statements and by delinquent notices, as well as by the receptionist at your appointment that you have a balance owing. If you are on the list for collections, you will be notified by the front desk at your appointment and have to pay a minimum of 50% of your balance to be taken off the collections list. You will then have 30 days to pay that balance off or you will be sent to collections with an additional 30% collections fee added to your balance, as well as you will be discharged from both clinics.

I have read and understand the collections policy as stated above.

_____ _____

Patient or guardian signature ***Date***

Welcome to Apine Center: Please complete the following intake information to help us get to know you better. Thank you.

Name: _____ Date: _____

1. Please describe the main problem for which you are seeking care:

2. When did this problem begin?

3. How has the problem changed over time?

4. How does it affect you currently?

5. If here for substance abuse, what substances are you using and how much, how often and since when?

Prior History of Susbtance Abuse Treatment

Please list all prior substance abuse treatment. Please list names of clinicians, clinics, approximate dates, forms of treatment, and whether it was beneficial or not. For more space please write on the back of this page.

Prior History of Mental Health Treatment

Please list all prior mental health treatment. Please list names of clinicians, clinics, approximate dates, forms of treatment, and whether it was beneficial or not. For more space please use the back of the this page.

1. Do you have thoughts of suicide or homicide?

2. Do you feel like you will act on these thoughts?

3. Have you ever attempted suicide in the past? Please describe.

Abuse History
Have you ever been sexually, physically, or emotionally abused?

Family Psychiatric History
Has anyone in your family been treated for mental health or substance abuse problems? Please include any family history of suicide or substance abuse/alcoholism.

Legal History
Please describe any legal problems you have had.

Physical Health
Please describe any physical problems you have. For example: Epilepsy, gynecological problems, diabetes, irritable bowel disease, migraines, asthma, etc.

Medications:

Please list any medications you currently take. Include prescriptions and over the counter medications, as well as dosages, when you started the medicine and the effect of the medicine. Also include herbal products or supplements you take. Please use the back of this page if you need additional space.

Name of Medication	Dosage	Date Started	Effect

Please list any medications you have taken in the PAST:

Name of Medication	Dosage	Date Started	Effect

Allergies to medications or other substances: _____

_____

_____

Reviewed by: _____ Date: _____

Supervisor: _____ Date: _____

Alpine Center Medical Services LLC

Controlled Substance Treatment Agreement

I, _____ understand that in order to receive care for the treatment of pain, opioid dependency, or other mental health disorders with the use of controlled medications through Alpine Center Medical Services, I agree to and will comply with the following:

1. MENTAL HEALTH AND/OR PAIN MANAGEMENT AND/OR OPIOID DETOX CONSULTANT: A mental health assessment and/or continuing psychological therapy is required. If I am currently involved in mental health therapy, or if I enter such therapy I will authorize my mental health practitioner to exchange unrestricted information regarding my condition and treatment with my care provider at Alpine Center Medical Services.
2. USE OF MEDICATIONS: I will take all medications as prescribed. I will speak with my care provider at Alpine Center Medical Services before making any changes in either the dose or frequency of my medications. There will be no early refills of controlled medications without prior authorizations. Medications must all be obtained from the same pharmacy each time (any exceptions must be approved by my care provider at Alpine Center Medical Services).
3. SEEKING PRESCRIPTIONS: I will neither seek nor fill prescriptions for any controlled medications from any other health care providers.
4. MEDICAL RECORDS RELEASES: I will inform all of my health care providers that I receive medication management through Alpine Center Medical Services and will maintain an unrestricted and current medical records release on file with Alpine Center Medical Services.
5. DRUG SCREENINGS: I will participate in drug screenings as a part of my treatment plan. I understand that drug screenings may be conducted at least every month and may be required more frequently at the discretion of my primary care provider. Screenings may include urinalysis, blood testing or pills counts. I agree to pay all costs associated with drug testing not covered by my insurance. Refusal to submit to screening at the time specified may result in termination of services.
6. ILLEGAL AND NON-PRESCRIBED DRUG USE: I understand that the use of any controlled medication not prescribed by my care provider at Alpine Center Medical Services may result in termination of care. I authorize Alpine Center Medical Services to cooperate fully with any city, state, or deferral law enforcement agency, including this state's Board of Pharmacy, In the investigation of any possible misuse, sale, or other diversion of controlled medicines. I authorize Alpine Center Medical Services to provide a copy of this agreement to my pharmacy. I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations. I also understand that the use of any illegal substance, including marijuana, may result in termination of care by Alpine Center Medical Services.
7. LOST OR STOLEN MEDICATIONS: I agree to safeguard all medications prescribed by my care provider at Alpine Center Medical Services and understand that lost or damaged medications will NOT be replaced.
8. PRESCRIPTIONS WHILE TRAVELING: Alpine Center Medical Services may provide prescriptions for up to 90 days when the patients are traveling out of state. Patients will have to arrange for shipment of controlled substances by their pharmacy at their own expense. Patients who will be out of state longer than 90 days need to arrange for health care at their travel.

9. DRIVING AND OPERATING EQUIPMENT: Many medications can cause drowsiness and/or a very relaxed state of mind causing operation of equipment or vehicles to be dangerous. I agree to refrain from driving or operating dangerous equipment for 72 hours after any change in medication dosage and whenever I feel drowsy.
10. OTHER RESTRICTIONS AND/OR CONSIDERATIONS:
11. TERMINATIONS: I will no longer be eligible for care at Alpine Center Medical Services if I am in possession of illicit drugs or substances., trafficking in controlled or illegal substances, intoxicated or if arrested for DUI. If I alter my prescriptions in any way, sell or share my medication, I will no longer be eligible for care at Alpine Center Medical Services.

I UNDERSTAND AND AGREE TO THE CONDITIONS OF CARE DESCRIBED ABOVE AND WILL COMPLY WITH THEM, ALL OF MY QUESTIONS ABOUT THE TERMS OF THIS AGREEMENT HAVE BEEN ANSWERED TO MY SATISFACTION. FAILURE TO COMPLY WITH ANY OF THE TERMS OF THIS AGREEMENT MAY RESULT IN IMMEDIATE TERMINATION OF SERVICE AND PRESCRIPTIONS FROM ALPINE CENTER MEDICAL SERVICES.

Patient Signature_____Date_____

Print Patient Name: _____

Alpine Center Medical Services

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you may access this information. Please review it carefully.

Alpine Center Medical Services is committed to protecting your medical information. Alpine Center Medical Services through its programs are required by law to maintain the privacy of your medical information, provide this notice to you and abide by the terms of this notice.

HOW WE USE YOUR HEALTH INFORMATION

When you receive services from Alpine Center Medical Services, protected health information (PHI) about those services is created. This information becomes private and is protected by federal law. We may not release it to anyone without your written permission except in limited circumstances. 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 information include:

Treatment: We keep records of care and services provided to you. Health care and service providers use these records to deliver quality care to meet your needs. For example an employee of Alpine Center Medical Services may share your information with other treatment professionals who may assist in your treatment. Some health records, including confidential communications with a mental health professional, may have additional restrictions for use and disclosure under state and federal laws.

Payment: We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or other 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 services provided to you to claim and obtain payment from your insurance company.

Health Care Operations: We use health information to improve the quality of care, train staff and students, provide customer service, manage costs, conduct required business duties (auditing, business planning, obtaining legal services) and make plans to better serve the community. For example, we may use your health information to evaluate the quality of treatment and services provided by our therapists, social workers (licensing and credentialing, case management, obtaining medical review) and others in our treatment provider network (care coordination).

OTHER SERVICES WE PROVIDE:

We may use your health information to recommend treatment alternatives, tell you about health services and products that may benefit you, share information with family or friends involved in your care (with your permission) or payment for your care, and share information with third parties who assist us with treatment, payment and health care operations.

YOUR INDIVIDUAL RIGHTS:

You have the right to:

- Request restrictions on how we use and share your health information. We consider all requests for the restrictions carefully but are not required to agree to any restriction.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your health information, including billing records. Fees may apply. Under limited circumstances we may deny you access to a portion of your health information and you may request a review of denial.*
- Request corrections or additions to your health information.

- Request and accounting certain disclosures of your health information made by us. The accounting does not include disclosures made for treatment, payment and health care operation and some disclosures required by law. Your request must state the period of time desired for the accounting, which must be within 6 years prior to your request and exclude dated prior to April 14, 2003. Except for the costs of photocopying, the first accounting is free, but a fee will apply if more than one request is made within a 12 month period.
- Request a paper copy of this notice even if you agree to receive it electronically.

Requests marked with a * must be made in writing. Contact the Privacy Officer for the appropriate form for your request.

SHARING YOUR HEALTH INFORMATION

There are limited situation when we are permitted or required to disclose health information without your signed authorization. These situations are outlined below:

- For public health purposes such as reporting communicable diseases, work related illnesses, reporting births and deaths.
- To protect victims of abuse, neglect or domestic violence.
- For health oversight activities such as investigations, audits, inspections and administrative actions.
- For lawsuits and similar proceedings.
- When otherwise required by law.
- When requested by law enforcement as required by law or court order.
- To coroners, medical examiners, and funeral directors.
- For organ and tissue donations.
- For research approved by our review process under strict federal guidelines.
- To reduce or prevent a serious threat to public health and safety.
- For Workers Compensation or other similar programs if you are injured at work.
- For specialized government functions such as intelligence and national security.

All other uses and disclosures, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement, except for authorized releases, which have already been made. Releases to law enforcement and courts cannot be revoked.

OUR PRIVACY RESPONSIBILITIES

Alpine Center Medical Services is required by law to:

- Maintain the privacy of your health information.
- Provide the notice that describes the ways we may use and share your health information.
- Follow the terms of the notice currently in effect.

We reserve the right to make changes to this notice at any time and make the new privacy practices effective for all information we maintain. Current notices will be posted in the admission and all treatment facilities. You may also request a copy of any notice directly from Alpine Center Medical Services.

CONTACT US

If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or have any concerns at all please contact Alpine Center Holdings Office at:

5689 S Redwood Road Suite 30
Salt Lake City, UT 84123

We will investigate all complaints and will not retaliate against you for filing a complaint.

You may also file a complain with the Department of Human Services, Department of Licensing:

Phone: 801-538-4242
195 N 1950 W
Salt Lake City, UT 84116

And also to The Joint Commission, our accreditation agency:

Fax: 630-792-5636
One Renaissance Blvd.
Oakbrook Terrace, IL 60181
Or online at: https://www.jointcommission.org/report_a_complaint.aspx

Agreement to Mediate

This Agreement to Mediate (the "Agreement") is entered into by and between the undersigned (the "Client"), the Client's parent or guardian, if applicable, and Alpine Center Holdings, LLC, a Utah limited liability company, or its affiliates (collectively, the "Company").

In exchange for good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Mediation. The Client agrees that any dispute related to the care the Company provides to the Client, including but not limited to, any claims that such care rendered by the Company was unnecessary or unauthorized or was improperly, negligently, or incompetently rendered, shall first be submitted to mediation before the Client may file any lawsuit or other legal proceeding. The Client agrees to make a good faith effort to resolve any such dispute during mediation. If the parties are not able to resolve the problem on their own, either party may submit to the other party a demand to mediate the dispute.

2. Applicable to All Claims. The Client agrees that it is the intention of the Company that this Agreement bind all parties whose claims may arise out of or be related to the treatment or services provided by the Company, including but not limited to, any spouse, children, or heirs of the Client at the time of the occurrence giving rise to any such claim. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the Company, its members, managers, employees, representatives, and agents must be mediated including, without limitation, claims for punitive damages.

3. Procedure and Jurisdiction. In the event, either party delivers to the other a demand to mediate pursuant to Section 1 of this Agreement, the parties shall mutually select a mediator within fifteen (15) days to resolve the dispute. If the parties cannot mutually agree on a mediator, each party shall select a mediator and the selected mediators shall mutually select an independent mediator. The parties agree that the independent mediator shall be the sole mediator to help the parties resolve the dispute. If the parties are not able to resolve their dispute through mediation, then either party may file a lawsuit in district court. Each of the parties agrees that any lawsuit must be filed in the state or federal courts located in Salt Lake County, Utah. Utah law shall govern any proceeding filed to resolve a dispute between the parties.

4. Expenses. Each party to the mediation shall pay such party's pro rata share of the expenses and fees of the mediator. Each party shall be responsible for its own attorneys' fees and other costs that the party may incur to prepare for and participate in mediation.

5. Attorneys' Fees. If either party files a court proceeding of any kind without first participating in mediation in good faith, the filing party shall be liable to the non-filing party for any expenses the non-filing party incurs to defend such court action, including but not limited to, reasonable attorneys' fees and costs.

Dated effective _____.

CLIENT:	PARENT OR GUARDIAN (if Client is under 18)
_____	_____
Signature	Signature
_____	_____
Printed Name	Printed Name