

**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 IHC Health Services, Inc. ("Intermountain Healthcare") and any person or entity employed by Intermountain Healthcare as well as independent persons or entities not employed by Intermountain Healthcare whose practice is primarily in an Intermountain Healthcare hospital or facility (such as anesthesiologists, radiologists, pathologists, emergency room physicians, etc.).
- 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, the Federal Arbitration Act and 78-14-1 through 78-14-16 of the Utah Healthcare Malpractice 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 it is postmarked. The notice shall be mailed to “Intermountain Healthcare Dispute Resolution” Attn: Risk Management, 36 South State Street, 16th Floor, Salt Lake City, UT 84111-1486 and must include your name, birth date and signature. 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 at: “Intermountain Healthcare Dispute Resolution” Attn: Risk Management, 36 South State Street, 16th Floor, Salt Lake City, UT 84111-1486. You must include your name, birth date and signature. 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 Explanation of Arbitration**

I have had the opportunity to ask questions and to have my questions answered. I understand that any Claims I might have must be resolved through the dispute resolution process described in this Agreement instead of being 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 canceled 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.**

IHC Health Services, Inc.

*Linda Leckman MD*

By: **Linda Leckman, M.D.**  
CEO and Vice President of Intermountain Medical Group

\_\_\_\_\_  
Name of Patient (Print)

\_\_\_\_\_  
Signature of Patient or Patient’s Representative (Date)

For office use only: MRN:m \_\_\_\_\_



PATIENT NAME LAST, FIRST, MI	DATE OF BIRTH (MO / DAY / YR)	MEDICAL RECORD #
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**As either the Patient or the legally authorized representative of the Patient, on behalf of the Patient receiving care in this IHC Health Services, Inc. (Intermountain) facility, I make the following consents, understandings, and agreements on my own behalf and on behalf of the Patient, in partial consideration of health care services to be provided to the Patient in the Facility:**

**Consent for Services:** I hereby give consent to the Facility, its contractors, physicians, and employees to provide health care services to the Patient and to administer physician orders for the benefit of the Patient for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that there is a risk of substantial and serious harm involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made. I understand and accept that there is some uncertainty involved in the health care services for which this consent is given. I understand that physicians are separately responsible to explain what they do and, in some cases, to obtain separate consent for some of the services they perform.

**Independent Contractors:** I understand that some physicians and other health care providers furnishing service to the patient, including residents, interns and other persons in training may be independent contractors and not employees of Intermountain; some may be employees of the State of Utah, the University of Utah Hospital, and / or University of Utah School of Medicine. University and State employees are subject to provisions of the Utah Governmental Immunity Act, UCA 63-30-1, et seq., U.C.A. 1953 as amended, which controls all procedures and provisions with respect to any claim of liability or malpractice involving such individuals.

**Release of Information:** The Facility is required by law to make and keep records of the Patient's medical treatment. The Facility safeguards those records and it uses and discloses such records and the information they contain only in accordance with the State and Federal privacy laws. Such uses and disclosures are described in detail in the Facility's Notice of Privacy Practices, which may be amended from time to time. I understand that either the Patient or I may ask to see a copy of the current notice at any time.

**Assignment of Benefits:** Any and all benefits from insurance companies and other third party payors that are payable to the Patient or on behalf of the Patient for health care services and related payments for services rendered or provided to the Patient are hereby transferred and assigned to the Facility for the exclusive purpose of paying for charges associated with the health care services provided to the Patient in the Facility. I understood and intend that all insurance companies and other third party payors will pay benefits directly to the Facility in payment of the Facility's charges and the charges of any other health care providers for whom the Facility is authorized to bill in connection with health care services provided to the Patient.

**Financial Responsibility:** Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all the health care services rendered to the Patient in the Facility including but not limited to any amounts not paid by any insurance company or other third party payor (excluding contract discounts). Patient and the undersigned, if other than the Patient, remain responsible for all co-payments, deductibles, co-insurance, and / or non-covered services regardless of amount paid by insurance or third party payor. I understand and agree that any amounts not paid within 30 days of the date of the Facility's bill or statement for payment shall accrue interest at the rate of 1 1/2% per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed with a collection agency or attorney for collection, Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay costs and reasonable attorney's fees in connection with the collection process. A service charge may be collected in connection with any check or other instrument tendered by the Patient or the undersigned but returned unpaid to the Facility.

**Medicare / Medicaid / Tricare Patient's Certification:** I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, other intermediaries or carriers, or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the Facility for its charges and for any charges of physicians or other providers for whom the Facility is authorized to bill in connection with its service.

**The following applies if initialed at the end of this paragraph:** Because of the Patient's strongly held religious beliefs, this consent does not include consent to administer blood or blood products unless the Patient subsequently agrees otherwise. The Patient understands that this limitation may cause some health care providers to decline to provide care, and may, in the opinion of some providers, adversely affect the outcome of the care.

Date: \_\_\_\_\_ Initials: \_\_\_\_\_

The undersigned signs this document either as the Patient or as the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document. This document will remain in effect unless revoked in writing.

Date:	Signature:
Witness To Signature:	Relationship if other than patient:

I hereby acknowledge that I have received or been offered a copy of Intermountain's Notice of Privacy Practice. Date: \_\_\_\_\_ Initials: \_\_\_\_\_

NOMBRE DEL PACIENTE APELLIDO, PRIMER NOMBRE, SEGUNDO	FECHA DE NACIMIENTO (MES / DÍA / AÑO)	HISTORIAL MÉDICO #
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Ya sea como Paciente o como representante legalmente autorizado por el mismo, en representación del Paciente que recibe atención en este centro de IHC Health Services, Inc. (IHC), hago los siguientes consentimientos, entendimientos y acuerdos a nombre propio o en nombre del Paciente, en consideración parcial de los servicios de atención médica que le proveerán al Paciente en este centro:

**Consentimiento para servicios:** Por medio de la presente autorizo al Centro, sus contratistas, médicos y empleados para que le provean al Paciente servicios de atención médica, apliquen las órdenes del médico para el beneficio del Paciente en esta consulta, así como en cualquier otra en lo sucesivo. Entiendo que la presente autorización puede revocarse por escrito en cualquier momento. Entiendo que hay un riesgo de daños generales y graves implicados en tales servicios, y acepto dichos riesgos con la esperanza de obtener resultados beneficiosos de tales servicios. No se han hecho promesas de ningún resultado en particular o resultado exitoso. Entiendo y acepto que hay cierta incertidumbre en los servicios de atención médica por los cuales se da este consentimiento. Entiendo que los médicos son individualmente responsables de explicar lo que ellos hacen y, en algunos casos, de obtener consentimiento por separado para algunos de los servicios que ^prestan.

**Contratistas independientes:** Entiendo que algunos médicos y otros proveedores de atención médica que proveen servicio al Paciente, incluyendo los residentes, internos y otras personas que se hallen capacitándose, pueden ser contratistas independientes y no empleados de IHC; algunos pueden ser empleados del Estado de Utah, del Centro Médico de la Universidad de Utah y/o de la Facultad de Medicina de la Universidad de Utah. Los empleados de la Universidad y del Estado están sujetos a las estipulaciones de la Ley de Inmunidad Gubernamental de Utah, UCA 63-30-1, y la que sigue, U.C.A. 1953, según fue enmendada, la cual controla todos los procedimientos y estipulaciones con respecto a cualquier reclamación de responsabilidad o negligencia médica que involucre a dichas personas.

**Divulgación de información.** La ley exige que el Centro haga y guarde registros del tratamiento médico del Paciente. El Centro protege esos registros y usa, y divulga los mismos, así como la información que contienen, únicamente de acuerdo con las leyes de privacidad federales y estatales. Tales usos y divulgaciones se describen en detalle en el Aviso de Prácticas de Privacidad, el cual puede ser enmendado de vez en cuando. Entiendo que tanto el Paciente como yo, podemos solicitar ver una copia del aviso actual en cualquier momento.

**Asignación de beneficios:** Todos los beneficios de las compañías de seguros y de otros terceros pagadores de los servicios de atención médica del Paciente, y todos los pagos relacionados por servicios prestados o provistos al Paciente en el Centro, son transferidos y asignados al mismo, con el propósito exclusivo de obtener el pago de los cargos relacionados con los servicios de atención médica provistos al Paciente en este Centro. Entiendo y acepto que todas las compañías de seguros y demás terceros pagadores abonarán los beneficios directamente al Centro en pago de los cargos del mismo y de cualquier otro cargo de proveedores de atención médica para quienes el Centro esté autorizado a facturar por los servicios de atención médica provistos al Paciente.

**Responsabilidad financiera.** El Paciente y el abajo firmante, si no es el Paciente, conjuntamente y por separado, están de acuerdo en pagar por todos los servicios de atención médica prestados al Paciente en el Centro, incluyendo, pero sin limitarse, a cualquier monto que no sea abonado por las compañías de seguros u otro tercero pagador (excluyendo los descuentos por contrato). El Paciente y el abajo firmante, si no es el Paciente, también son responsables de pagar todos los copagos, deducibles, seguros secundarios y/o todos los cargos por servicios que no estén cubiertos, sin reparar en el monto pagado por el seguro o cualquier otro tercero pagador. Entiendo y acepto que los pagos que no se efectúen en un plazo de 30 días a partir de la fecha de facturación o cuenta de pago del Centro, acumularán interés a una tasa mensual de 1 1/2 % (18% anual) sobre el saldo impago. En caso de que cualquier saldo a pagar se ponga en manos de una agencia de cobros o abogado a fin de cobrar lo que se debe, el Paciente y el abajo firmante, si no es el Paciente, conjuntamente y por separado están de acuerdo en pagar por los gastos y los honorarios razonables del abogado con respecto al proceso de cobro. Se cobrará un determinado monto en concepto de cargos de servicio, por cualquier cheque o documento presentado por el Paciente o por el abajo firmante que sea devuelto impago al Centro.

**Certificación del paciente por Medicare / Medicaid / Tricare:** Certifico que la información dada al solicitar el pago bajo los Títulos XVIII y XIX de la Ley del Seguro Social, o en conexión con cualquier otro programa del gobierno, es correcta. Autorizo a cualquiera que posea información médica o de otro tipo acerca de mi persona, a que facilite a la Administración del Seguro Social, a sus intermediarios o aseguradores, o al Estado, cualquier información que sea necesaria para tramitar una reclamación de pago por éste o cualquier otro servicio. Solicito que el pago de los cargos autorizados se haga a mi nombre, directamente al Centro por sus cargos y por cualquier otro cargo de los médicos o de otros proveedores para quienes el Centro esté autorizado a facturar por sus servicios.

**Lo siguiente se aplica únicamente si la persona ha puesto sus iniciales al final de este párrafo:** Debido a creencias religiosas firmemente arraigadas en el Paciente, la presente autorización no incluye el consentimiento para administrarle sangre o productos sanguíneos, a menos que el Paciente lo apruebe con posterioridad al presente. El Paciente entiende que esta limitación puede causar que algunos proveedores de atención médica se nieguen a prestar dicha atención, o que puede, en opinión de algunos proveedores, afectar en forma adversa los resultados de dicha atención médica.

Fecha: \_\_\_\_\_ Iniciales: \_\_\_\_\_

El abajo firmante firma este documento ya sea como Paciente, o como el agente o representante del Paciente, autorizado para firmar este documento, y para aceptar y estar de acuerdo con las condiciones del mismo en nombre del Paciente. He leído lo anterior y he tenido la oportunidad de hacer cualquier pregunta al respecto. He quedado satisfecho con las respuestas a dichas preguntas y firmo abajo para indicar mi total entendimiento del acuerdo. Entiendo que tengo derecho a solicitar y obtener una copia de este documento. El presente documento mantendrá su validez a menos que sea revocado por escrito.

Fecha:	Firma:
Testigo para firmar:	Relación, si no es el paciente:

Por el presente reconozco que recibí o me fue ofrecida una copia del Aviso de Prácticas de Privacidad Intermountain. Fecha: \_\_\_\_\_ Iniciales: \_\_\_\_\_