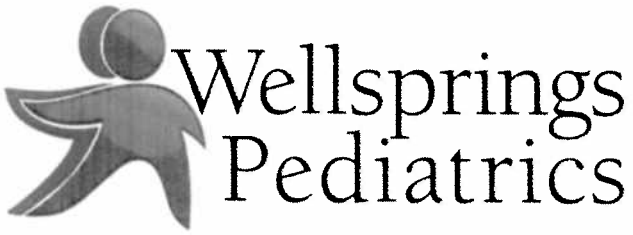


Pediatric Patient Demographic Sheet

Today's Date _____

PATIENT INFORMATION

Full Name: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** ____

Address: _____ **Social Security #:** _____

City, State, Zip: _____ **Preferred Pharmacy:** _____

Home Phone #: _____ **Alternate Phone #:** _____

Emergency Contact and Phone #: _____

Mother's Name: _____ **Father's Name:** _____

Mother's Phone #: _____ **Father's Phone #:** _____

RESPONSIBLE PARTY **(if same leave blank)**

Full Name: _____ **Date of Birth:** _____

Social Security #: _____ **Phone #:** _____

Address: _____ **City, State, Zip:** _____

Employer and Phone #: _____

ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE
PLEASE COMPLETE THE INSURANCE SECTION – (EVEN IF COPIES HAVE BEEN MADE OF YOUR INSURANCE CARDS)

PRIMARY INSURANCE: **Insurance Name:** _____

Policy # _____ **Group #:** _____

Policy Holder Name: _____ **Policy Holder Date of Birth** _____

Policy Holder Social Security # _____ **Relationship to Patient:** _____

SECONDARY INSURANCE: **Insurance Name:** _____

Policy # _____ **Group #:** _____

Policy Holder Name: _____ **Policy Holder Date of Birth** _____

Policy Holder Social Security # _____ **Relationship to Patient:** _____

Was this an accident? Yes_____ No_____ Date of Accident_____
If so please indicate: Auto_____ Worker's Comp_____ Other_____

FINANCIAL POLICY (please initial)

We strongly feel all patients deserve the very best medical care that we can provide. Everyone benefits with financial arrangements are agreed upon. We have prepared this material to acquaint you with our policy.

Our professional services are rendered to you, not the insurance company. Payment for treatment is your responsibility.

_____ SELF PAY PATIENTS: I have no medical insurance coverage I understand that I am responsible for payment of services rendered to myself of dependents at the time of service.

_____ ALL PATIENTS: I understand if I fail to pay amounts owed; the clinic has the right to secure an on outside collection agency and/or attorney to collect the unpaid debt and to report the unpaid debt to a credit -reporting agency. I further understand that I will be responsible for any additional charges or fees necessitated by securing the collection agency or attorney, including reasonable attorney's fees.

_____ INSURANCE AUTHORIZATION: I hereby authorize the release of any information necessary to process insurance claims and request payment of benefits to be made for services rendered to my dependents or myself.

_____ CO-PAYMENT, COINSURANCE, DEDUCTIBLE: I understand I am responsible *at the time of service* for paying any required co-payment, coinsurance and/or deductible.

ALL CHECKS ARE PROCESSED ELECTRONICALLY.

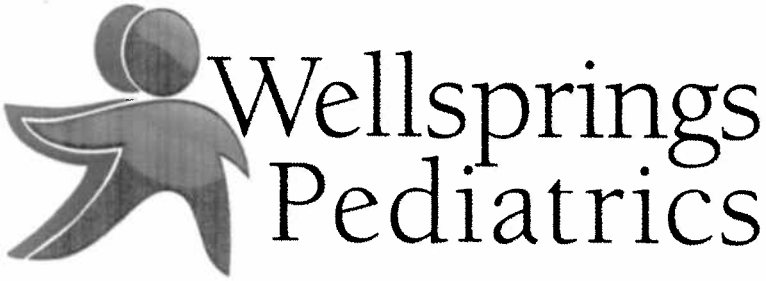
THERE WILL BE A $25.00 CHARGE ON ALL RETURNED CHECKS.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY OF THIS OFFICE AND AGREE TO ABIDE BY THE SAID POLICY.

_____ _____
Patient/Parent/Guardian Date

Please present both your insurance card and your driver's license so we may make a copy for our records.

Tooele Clinic Corporation



Dear Patient,

The US Department of Health and Human Services and the U.S. Centers for Disease Control and Prevention (CDC), working with several Accrediting organizations – Joint Commission, the National Committee for Quality Assurance and URAC – have set standards requiring the collection of race, ethnicity and language data in order to track health care disparities and help promote equity.

Details about this requirement can be found on www.hhs.gov or www.ahrq.gov.

While it is compulsory that we ask these questions, you may decline to answer.

Please Complete and return to Receptionist BEFORE you see the Provider.
Please check here if you decline to answer these questions. _____

Demographic information (please circle appropriate response)

Race: American Indian or Alaska Native Asian Black or African American

Native Hawaiian or Pacific Islander Caucasian Other (Please specify)_____

Ethnicity: Hispanic or Latino Not Hispanic or Latino_____

Primary Language: English ___ Other (please specify) _____

Name _____DOB_____

Wellsprings Pediatrics

Today's Date: _____

Patient Name: _____ DOB: _____

PLEASE BE SURE TO SUPPLY THE NURSE A COPY OF THE PATIENTS IMMUNIZATION RECORD

Reason for Visit: _____

Preferred Pharmacy: _____

MEDICATIONS:

Medication Name:	Dosage:	Medication Name:	Dosage:

ALLERGIES:

Drug/Food Name:	Reaction:	Drug/Food Name:	Reation:

SOCIAL HISTORY:

Diet Type (regular/vegan etc.)		
General Stress Level	Low medium high	
Exercise Level	None occasional Moderate heavy	
Sporting Activities		
Seat Belt uses routinley	yes no	
Sunscreen used routinley	yes no	
Exposed to Second hand smoke?	yes no	
Caffeine Intake	yes no	How Often:
Fluoride In Home Water?	yes no unknown	
Teens: Smoking status	yes no	How Much:
Teens: Alcohol Intake	yes no	How Much:
Teens: Illicit Drugs	yes no	Type:
Teens: Sexually Active	yes no	Protected Sex? yes no

SIBLINGS:

Name:	Age:	Name:	Age:

PARENTS:

MOTHER'S NAME:	DOB:
FATHER'S NAME:	DOB:

PAST MEDICAL HISTORY:

	Y/N	Notes		Y/N	Notes
ADHD			GERD/Acid Reflux		
Allergies			German Measles		
Asthma/Breathing Problems			Headaches/Dizziness		
Bladder/Kidney Problems			Heart Murmur/Valvular Disease		
Blood Disease			Hernia		
Broken Bones			Hypoxemia		
CHF			Abnormal Weight Loss		
Chicken Pox			Parathyroidism		
Chronic Pain			Pulmonary Hypothyroidism		
Congenital Anomalies			Seizures or Convulsions		
Constipation			Serious/Traumatic Injuries		
Developmental or Behavioral Disorders			Skin Problems		
Diabetes			Vision or Eye Problems		
Ear/Hearing Problems			Other (please list)		

BIRTH HISTORY:

Gestational Age		Vaccines Given	
Gestational Weight		Hearing Screening Given	
Birth Height		City/State of Birth	
Birth Weight		Birth Hospital	
Hospital Course			

	Y/N	Notes		Y/N	Notes
Breathing Problems			Low Apgar Score		
C-Section			Maternal Infection		
Clavicle Fracture			NICU Admit		
Congenital Anomalies			Premature Rupture of Membranes		
Fetal Distress			Preterm Labor		
Infection			Scalp Bruise		
Intubation			Vacuum Extraction		
Jaundice			Group B Positive		

SURGICAL HISTORY:

Type:	Date:	Type:	Date:

FAMILY HISTORY: **Please specify if it's Maternal or Paternal. Include uncles, aunts, grandparents, cousins, parents and siblings. Please Circle all that apply.**

Problem:	Who:	Problem:	Who:
Asthma / cystic fibrosis / other lung disease		Heart Attack	
Attention Deficit Disorder		High Blood Pressure	
Bipolar Disorder/schizophrenia		Kidney Problems	
Clef Palate / birth defect		Blindness / eye Problem / cross-eyed	
Cancer		Liver Failure or Hepatitis	
Thyroid Disease		Lupus or rheumatoid arthritis	
Depression		Problems w/ drugs or alcohol	
Diabetes		Seasonal Allergies / hay fever	
Eating Disorders		Seizures	
Eczema		Learning Disorder/ Mental Retardation	
Hearing loss/aids as a child		Bowel Problems	
Ulcers		Sudden Infant Death / Sudden Death / Long QT Syndrome	

FEMALE PATIENTS ONLY:

Date of First Period:		Date of Last Period:		Cramping: Y or N
Period: Regular or Irregular	Birth Control: Y or N	Type of Birth Control:		

Wellsprings Pediatrics

GENERAL CONSENT FOR TESTS, TREATMENT, PHOTO, VIDEO AND SERVICES.

I consent to examinations, blood tests (including blood test for communicable diseases such as hepatitis and HIV/AIDS when healthcare personnel have been exposed to my blood and/or body fluids), laboratory and imaging procedures, medications, infusions, nursing care and other services or treatments rendered by my physician, consulting physician(s), fellow(s), resident(s), intern(s), and their associates and assistants, or rendered by facility personnel under the instructions, orders or direction of such physician(s), fellow(s), resident(s), or intern(s).

I agree and understand that all physicians (including fellows, residents, and interns), dentists, oral surgeons, and podiatrists involved in my care in any way are responsible and liable for their own acts and omissions, and the facility is not responsible or liable for the acts or omissions of the aforementioned. Service may be performed by independent contractors who are not employed by the facility. I am aware that the practice of medicine is not an exact science; and further understand that no guarantee has been or can be made as to the results of the treatments, care or examination in the facility.

I have been informed of the treatment procedures considered necessary for me and that the treatments/procedures will be directed by a physician and may be performed by such physician and/or one or more additional physicians, fellows, residents, interns, and employees of the facility. I understand that one or more physicians, fellows, residents, and/or interns at the facility may treat me or participate in my treatment. I understand that no guarantee or assurance has been made regarding (1) which physician and/or fellows, residents, or interns will treat me or participate in my treatment and/or (2) the results that may be obtained from treatment.

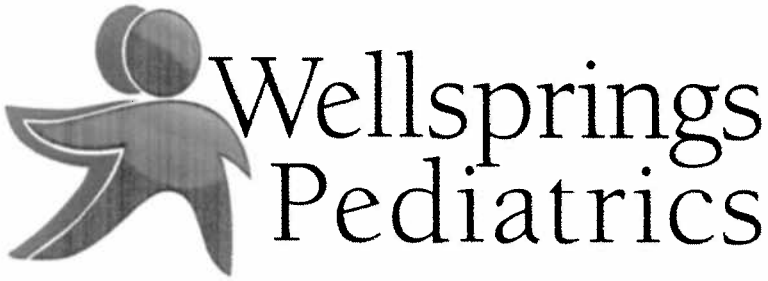
I consent to the photography or videotaping, including appropriate portions of my body, for medical and medical records documentations purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations.

The undersigned certifies that s/he has read the foregoing, understands it, accepts its terms, has received a copy of it and is patient or is duly authorized by the patient as their agent to execute the above.

Patient's Signature or Legal Representative Date Time

Relationship to Patient Interpreter, if utilized

Witness Signature If telephone consent, 2nd witness signature



Tooele Clinic Corporation
HIPAA Information and Consent
Health Information Portability Accountably Act

As of April 14, 2003, it is required by law to have a privacy policy in place and accessible to you. A copy has been provided for you to read in the office or you may have your own copy upon request.

Your Personal Health Information is protected from anyone but yourself unless you specifically list those whom you feel are appropriate to give information to on your behalf. Your personal Health Information may be given without consent if it is requested by a court or the military. It may also be shared with another doctor's office that you have been referred by our office. I have read and understand this agreement.

_____

Patient Name

_____

Signature of patient or Personal representative **Date**

_____

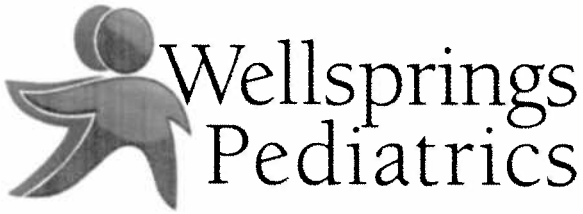
Relationship to Patient

If in the event you are unable to communicate with us and you feel it is appropriate for us to give information to someone else, please list them below.

_____ _____

_____ _____

_____ _____



Patient Consent for E-Prescribing (Electronic Prescribing)

I have been made aware and understand that the medical practices and offices may use and electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Patient Name:	DOB:
Patient's Signature or Authorized Representative:	
Print Name:	Date:
Relationship to Patient:	Interpreter, if utilized
Witness' Signature:	
Retail Pharmacy:	Medication Allergies:

NOTICE OF PRIVACY PRACTICES

Your rights under the Health Insurance Portability & Accountability Act of 1996 (HIPAA)

How Your Medical Information May Be Used and Disclosed & How You Can Get Access To This Information

If you have any questions about this notice, please contact the Facility Privacy Officer.

PLEASE REVIEW CAREFULLY.

Who Will Follow This Notice: This notice describes the facility's practices and that of:

- Any health care professional authorized to enter information into your facility chart
- All departments and units of the facility
- Any member of a volunteer group allowed to help you while you are in the facility
- All employees, staff, agents and other facility personnel
- All entities, sites and locations within this facility's system will follow the terms of this notice. They also may share medical information with each other for treatment, payment and health care operations purposes.

Our Pledge Regarding Medical Information: We understand that medical information about you and your healthcare is personal. We are committed to protecting medical information about you. A record is created of the care and services you receive at this facility. This record is needed to provide the necessary care and to comply with legal requirements. This notice applies to all of the records of your care generated by the facility. Your personal physician may have different policies or notices regarding the physician's use and disclosure of your medical information in the physician's office or clinic.

This notice will tell about the ways in which the facility may use and disclose medical information about you. Also described are your rights and certain obligations we have regarding the use and disclosure of medical information.

The law requires the facility to:

- Make sure that medical information that identifies you is kept private;
- Inform you of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of the notice that is currently in effect.

HOW THE FACILITY MAY USE and DISCLOSE YOUR MEDICAL INFORMATION:

The following categories describe different ways the facility uses and discloses medical information. Each category will be explained. Not every possible use or disclosure will be listed. However, all the different ways the facility is permitted to use and disclose information will fall within one of these categories.

- **Treatment.** Your medical information may be used to provide you with medical treatment or services. This medical information may be disclosed to physicians, nurses, technicians, or other agents of the facility who are involved in your care at the facility.

  Your medical information may also be disclosed to healthcare students, interns and residents.

  For example: A doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. The doctor may need to tell the dietitian about the diabetes so appropriate meals can be arranged. Different departments of the facility may also share medical information about you in order to coordinate your different needs, such as prescriptions, lab work and x-rays. The facility also may disclose medical information about you to people outside the facility who may be involved in your medical care after you leave the facility, such as family members, home health agencies, or others used to provide services that are part of your care.

- **Payment.** Your medical information may be used and disclosed so that the treatment and services received at the facility may be billed and payment may be collected from you, the insurance company and/or a third party.

  For example: The health plan or insurance company may need information about surgery you received at the facility so they can provide payment for the surgery. Information may also be given to someone who helps pay for your care. Your health plan or insurance company may also need information about a treatment you are going to receive to obtain prior approval or to determine whether they will cover the treatment.

- **Health Care Operations.** Your medical information may be used and disclosed for purposes of furthering day-to-day facility operations. These uses and disclosures are necessary to run the facility and to monitor the quality of care our patients receive.

  For example: Your medical information may be:

1. Reviewed to evaluate the treatment and services performed by our staff in caring for you.
2. Combined with that of other facility patients to decide what additional services the facility should offer, what services are not needed, and whether certain new treatments are affective.
3. Disclosed to doctors, nurses, technicians, and other agents of the facility for review and learning purposes.
4. Disclosed to healthcare students, interns and residents.
5. Combined with information from other facilities to compare how we are doing and see where we can improve the care and services offered. Information that identifies you in this set of medical information may be removed so others may use it to study health care and health care delivery without knowing who the specific patients are.

- **Appointment Reminders.** Your medical information may be used to contact you as a reminder of an appointment you have for treatment or medical care at the facility.
- **Treatment Alternatives.** Your medical information may be used to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- **Health-Related Benefits and Services.** Your medical information may be used to tell you about health-related benefits or services that may be of interest to you.
- **Individuals Involved in Your Care.** With your permission, your medical information may be released to a family member, guardian or other individuals involved in your care. They may also be told about your condition unless you have requested additional restrictions. In addition, your medical information may be disclosed to an entity assisting in a disaster relief effort so your family can be notified about your condition, status, and location.
- **Research.** Under certain circumstances, your medical information may be used and disclosed for research purposes.
- **As Required by Law.** Your medical information will be disclosed when required to do so by federal, state, or local authorities, laws, rules and/or regulations.
    - **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, your medical information will be disclosed in response to a court or administration order, subpoena, discovery request, or other lawful process by someone else involved in the dispute when we are legally required to respond.
    - **Law Enforcement.** Your medical information will be released if requested by a law enforcement official:
        - In response to a court order, subpoena, warrant, summons or similar process;
        - To identify or locate a suspect, fugitive, material witness, or missing person;
        - About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
        - About a death we believe may be the result of criminal conduct;
        - In emergency circumstances to report a crime; the location of the crime or victims; or the identify, description or location of the person who committed the crime.
    - **National Security and Intelligence Activities.** Your medical information will be released to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.
    - **Protective Services for the President and Others.** Your medical information may be disclosed to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
    - **To Alert a Serious Threat to Health or Safety.** Your medical information may be used and disclosed when necessary to prevent a serious threat to your health and safety and that of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.
    - **Health Oversight Activities.** Your medical information may be disclosed to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

SPECIAL SITUATIONS:

- **Organ and Tissue Donation.** If you are an organ or tissue donor, your medical information may be released to organizations that handle organ procurement or organ, eye and tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- **Military and Veterans.** If you are a member of the armed forces, your medical information may be released as required by military command authorities. If you are a member of the foreign military personnel, your medical information may be released to the appropriate foreign military authority.
- **Workers' Compensation.** If you seek treatment for a work-related illness or injury , we must provide full information in accordance with state-specific laws regarding workers' compensation claims. Once state-specific requirements are met and an appropriate written request is received, only the records pertaining to the work-related illness or injury may be disclosed.
- **Public Health Risk.** Your medical information may be used and disclosed for public health activities. These activities generally include the following:
  - To prevent or control disease, injury or disability;
  - To report births and deaths;
  - To report child abuse or neglect
  - To report reactions to medications or problems with products;
  - To notify people of recalls of products they may be using;
  - To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.
- **Coroners, Medical Examiners, and Funeral Directors.** Your medical information may be released to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients of the facility to funeral directors as necessary to carry out their duties.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official. This release would be necessary for the following reasons:
  - For the institution to provide you with health care;
  - To protect the health and safety of you and others;
  - For the safety and security of the correctional institution.

ADDITIONAL SITUATIONS:

- **Other Uses of Medical Information.** Other uses and disclosures of medical information not covered by this notice or the laws that apply to this facility will be made only with your written permission. If you provide the facility permission to use or disclose your medical information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your medical information for the reasons covered in your written authorization. You understand that we are unable to take back any disclosures already made with your permission, and that we are required to retain our records of the care that the facility provided to you.

ADDITIONAL INFORMATION CONCERNING THIS NOTICE:

- **Changes To This Notice.** We reserve the right to change this notice and make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. The facility will post a current copy of the notice with the effective date. In addition, each time you register at, or are admitted to, the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.
- **Complaints.** **You will not be penalized for filing a complaint.**
  If you believe your privacy rights have been violated, you may file a complaint with the facility or with the Secretary of the Department of Health and Human Services. To file a complaint with the facility, contact the Facility Privacy Officer. All complaints must be submitted in writing.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

***** NOTE: All Requests Must Be Submitted in Writing to the Facility Privacy Officer.***

- **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Except where individual state laws are more stringent, this facility has a minimum of 30 days to act on your request.

  To inspect and copy medical information that may be used to make decisions about you, you must submit a written request. If you request a copy of the information, we may charge a fee for the cost of copying, mailing or other supplies associated with your request.

  We may deny your request to inspect and copy in some limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional, other than the person who denied your request, will be chosen by the facility to review your request and the denial. The facility will comply with the outcome of the review.

  - A licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of the individual or another person.
  - The protected health information makes reference to another person (unless such other person is a health care provider) and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person.
  - The request for access is made by the individual's personal representative, and a licensed health care professional has determined, in the exercise of professional judgment, that the provision of access to such personal representative is reasonably likely to cause substantial harm to the individual or another person.

- **Right to Amend.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment to information kept by or for the facility. Except where individual state laws are more stringent, this facility has a minimum of 60 days to act on your request.

  To request an amendment, your must submit a written request. You must also provide a reason that supports your request.

  Your request for an amendment may be denied if:
  - Your request is not in writing or does not include a reason to support the request;
  - The medical information was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
  - The medical information is not part of the medical information kept by or for the facility;
  - The medical information is not part of the information you would be permitted to inspect and copy; or
  - The medical information is accurate and complete.

- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your medical information for purposes other than treatment, payment and health care operations. Except where individual state laws are more stringent, this facility has a minimum of 60 days to act on your request.

  To request this list or accounting of disclosures:
  - You must submit your request in writing.
  - Your request must state a time period, which may not be longer than six years and may not include dates before April14, 2003.
  - Your request should indicate in what form you want the list (for example, on paper, electronically).

  The first list you request within a12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member.

  For example: You could ask that we not use or disclose information about a surgery you had.

  We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions, you must make your request in writing. In your request, you must tell us:
  - What information you want to limit;
  - Whether you want to limit our use, disclosure or both;

- To whom you want the limits to apply, for example, disclosures to your spouse.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
  For example: You can ask that we only contact you at work or by mail.

  To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a copy of this notice. You may ask us to give you a copy at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.