Doctor-Patient Confidentiality Agreement, Release of Information Authorization, Consent to Examination and Treatment And Assignment of Benefits

I understand and agree that the information contained in my case is confidential between me and the doctor and that no disclosure of any kind shall occur without my knowledge except as herein defined for the purpose of demonstrating medical necessity for collection fees from other parties.

I understand and agree that I am responsible for payment of all fees for services rendered to me at this office or by doctors and/or staff hereof and that the fee schedule charged for my services is equivalent to the 2014 Relative Value Study of the State of Utah traditionally published by the insurance commissioner. I agree to receive a cash discount for payment at the time of service as a part of Discount Medical Plan Organization.

I hereby give authorization to this office to release any necessary information to my insurance company or third party reimbursement administrator or attorney regarding the expedition of my case.

I hereby assign all benefits due to Dr. Bruce Gundersen, Holladay Physical Medicine or The Personal Injury Clinic, as the primary, attending or supervising physician and facility on my case, and in so doing declare that all payments made by third parties regarding my care rendered by him or at his office should be directed to him.

I hereby consent to the physical examination, x-ray studies if needed, laboratory procedures if needed, treatment and management or other clinic service that is ordered and delivered under the general and/or specific instructions of the doctor and agree that any and all arbitration shall be in the common law court.

I hereby waive the statue of limitations regarding the physician's right to recover the fees that are due him for my care and case management.

I hereby agree to cooperate in the collecting of my account, including contacting my insurance company, attorney or appearing in court and providing testimony, should it be necessary.

I hereby understand and agree that there may be instances when certain examination and treatment procedures are excluded from any of my current benefits for whatever reason, contract or review; that I am responsible for the payment of those services if excluded or not covered.

I hereby agree that if there is an unpaid balance with Dr. Bruce Gundersen, Holladay Physical Medicine or The Personal Injury Clinic, and insurance benefits have been received by me, applied to deductible or declined for any reason, I will pay the account in full at once.

I agree that my account may be charged up to 50% of the balance to pay attorney fees, court costs, collections costs for professional collection services and or legal action is required against me. I agree to pay collection costs up to fifty (50) % and interest at the rate of one and one half percent per month (eighteen percent per year) that may be assessed to my by any collection agency retained to pursue this matter.

_____ _____

date Signature

_____

Witness