Wasatch Integrated Wellness

MEDICAL MEMBERSHIP APPLICATION

CLINIC USE ONLY
Membership No.
Effective Date
Plan

A. MEMBER INFORMATION

Name (Last) _____ (First) _____ (MI) _____

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner*

Address _____ Apt. ____ City _____ State _____ Zip _____

Home (or other) Phone (___) _____ Business Phone (___) _____ Email Address: _____

Employer _____ Business (or other) Phone (___) _____

Spouse's Employer _____ Spouse's Business (or other) Phone (___) _____

B. ENROLLING MEMBER / SPOUSE / DOMESTIC PARTNER / DEPENDENTS

List yourself and all dependents applying for membership. Attach a separate sheet if necessary.

	Name (Last, First, Middle)	Social Security #	Date of Birth MM/DD/YYYY	Age	Gender	Weight	Height
Employee							
Spouse/ Domestic Partner							
Dependent							
Dependent							
Dependent							
Dependent							
Dependent							

C. CURRENT/PRIOR COVERAGE INFORMATION

Indicate and health care coverage, Medicaid, or Medicare in effect within the last 24 months. If no health care coverage was in effect within the past 24 months, indicate NONE.

	Insurer, Medicaid or Medicare	Date of Coverage MM/YYYY		Type of Coverage (Check all that apply)
		Start Date	End Date	
Employee:				☐Group ☐Individual ☐Governmental ☐Medical ☐Dental ☐Other
Spouse/Domestic Partner:				☐Group ☐Individual ☐Governmental ☐Medical ☐Dental ☐Other
Dependent:				☐Group ☐Individual ☐Governmental ☐Medical ☐Dental ☐Other
Dependent:				☐Group ☐Individual ☐Governmental ☐Medical ☐Dental ☐Other
Dependent:				☐Group ☐Individual ☐Governmental ☐Medical ☐Dental ☐Other
Dependent:				☐Group ☐Individual ☐Governmental ☐Medical ☐Dental ☐Other
Dependent:				☐Group ☐Individual ☐Governmental ☐Medical ☐Dental ☐Other

***Enrollment in Medicaid or Medicare will automatically end the Medical Membership.**

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D. HEALTH STATEMENT

EACH QUESTION MUST BE CHECKED "YES" OR "NO." ALL questions must be answered and complete or the application will be returned. It is your responsibility to notify the clinic of any change in health status while this application is pending. **DO NOT REPORT GENETIC INFORMATION ON THIS FORM**. Information about manifested diseases or conditions of an applicant is not considered genetic information and is to be reported, even if the disease or condition is caused by or associated with genetics. The information provided in this section may be used for coordination of care but will not be used to deny membership.

	HEALTH QUESTIONS	YES	NO
1	Is any applicant pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months? If currently pregnant, provide expected due date_____.	☐	☐
	►Do you anticipate complications or multiple births?	☐	☐
	►Have you had prior complications or multiple births?	☐	☐
2	**Within the past 12 months** has any applicant:		
	A. Taken any prescribed medications for any health condition identified in Section D?	☐	☐
	B. Been injected with a drug or medication by a health care provider excluding immunizations?	☐	☐
	►Are all applicants' immunizations current?	☐	☐
3	**Within the past 12 months** has any applicant used any form of tobacco, including but not limited to cigars, cigarettes, or chewing tobacco)? If applicant has quit using tobacco give approximate quit date:_____.	☐	☐
4	**Within the past 5 years**, has any applicant applying for coverage been tested for or diagnosed with, had treatment recommended, received treatment, including prescription medications, or been hospitalized for any illness, injury, or health condition related to any of the categories listed below?		
	A. Cardiovascular disease or heart attack, stroke, high blood pressure, or any other diseases or disorders of the heart, arteries, blood, or blood vessels?	☐	☐
	B. Asthma, emphysema, tuberculosis, or any other diseases or disorders of the lungs or respiratory system?	☐	☐
	C. Diabetes or any other diseases or disorders of the pancreas? If yes, check all that apply: ☐ Non Insulin Dependent ☐ Insulin Dependent ☐ Insulin Pump	☐	☐
	D. Hepatitis or any other diseases or disorders of the liver, stomach, colon, or intestines?	☐	☐
	E. Chronic kidney stones or any other diseases or disorders of the kidney, prostate, or bladder?	☐	☐
	F. Male or female reproductive organs or any other diseases or disorders including infertility?	☐	☐
	G. Arthritis or any other diseases or disorders of the joints, muscles, back, or bones?	☐	☐
	H. Mental health diseases or disorders or alcohol/drug abuse?	☐	☐
	I. Seizures/epilepsy, paralysis, or any other diseases or disorders of the brain or nervous system?	☐	☐
	J. Lupus or any other diseases or disorders of the immune system?	☐	☐
5	**Within the past 5 years**, has any applicant applying for coverage been diagnosed or treated by a licensed medical professional for HIV, AIDS, or AIDS Related Complex?	☐	☐
6	**Within the past 5 years**, excluding routine or preventative care, has any applicant applying for coverage been tested for or diagnosed with, had treatment recommended, received treatment, including prescription medications, or been hospitalized for any illness, injury or health condition not indicated above?	☐	☐
7	Has any applicant **ever** had any organ or tissue transplant?	☐	☐
8	Has any applicant **ever** had cancer (including skin cancer or melanoma)?	☐	☐

IF ANY OF THE QUESTIONS IN THIS SECTION WERE CHECKED "YES", PROVIDE DETAILS IN SECTIONS E & F.

E. PRESCRIPTION INFORMATION WITHIN LAST 12 MONTHS Refer to Section D

IF ANY OF THE QUESTIONS IN SECTION D WERE CHECKED "YES", PROVIDE DETAILS IN THIS SECTION.

Name of Member	Name of Medication	Reason for Medication	Start Date MM/YYYY	End Date MM/YYYY	Physician, clinic, or hospital name.

F. ADDITIONAL INFORMATION Refer to Section D

IF ANY OF THE QUESTIONS IN SECTION D WERE CHECKED "YES", PROVIDE DETAILS IN THIS SECTION.

Question #	Name of Member	Explain diagnosis, injury, treatment received, testing, consultations, future treatments, and remaining symptoms or problems.	Diagnosis / Treatment Date (s)		Physician, clinic, or hospital name.
			Start Date MM/YYYY	End Date MM/YYYY	

G. DISABILITY INFORMATION

Are you or any dependent(s) disabled? □ Yes □ No If yes, indicate first and last name(s). _____

Reason for disability: _____

Is the disabled individual currently unable to perform routine daily functions for two weeks or more? □ Yes □ No

Have you or any dependent(s) filed workers' compensation claims or disability claims within the last five years? □ Yes □ No

If so, what is the status of the claims? _____

H. ACKNOWLEDGEMENT AND SIGNATURE

I agree to abide by the Clinic's Membership Agreement.

This Membership contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE CLINIC MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE CLINIC. THE CLINIC SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSES, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE CLINIC. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I certify that all information completed on this form is true, accurate, correct and complete. I acknowledge that if any information provided is false, the clinic may without advance notice pursue any remedies available under state or federal law, including declaring the Membership null and void and canceling the Membership retroactive to its original effective date.

I have read the Acknowledgment of this document and agree to its terms. I have also completed an authorization to disclose protected health information form, if such form accompanies this application.

Member Signature _____ Date _____