

RESPONSIBLE PARTY INFORMATION (if different from patient)

DATE: _____

NAME : _____ RELATIONSHIP TO PATIENT - SPOUSE-FATHER-MOTHER-OTHER _____

MAILING ADDRESS: _____ APT# _____ CITY _____ STATE _____ ZIP _____

PHONE:() _____ DATE OF BIRTH / / AGE SOCIAL SEC. NO. - -
(Mo (Day) (Year)

EMPLOYER: _____ EMPLOYER PHONE:() _____
(If self employed, please list business)

PATIENT INFORMATION

NAME : _____ PREFERRED NAME: _____

MAILING ADDRESS: _____ APT# _____ CITY _____ STATE _____ ZIP _____

STREET ADDRESS: _____ APT# _____ CITY _____ STATE _____ ZIP _____

PHONE:() _____ DATE OF BIRTH / / AGE SEX: F M MARITAL STATUS: Married Single Other

MOBLIE:() _____ SPOUSE NAME: _____
(If self employed, please list business)

SOCIAL SEC. NO. - - EMPLOYER: _____ PHONE:() _____

PATIENT'S PRIMARY CARE PHYSICIAN: _____ WHOM CAN WE THANK FOR REFERRING YOU TO US: _____

PERSON TO CONTACT IN CASE OF EMERGENCY (If possible, list someone with a different phone number than your own)

NAME : _____ RELATION TO PATIENT: _____ PHONE:() _____

ADDRESS: _____ APT# _____ CITY _____ STATE _____ ZIP _____

INSURANCE INFORMATION

1) PRIMARY INSURANCE COMPANY: _____

CLAIMS ADDRESS _____ CITY _____ STATE _____ ZIP _____

NO. ID _____ GROUP NO. _____

RELATIONSHIP OF PATIENT TO INSURED (Circle one) Self Spouse Child Other _____

POLICY HOLDER: _____ DATE OF BIRTH / / AGE _____

EMPLOYED WITH: _____

2) SECONDARY INSURANCE COMPANY: _____

CLAIMS ADDRESS _____ CITY _____ STATE _____ ZIP _____

ID NO. _____ GROUP NO. _____

RELATIONSHIP OF PATIENT TO INSURED (Circle one) Self Spouse Child Other _____

POLICY HOLDER: _____ DATE OF BIRTH / / AGE _____

EMPLOYED WITH: _____

REASON FOR VISIT: INJURY (EXPLAIN) _____

OTHER: (EXPLAIN) _____

Central Utah Clinic, PC

ASSIGNMENT OF BENEFITS / MEDICAL RELEASE / CONSENT FOR TREATMENT

With this form I acknowledge I have been provided a copy of the NOTICE OF PRIVACY from CENTRAL UTAH CLINIC (CUC) and authorize the release and disclose of portions of my medical record necessary to obtain reimbursement for myself and for my covered dependents. This authorization gives CENTRAL UTAH CLINIC the right to request and receive medical information from other health care entities and providers to include but not limited to copies of lab results, diagnostic test reports, films/images, and other clinic information deemed necessary by CENTRAL UTAH CLINIC physicians or representatives. I understand I am not required to sign this authorization as a condition of my treatment, unless permitted by law. I also understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with CENTRAL UTAH CLINIC'S privacy policy.

INSURED'S SIGNATURE: _____ DATE: _____

I hereby consent to any medical treatment, x-ray, laboratory, or other procedure, which the physician(s) may consider or advise in treatment of my case (or as legal guardian for patient). I hereby authorize any benefits due me to be paid directly to CENTRAL UTAH CLINIC, 1055 North 500 West Provo, Utah 84604. This agreement will remain in effect until I choose to revoke it in writing.

INSURED'S SIGNATURE: _____ DATE: _____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier.

A finance charge (1.5% per month/APR 18%) may be added to any amount for which payment has not been received within 60 days from the date of the statement on which the amount first appears. I hereby agree to pay a service charge of \$20.00 for each check or other instrument tendered by me but returned to this facility. Additional service charges may be levied for accounts placed with third-party collection agencies, or failure to make necessary co-payments at the time of service.

It is understood and agreed that if I fail to pay this account in accordance with policy, then I will pay all reasonable attorney fees and other costs incurred for collection of this account.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of the CENTRAL UTAH CLINIC financial policy and agree to pay for said medical services according to such terms.

INSURED'S SIGNATURE: _____ DATE: _____

EMPLOYEE SIGNATURE: _____ DATE: _____

MEDICARE PATIENT AGREEMENT (Required by Medicare for all Medicare claims)

ENTITLED'S NAME

MEDICARE SUBSCRIBER NUMBER

Request that payment of authorized Medicare benefits be made either to me or on my behalf to CENTRAL UTAH CLINIC for any services furnished me by that provider. I authorize any holder of medical information about me to release to Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

This authorization is in effect until I choose to revoke it in writing.

SIGNATURE: _____
DATE: _____

GM 16 10/10/06