Central Utah Clinic, PC
Your Health, Your Choice.®

Chart No. _____

PATIENT INFORMATION

Date: _____

Name: _____ Preferred Name: _____

Mailing Address: _____ Apt# _____ City _____ State _____ Zip _____

Street Address: _____ Apt# _____ City _____ State _____ Zip _____

Preferred Phone:( ) _____ Alternate Phone:( ) _____ Date of Birth: ____/____/____
(Mo.) (Day) (Year)

Sex: M F Email: _____ Marital Status: Married Single Other

Preferred Language: _____ Ethnicity: ❑ Hispanic ❑ Non-Hispanic

Race: ❑ Caucasian ❑ Native American ❑ Asian ❑ African American ❑ Pacific Islander ❑Other_____

Social Security No.: - - Employer: _____ Employer Phone: ( ) _____

Primary Care Physician: _____

Whom We Can Thank for Referring You to Us: _____

RESPONSIBLE PARTY INFORMATION (*If different from patient.*)

Name: _____

Relationship to Patient: (Circle One) Spouse Father Mother Other: _____

Mailing Address: _____ Apt# _____ City _____ State _____ Zip _____

Preferred Phone:( ) _____ Date of Birth ____/____/____ Social Sec. No.: - -
(Mo.) (Day) (Year)

Employer: _____ Employer Phone: ( ) _____

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

Name: _____ Relationship to Patient: (Circle One) Spouse Father Mother Other: _____

Home Phone: _____ Mobile Phone: _____

INSURANCE INFORMATION

1) Primary Insurance Company: _____

Claims Address: _____ City _____ State _____ Zip _____

Group No. _____ ID No. _____

Relationship of Patient to Insured: (Circle One) Self Spouse Child Other

Policy Holder: _____ Date of Birth: _____/_____/_____
(Mo.) (Day) (Year)

2) Secondary Insurance Company: _____

Claims Address: _____ City _____ State _____ Zip _____

Group No. _____ ID No. _____

Relationship of Patient to Insured: (Circle One) Self Spouse Child Other

Policy Holder: _____ Date of Birth: _____/_____/_____
(Mo.) (Day) (Year)

(CONTINUED ON BACK)

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MEDICAL INFORMATION RELEASE

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of Central Utah Clinic, P.C. (the "Clinic") and that the Clinic may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or worker's compensation carriers. I further acknowledge that the Clinic may disclose my patient information to referring or treating health care providers, and for payment and health care operations. I hereby authorize the Clinic to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnostic test reports, films/images, and other clinic information deemed necessary by the Clinic physicians or representatives. I 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 the Clinic's privacy policy.

Patient/Responsible Party Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby consent to the medical treatment, diagnostic and laboratory tests, and other procedures, which the physician(s) may deem advisable in treatment of my case (or as legal guardian for patient). The Clinic will determine the proper disposition of any tissues, parts, or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.

Patient/Responsible Party Signature: _____ Date: _____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I hereby authorize any benefits due me to be paid directly to the Clinic, 1055 North 500 West, Provo, Utah 84604. 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. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

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 Clinic's financial policy and agree to pay for said medical services according to such terms.

I hereby expressly consent to receiving voice and SMS (text) messages (including pre-recorded messages) on my mobile phone number and any other telephone number(s) that I provide (either directly or through an intermediary) to Central Utah Clinic or any of its affiliates, agents or contractors (including third-party billing and/or collection companies). I understand and agree that such messages may be sent by Central Utah Clinic and/or by its affiliates, agents or contractors and may be sent via automated dialing technology (i.e. autodialer) and may consist of such things as offers, advertisements, solicitations for business, and/or collection efforts.

Patient/Responsible Party Signature: _____ Date: _____

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

_____

Entitlee's Name Medicare Subscriber Number

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to CENTRAL UTAH CLINIC, P.C. 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: _____

Employee Signature: _____ Date: _____