# Central Utah Clinic, PC

CHART NO.

## RESPONSIBLE PARTY INFORMATION (if different from the patient)

Date: 2/7/05

Name | Relationship to Patient

Mailing Address | City | State | Zip Code

Phone | Date of Birth | Age | Social Security No. (no spaces or dashes)

Employer (If self employed, please list business) | Employer Phone

## PATIENT INFORMATION

Name | Preferred Name

Mailing Address | City | State | Zip Code

Street Address | City | State | Zip Code

Phone | Date of Birth | Age | Sex | Marital Status

Social Security No. | Employer (If self employed, please list business) | 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 | City | State | Zip Code

## INSURANCE INFORMATION

1) Primary Insurance Company

Claims Address | City | State | Zip Code

ID Number | Group Number | Relationship of Patient to Insured

Policy Holder | Date of Birth | Age

Employed With

2) Secondary Insurance Company

Claims Address | City | State | Zip Code

ID Number | Group Number | Relationship of Patient to Insured

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 MULTI-SPECIALTY CLINIC (CUMC) 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 CUMC 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 CUMC 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 CUMC'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 consier 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 CUMC, 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 medial services rendered, I (we) acknowledge that I (we) have received notice of the CENTRAL UTAH MULTI-SPECIALTY CLINIC financial policy and agree to pay for said medical services according to such terms.

Insured's Signature ______________________ Date ______________

Employee Witness ______________________ Date ______________

## MEDICARE PATIENT AGREEMENT
## (Required by Medicare for all Medicare Claims)

Entitlees Name ______________________ Medicare Subscriber Number ______________

Request that payment of authorized Medical benefits be made either to me or on my behalf to CENTRAL UTAH MULTI-SPECIALTY 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 ______________