SALT LAKE SPINE & SPORTS MEDICINE

Account # _____

Patient Information					
Patient's Last Name	Patient's First Name			Patients Middle Name	
Patient's Mailing Address - Street		City		State	Zip
Race:	Ethnicity:			Primary Language:	
Sex: M/F	Date of Birth: (MM/DD/YYYY)	Age:	Social Security No.	Home Phone #: Cell Phone #:	
Patient's Email Address: (Optional)					
Patient's Employer			Patient's Work Number		
Emergency Contact Not Living with Patient		Emergency Contact's Number		Relationship to Patient	
Marital Status: Single/Married/Other	Spouse's Name		Spouse's Contact Number		
Full Name of Primary Care Provider:			Full Name of Referring Provider, Friend, or Other:		

❑**Private Pay/No Insurance**

Private Insurance Information **(If not filled out completely, we are unable to bill your insurance. Your insurance card does not have all the information we need)**					
Primary Insurance Carrier			**Secondary Insurance Carrier**		
Primary Insurance Name	Plan Name	Telephone	Secondary Insurance Name	Plan Name	Telephone
Address			Address		
Policy Holder's Name	Relationship to Patient		Policy Holder's Name	Relationship to Patient	
Policy Holder's Date of Birth	Policy Holder's Telephone		Policy Holder's Date of Birth	Policy Holder's Telephone	
Group Number	Policy Number		Group Number	Policy Number	
Policy Holder's Employer and Telephone Number			Policy Holder's Employer and Telephone Number		

Auto/Industrial Insurance Information					
Insurance Company Name		Date of Injury: (MM/DD/YY)		Industrial? Yes/No	Auto? Yes/No
Address – Street City State Zip			Adjuster's Name		Adjuster's Telephone
Employer at time of injury:	Employer Address – Street, City, State, Zip			Employer Telephone	
Claim Number:	Attorney Name (If you have one):			Attorney Telephone:	

I have read the "Financial Arrangements" and "Release of Information" disclosures on the reverse side and, as the patient, or the patient's authorized representative for the purpose of signing this document, I accept the terms.

Date: _____ Signature: _____

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Release of Information

The law requires us to make and keep records of each patient's medical treatment. We safeguard those records and their uses and disclose such records and the information they contain only in accordance with state and federal privacy laws.

I authorize this facility to release to my insurance company and all parties involved in my treatment any information concerning the diagnosis, treatment plan, professional opinion, and medical or surgical procedure(s) performed, as well as information contained on this form.

I also authorize any physician, practitioner, hospital, or any other medically related facility to release to this facility any and all information regarding my medical history to include: medical, hospital, and other facility records; as well as x-rays, scans, laboratory reports, and any other related testing results.

Financial Responsibility

GENERAL: I understand that I am responsible for the payment of all charges incurred in connection with my treatment and I agree to make full payment for such charges known to not be covered by insurance. These are due in full at the time of service. I certify that the information I have provided is correct. Please note that liens on settlements are not an acceptable payment arrangement with Salt Lake Spine & Sports Medicine.

ASSIGNMENT OF BENEFITS: I hereby assign and transfer to this facility al insurance benefits payable to me by my insurance company(s), as listed on the face of this form, or which may change from time to time, for services and costs incurred in connection with my treatment. I understand that this assignment of benefits shall be exclusively for my insurance company(s) and Salt Lake Spine & Sports Medicine and/or its associated doctors.

MEDICARE/MEDICAIDE/TRICARE CERTIFICATION AND ASSIGNMENT: I certify that the information given by me in applying for payment for Medicare, Medicaid, and TriCare benefits or any other government program is correct. I authorize any holder of medical or other information about me to release to the TriCare administrator, Social Security Administration or ins intermediaries, or other carriers or program administrators, to the State or any other government payer, any information needed to substantiate and process a claim for payment for this or any facility for its charges or those of its associated physicians.

OTHER AGREEMENTS: I understand that I will be responsible for any deductibles, co-insurance, or other amounts not paid by my insurance company(s). Balances remaining after insurance benefits have been paid should be pain within 30 days. I further agree to pay a service charge of $30.00 for each check tendered by me but returned to this facility unpaid by my bank or credit union. I further agree to pay an additional 33% of my balance plus all costs and expenses including attorney's fees that are incurred in the collection of such checks or outstanding balances.

I have read the above information and agree. Please Initial _____ Date: _____