PLEASE
FILL IN ALL BLANKS

Utah Neurological Clinic

OFFICE USE ONLY
Medical Record #_____
Chart #_____

Today's Date:_____ Dr. to be seen_____

Patient's Name LAST	FIRST	MIDDLE	MAIDEN		
Patient's Mailing Address	Apt #	CITY	STATE	ZIP CODE	
(Area Code) Phone HOME CELL OFFICE	Date of Birth	Age	Soc Sec #	Sex M F	
Marital Status S M D W	Student Status FT PT	List Medication Allergies ☐ None	List Current Medications		
Employment Status FT PT RETIRED	Patient Employer Name/Phone/Address	Primary Care Physician Name (First & Last Please) Phone #			
Spouse's Name LAST	FIRST	MIDDLE	MAIDEN		
Spouse's Date of Birth	Spouse's Soc Sec #	Spouse's Employer Name	Employer Phone & Address		
Nearest Relative or Friend (not in same household)	(Area Code) & Phone	Relationship			

Fill in if Patient is a Minor or if Insured is Other than Self

Mother's Name LAST	FIRST	MIDDLE	Date of Birth	Soc Sec #
Home Phone/Address	Employer Name/Phone & Address			
Father's Name LAST	FIRST	MIDDLE	Date of Birth	Soc Sec #
Home Phone/Address	Employer Name/Phone & Address			

Information Mandatory for Insurance Billing

Briefly describe your symptoms			When did symptoms begin? Month/Day/Year
Is this problem the result of an injury or an accident? ☐ YES ☐ NO	If YES, Check ☐ AUTO ☐ INDUSTRIAL ☐ OTHER	**DESCRIBE**–WHEN	
DESCRIBE–WHERE (City and State)	**DESCRIBE**–HOW		

☐ Private Pay/No Insurance ☐ Health Insurance ☐ Industrial ☐ Auto

Insurance Information **<u>All spaces must be filled in or your insurance will not be billed</u>.**

Primary Insurance Company		Secondary Insurance Company	
Ins. Billing Address		Ins. Billing Address	
City State Zip Code		City State Zip Code	
Insurance Company Phone #		Insurance Company Phone #	
Policy Number Group Number		Policy Number Group Number	
Policy Holder's Name	Patient Relation to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other	Policy Holder's Name	Patient Relation to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other
Claim # for industrial or auto insurance		Adjuster Name & Phone #	

Signed _____ Date_____

<u>Please Complete Reverse Side</u>

To All Our Patients

This statement was prepared in an effort to avoid any misunderstanding which may arise regarding your account with this office and your primary insurance company. We will try in every way we can to make the processing of your insurance claim as simple as possible. I urge you to **know your insurance benefits.** Please remember, it is your insurance. You are the one who has made the arrangement with the insurance company, not the doctor. Our services are rendered to you, not your insurance company. Even though a claim is filed, you will receive a statement each month if your account has a balance due. **We cannot accept responsibility for collecting your insurance claim. It is your responsibility to see that your insurance company pays that part of your bill which is covered by your policy within a reasonable length of time. You are responsible for the payment of your account.**

Payment Policies

First initial office visit charges are due, in full, at time of service. All deductible amounts, co-payments and co-insurance amounts are due, in full, at the time of service. With the exception of the items just listed, and at the discretion of this office, limited payment arrangements can be setup for amounts exceeding $100.00. Please contact our billing department for details.

Collection/Attorney's Fees

By signing below I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

Check Agreement

I/We hereby agree to pay a return check charge of $30.00 for each check tendered by me/us and returned to the Utah Neurological Clinic.

Second Opinion

To insure proper medical care, Utah Neurological Clinic reserves the right to seek the opinion and expertise of other physicians. This may include additional fees and/or consultations.

Assignment of Benefits and Release of Information

I/We hereby assign and transfer to Utah Neurological Clinic all insurance benefits payable to me/us by my/our insurance company(s) listed on this form, for the services and costs incurred in connection with treatment. I/We authorize payment of such benefits be made by said insurance company(s) directly to Utah Neurological Clinic. I/We also authorize the release of any medical record information necessary to process any and all insurance claims.

Medical Records/Forms and Reports

I have received and read the Utah Neurological Clinic's office policy for obtaining medical records. I understand there will be a fee per request and that I must wait the amount of time required for processing.

Date _____ **I/We Agree To The Above** _____

(RESPONSIBLE PARTY SIGNATURE)

_____

(RESPONSIBLE PARTY SIGNATURE)