PATIENT INFORMATION

Patient's Name _____ (Last / First / Middle) Soc. Sec. # _____

Date of Birth: _____ (Mo. / Day / Yr.) Age: _____ Sex: _____ Marital Status: _____

Home Address: _____ (Street / City / State / Zip)

Home Phone: (_____) (Area Code) _____ Occupation: _____

Employer or School Name: _____ Work Phone: _____

Full Time ❑ Part Time ❑ Retired ❑ Student ❑ School_____ Cell Phone: _____

RESPONSIBLE PARTY INFORMATION

Responsible Party: _____ Soc. Sec. # _____

Address: _____ (Street / City / State / Zip)

Employer: _____ Occupation: _____

Work Phone: _____

Spouse Soc. Sec #: _____

Spouse's Name: _____ Address: _____

Spouse's Employer: _____ Phone: _____

INSURANCE INFORMATION

#1 Insurance Co. Name _____

Ins. Co. Address _____

Phone _____

Group# ID#/Claim#

_____

The insurance is under the name of:(Person)

Sex

_____ M ❑ F ❑

Date of Birth _____

Adjuster in work injury _____

#2 Insurance Co. Name _____

Ins. Co. Address _____

Phone _____

Group# ID#

_____

The insurance is under the name of:(Person)

Sex

_____ M ❑ F ❑

Date of Birth _____

EMERGENCY INFO

IN CASE OF EMERGENCY (Person NOT living with Patient)

Name: _____ Phone: _____

Relationship _____

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, Medicare, private insurance and other health plans to: R. Pepper Murray, M.D., P.C., John C. Edwards, M.D., Inc., Eric C. Johnston, M.D., Inc., and Steven B. Huish, M.D., Inc., Joshua M. Hickman, M.D., Inc., Mark G. Flammer, M.D., Michael M. Hess M.D., Inc., David W. Stevens, M.D., P.C. 1551 S. Renaissance Towne Drive, Suite 400, Bountiful, UT 84010. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment, via Fax transmittal or hard copy. Medical records will be accessible to all Physicians of Mountain Orthopaedics, LLC.

STATEMENT OF FINANCIAL RESPONSIBILITY

The patient/responsible party is responsible for all medical bills that result from services rendered by Mountain Orthopaedics, LLC.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies may pay fixed allowances for certain procedures, sometimes referring to these as "Reasonable and customary fees." We do not accept this as payment in full, unless otherwise restricted by law or contract agreement we may have with your insurance carrier. Many insurance companies pay only a percentage of the charge, leaving it your responsibility to pay any deductible amount, co-insurance amount and any other balance not covered by your insurance. Patient portion should be paid at the time of service.

INJURIES AT WORK: In the event it is determined by Workman's Compensation board, that the illness is not a result of a compensated Workman's Compensation case, you will be responsible to pay usual and customary fees for services rendered.

Auto insurance claims will be billed to auto carrier, if auto has been exhausted, arrangements for payment should be made with Mountain Orthopaedic's office manager.

Patients without insurance will be required to pay at the time of service.

Interest of 1.5% per month (18% per year) will be applied to any amount not paid after 30 days with a minimum charge of 50 cents per month.

A $20.00 handling charge will be applied to all returned checks. in the event that this account is turned over for collection, the collection fees and/or legal fees, including attorney fees up to 25% will be your responsibility.

SIGNED (Must be 18 or older): _____ Date: _____

WITNESS: _____ Date: _____