

MOUNTAIN MEDICAL VASCULAR SPECIALISTS

5323 SOUTH WOODROW ST, STE 102
MURRAY, UTAH 84107
801-713-1010

1160 EAST 3900 So, STE G300
SALT LAKE CITY, UTAH 84124
801-313-4101

1486 EAST SKYLINE DR, STE 201
SOUTH OGDEN, UTAH 84405
801-479-6687

Patient Information

Complete in FULL: (Please Print)

Acct. # _____

Patient Name _____ Birthdate _____

Address _____ Apt# _____ City _____ State _____ Zip _____
FIRST MI LAST REQUIRED

Home Phone _____ Mobile _____ SSN _____
OPTIONAL

Employer _____ Work Phone _____

Check appropriate box: Minor Single Married Divorced Widowed Separated Sex: Male
 Female

Email Address

Responsible Party (If other than patient)

Name _____ Relation _____

Address _____ Home Phone _____

Employer _____ Work Phone _____

Emergency Contact (Please use additional phone information, different from above.)

Name _____ Phone #1 _____ Relation _____

Name _____ Phone #2 _____ Relation _____

Physician Information

Referring Physician: _____ Office Phone: _____

Primary Physician: _____ Office Phone: _____

Last doctor's appointment: _____ Reason: _____

Payment Method (Please give the secretary your co-payment prior to seeing the doctor.)

Payment/co-payment will be made by: Cash Check Credit

If other payment arrangements are needed, please discuss your payment needs with the secretary.

Co-payment \$ _____

TO INSURE THAT YOUR INSURANCE CO. IS BILLED CORRECTLY, COMPLETE INSURANCE PORTION IN FULL

Insurance Information

Primary Insurance: (We have copies, but please complete all insurance information in full.)

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____
REQUIRED

Policy Holder _____ Relation _____

DOB _____ SSN _____ Is this thru your employer: Yes No

Secondary Insurance:

Insurance Company _____ Group # _____

Ins. Co. Address _____ City _____ State _____ Zip _____
REQUIRED

Policy Holder _____ Relation _____

DOB _____ SSN _____ Is this thru your employer: Yes No

Tertiary (3rd) Insurance: The secretary will have an additional form.

PLEASE TURN SHEET OVER AND SIGN.

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY. IT GIVES IMPORTANT INFORMATION REGARDING OUR BILLING PROCEDURES AND YOUR RESPONSIBILITY TO OUR OFFICE.

WHAT WE DO:

- *If we participate with your insurance, your company will be billed directly by our office.
- *If we do not participate with your insurance, we will submit a claim to your insurance company as long as complete billing information is provided. Full payment will be expected at the time of your visit.

WHAT WE EXPECT FROM YOU:

- *Provide complete and accurate information on your insurance.
- *Obtain necessary insurance referrals from your primary care physician.
- *Advise us immediately of any changes in your coverage.
- *Pay your balance due or your co-payments or deductibles at the time of service.
- ***When any type of testing is needed it is your responsibility to check which facilities are covered by your insurance company.*****

SELF PAY PATIENTS ARE REQUIRED TO PAY \$150.00 AT THE TIME OF THEIR FIRST VISIT AND \$50.00 FOR EACH ADDITIONAL VISIT. A BILLING REPRESENTATIVE WILL BE AVAILABLE TO SET UP A PAYMENT PLAN FOR THE REMAINING BALANCE.

IN ORDER TO CONTROL THE COST OF BILLING WE REQUIRE ALL COPAYS TO BE PAID AT EACH VISIT. IF YOU ARE UNABLE TO PAY YOUR COPAY AT THE TIME OF SERVICE, THERE WILL BE AN ADDITIONAL CHARGE. We accept payment by cash, check, or all major credit cards.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute of payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. If an assist in surgery is needed and it is not a covered benefit you will be responsible for payment. Also, some vascular procedures are considered "not medically necessary" by insurance companies. **It is the responsibility of the patient to verify insurance coverage, as well as to pay any deductible amount, co-insurance, or any other balance not paid by your insurance.** Our office does accept assignment for Medicare as well as a variety of other insurance companies. However, you are responsible for your yearly deductible.

I understand that in the event that I cannot make a scheduled appointment I must cancel within 24 hours prior to that appointment time. Failure to do so will result in a \$25.00 charge to my account (per incident).

I give my physician/provider permission to release my medical records, as needed to a referral physician(s) for continuity of care. I understand that I have the right to be informed before my records are released and can request a list of physicians to whom my records have been released. I have been given information regarding routine disclosures of medical records.

I understand that I am financially responsible for all charges whether paid or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of my or my family member's medical records.

In the event that full payment for charges incurred in my medical care is not made, I agree to pay any applicable interest or fees set by the collection agency. I also agree to submit myself to the jurisdiction of the courts of Salt Lake County, Utah.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as an original.

SIGNATURE: _____ **DATE:** _____
(Responsible Party)