Locations—

1486 E. Skyline Drive
S. Ogden, UT 84405 / Suite 201
P (801) 476-8346
F (801) 479-9184

5323 S. Woodrow Street
Murray, UT 84107 / Suite 101
P (801) 261-8346
F (801) 313-4120

Patient Information
Complete in FULL: *(Please Print)* Acct. # ______________________

Patient Name ____ Birthdate ____________
FIRST MI LAST REQUIRED
Address ______________________________ Apt# ____ City ____________________ State ____ Zip __________

Home Phone ________________________ Mobile ______________________ SSN ________________________
Email____________________________________

- ☐ I would like to be notified of Mountain Medical Vein Center Specials and Promotions by mail, phone or email.
- ☐ I would like to receive a patient satisfaction survey.

Employer ____ Work Phone ______________________

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

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: ____

<u>TO INSURE THAT YOUR INSURANCE CO. IS BILLED CORRECTLY, COMPLETE INSURANCE PORTION IN FULL</u>

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.

LEASE 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 (i.e. sclerotherapy injections) 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)

06/09/2009 KL