Murray Pediatrics 164 E 5900 S #A-112 Murray, UT 84107 801-262-2673

If NEW Patient, how did you hear about our office? _____

Patient Name: First _____ M Last _____

Date of Birth _____ Gender _____ Language _____ Race _____

Ethnicity: (circle one) Hispanic Latino Not Hispanic or Latino Prefer not to answer

Address _____ City _____ State _____ Zip _____

Parent or Guardian Information _____ Primary Phone _____

Name _____ Date of Birth _____ Soc. Sec # _____

Mailing Address _____ City _____ State _____ Zip _____

(If different than above)

Email _____ Cell Phone _____

Employer _____ Work Phone _____ **Relationship to Patient** _____

Other Parent or Guardian:

Name _____ Date of Birth _____ Soc Sec # _____

Mailing Address _____ City _____ State _____ Zip _____ Primary Phone _____

(If different than above)

Email _____ Cell Phone _____

Employer _____ Work Phone _____ **Relationship to Patient** _____

Emergency Contact: Not living at same address as patient

Name _____ Relationship to Patient _____ Phone Number _____

Billing Information:

Primary Insurance _____ Card Holder _____ Group # _____ Policy Number _____

Mailing Address _____ City _____ State _____ Zip _____

Secondary Insurance _____ Card Holder _____ Group # _____ Policy Number _____

Mailing Address _____ City _____ State _____ Zip _____

Consent to Treat and to Disclose Protected Health Information: I authorize the physician or physicians in charge of the care of the above named patient to administer anesthetics and/or medications and to perform such operations and/or diagnostic procedures as may be deemed necessary by the physician for the diagnosis and treatment of this patient.

The practice's Written Privacy Notice provides detailed information on how we may use and disclose protected health information. By signing this consent form, you acknowledge that you have received a copy of the Written Privacy Notice and are in agreement with our use and disclosure of protected health information for treatment, payment, and health care. Patients injured at work typically obtain information through their adjuster or employer. I have read and understand the above statements. Affixing my signature to this form represents my receipt of the Written Privacy notice, my consent to treatment, and the above listed uses of protected health information.

Signature of Responsible Party _____ Date

SEE OTHER SIDE

PATIENT FINANCIAL AGREEMENT

Murray Pediatrics

Dr. Ross Hightower, Dr. Anna Orchard and Dr. Gary Schlichter

Thank you for choosing us as your health care provider. We are committed to excellent patient care.

As the patient's financial representative, you understand and agree to the following:

1. Payment and/or copay is due at the time of service.
   If copay is not paid at the time of service a **$10.00** fee will be assessed to the account.

2. A **$30.00** fee will be assessed on all returned checks.

3. Self Pay Patients will receive services at a discounted rate of 20% if charges are paid in **Full** at the time of service. Payment in full is required of services rendered at each visit, if this is not possible you will need to make payment arrangements with our billing office.

4. You are responsible for knowing your insurance coverage and benefits. **It is your responsibility to make Murray Pediatrics aware of any changes not covered by your insurance, including all immunizations.** As a courtesy, Murray Pediatrics will bill your insurance and allow them 45 days to make payment. After 45 days it is your responsibility to follow up with your insurance. Any service provided, but not covered by your insurance, will be your responsibility to pay.

5. If your account is in good standing with no past history of collections or bankruptcy, Murray Pediatrics will extend credit on your account, with a minimum monthly payment of $50.00. Monthly payments are required on all accounts with outstanding balances. By signing below, you agree to pay collection costs up to 40% with or without suit and/or reasonable attorney's collection fees on any delinquent balance, if referred to any agency or attorney for collection or suit.

6. Patients who fail to appear for their scheduled appointment may be charged a NO SHOW fee of **$35.00**, unless the patient cancels the appointment at least 24 hours before the scheduled appointment time. This fee is NOT covered by your insurance.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to requesting referring providers (if any)

AUTHORIZATION TO PAY BENEFITS

I further authorize and direct said agency, attorney or Insurance Company to pay from the proceeds of benefits of any recovery of insurance payments in my case, directly to the providers of this office, for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

_____

Signature of Responsible Party **Date**

Driver's License # _____ **Relationship to Patient** _____