HIGHLAND FAMILY PRACTICE

4460 S. HIGHLAND DR. # 400
SALT LAKE CITY UT, 84124
(801) 272-4111

DATE _____

PATIENT NAME_____ PREFERRED NAME_____
FIRST M.I. LAST

PATIENT ADDRESS _____
STREET ADDRESS (PLEASE NO P.O. BOXES)

CITY STATE ZIP CODE

HOME PHONE # (_____)_____ DATE OF BIRTH _____/_____/_____ GENDER (circle one) M F

WORK PHONE # (_____)_____ MARITAL STATUS (circle one) S M W D RACE_____

CELL PHONE # (_____)_____ TEXT MESSAGING OK? _____ ETHNICITY_____

EMPLOYER _____

WORK ADDRESS _____
STREET ADDRESS

CITY STATE ZIP CODE

PERSON RESPONSIBLE FOR PAYMENT _____
FIRST M.I. LAST

MAILING ADDRESS_____
STREET ADDRESS (NO PO BOXES)

CITY STATE ZIP CODE

HOME PHONE # (_____)_____ WORK PHONE # (_____)_____

RELATIONSHIP TO PATIENT _____ DATE OF BIRTH _____/_____/_____

INSURANCE #1 _____ GROUP # _____ I.D._____

ADDRESS_____ NAME OF INSURED _____

_____ RELATIONSHIP TO PATIENT_____ D.O.B. _____
CITY STATE ZIP CODE

EMPLOYER _____

INSURANCE # 2 _____ GROUP # _____ I.D._____

ADDRESS_____ NAME OF INSURED _____

_____ RELATIONSHIP TO PATIENT _____ D.O.B._____
CITY STATE ZIP CODE

EMPLOYER _____

EMERGENCY CONTACT # 1_____ PLEASE LIST ALL MEDICATION ALLERGIES:

PHONE # (_____)_____ _____

EMERGENCY CONTACT # 2_____ AUTHORIZATION FOR ELECTRONIC CONFIRMATIONS?

YES NO

PHONE # (_____)_____ PHARMACY_____

DO YOU HAVE A LIVING WILL OR ADVANCED DIRECTIVE? PHARMACY PHONE #(_____)_____

_____

<OVER>

CONDITIONAL AGREEMENT

RELEASE OF INFORMATION: THE UNDERSIGNED AUTHORIZE THE OFFICE OF HIGHLAND FAMILY PRACTICE TO RELEASE PART OR ALL OF THE PATIENT'S RECORDS TO ANY PERSON OR ORGANIZATION LIABLE FOR THE BILL (CHARGES). THE UNDERSIGNED AUTHORIZE THE OFFICE OF HIGHLAND FAMILY PRACTICE TO SEND ELECTRONIC CONFIRMATIONS.

AUTHORIZATION TO PAY INSURANCE BENEFITS: THE UNDERSIGNED AUTHORIZE PAYMENT OF MEDICAL BENEFITS FROM HEALTH INSURANCE POLICIES DIRECTLY TO THE OFFICE OF HIGHLAND FAMILY PRACTICE FOR SERVICES RECEIVED. **THE UNDERSIGNED AGREES TO PAY ALL CHARGES NOT COVERED BY THE INSURANCE POLICIES.** HIGHLAND FAMILY PRACTICE IS COMMITTED TO THE CARE AND WELL BEING OF OUR PATIENTS. IT IS OUR GOAL TO PROVIDE YOU THE BEST MEDICAL CARE POSSIBLE. A PROVIDER WILL ORDER ANY AND ALL TESTS/PROCEDURES/REFERRALS THAT ARE NECESSARY TO ACCOMPLISH THIS GOAL. SOME OF THE TESTS, PROCEDURES, REFERRALS, ETC, MAY NOT BE COVERED BY YOUR INSURANCE POLICY OR MAY BE APPLIED TO A DEDUCTIBLE. IT IS THE PATIENT'S RESPONSIBILITY TO KNOW AND UNDERSTAND WHAT SERVICES HIS/HER POLICY COVERS. **IF THERE IS A QUESTION THE PATIENT SHOULD CALL HIS/HER INSURANCE BEFORE ANY SERVICE IS COMPLETED.**

FINANCIAL AGREEMENT: PAYMENT IS DUE AT THE TIME OF SERVICE. THIS INCLUDES ALL CO-PAYMENTS, DEDUCTIBLE PAYMENTS, AND OFFICE VISIT CHARGES (FOR CASH ACCOUNTS). IF PAYMENTS IS NOT MADE AT THE TIME OF SERVICE, THEN A $25.00 BILLING FEE WILL BE CHARGED TO YOUR ACCOUNT. THE UNDERSIGNED JOINTLY AND SEVERALLY AGREE TO PAY THE BILL AND FEES FOR SERVICES PROVIDED AT THE OFFICE OF HIGHLAND FAMILY PRACTICE. AS A COURTESY, WE WILL BILL YOUR INSURANCE AND WAIT UP TO 60 DAYS FOR PAYMENT. ANY OUTSTANDING BALANCE IS DUE AT THAT TIME. A FINANCE CHARGE OF 1.5 PERCENT PER MONTH WILL BE APPLIED ON ANY AMOUNT THAT HAS NOT BEEN PAID WITHIN 60 DAYS FROM THE FIRST ITEMIZED STATEMENT. ACCOUNTS THAT ARE OVER 90 DAYS LATE WILL BE SENT TO AN OUTSIDE COLLECTION AGENCY AND RELEASED FROM PRACTICE. IN EVENT THAT FULL PAYMENT FOR CHARGES INCURRED ARE NOT MADE, THE UNDERSIGNED AGREE TO PAY ALL COLLECTION FEES OF COLLECTIONS, INCLUDING ANY ATTORNEY'S FEES, AND INTEREST AT THE RATE OF 30 PERCENT ANNUM. THE UNDERSIGNED ALSO AGREE TO SUBMIT TO THE JURISDICTION OF THE COURTS OF SALT LAKE CITY COUNTY, UTAH. **THE UNDERSIGNED IS AWARE HIGHLAND FAMILY PRACTICE DOES NOT ACCEPT MEDICARE, MEDICARE-SUPPLEMENT PLANS OR ANY FORM OF MEDICAID. THE UNDERSIGNED IS AWARE IT IS THEIR RESPONSIBILITY TO MAKE SURE WE ARE COVERED PROVIDERS UNDER THEIR INSURANCE PLAN.**

Please be aware that some, and perhaps all, of the services provided may be "non-covered services" and may not be considered "reasonable and necessary" under the Medicare (CMS) Program and/or other medical insurance programs. Services may be considered "pre-existing" and not payable under your contract with the insurance company. ALL CHARGES / SERVICES ARE ULTIMATELY YOUR RESPONSIBILITY.

SCHEDULING AGREEMENT: THE UNDERSIGNED AGREES TO MAKE EVERY EFFORT TO KEEP SCHEDULED APPOINTMENTS AND ARRIVE 10-15 MINUTES EARLY. APPOINTMENTS THAT CANNOT BE KEPT SHOULD BE CANCELLED 24 HOURS IN ADVANCE. APPOINTMENTS THAT ARE NOT CANCELLED AT LEAST 24 HOURS PRIOR TO THE SCHEDULED TIME WILL BE SUBJECT TO A NO SHOW FEE OF $50.00 TO $100.00 DEPENDING ON THE LENGTH OF THE APPOINTMENT. PATIENTS THAT ARRIVE 15 MINUTES OR LATER FOR A SCHEDULED APPOINTMENT WILL BE ASKED TO RESCHEDULE, AND MAY ALSO BE SUBJECT TO A NO SHOW FEE, TO BE DETERMINED ON A CASE-BY-CASE BASIS. PATIENTS THAT NO SHOW 3 OR MORE SCHEDULED APPOINTMENTS IN 1 YEAR, WITHOUT CALLING TO CANCEL THE APPOINTMENT, WILL BE REVIEWED AND MAY BE RELEASED FROM THE PRACTICE.

PRIVACY ACT: IN AN EFFORT TO KEEP PATIENT INFORMATION CONFIDENTIAL, HIGHLAND FAMILY PRACTICE HAS SET FORTH POLICIES THAT ENSURE DISCRETION AND CONFIDENTIALITY FOR ALL PATIENT MATTERS.

INTERPRETATION/DISCRIMINATION: THIS OFFICE DOES NOT DISCRIMINATE ON THE BASIS OF RACE, SEX, AGE, DISABILITY OR NATIONAL ORIGIN. WRITTEN MATERIALS AND INTERPRETATION SERVICES ARE AVAILABLE UPON REQUEST. WE ARE ABLE TO PROVIDE TRANSLATION IN OVER 40 LANGUAGES BY REQUEST.

_____ DATE_____
PATIENT SIGNATURE

_____ DATE_____
PATIENT OR GUARDIAN SIGNATURE (IF PATIENT IS UNDER 18)