

SALT LAKE ORTHOPAEDIC CLINIC

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Date: _____

Account Number: _____

Please complete and return this form to the receptionist. Please read and sign the reverse side. **Ref: Physician** _____
We will file with your insurance company if you supply us with complete insurance information.

PATIENT INFORMATION			
Patient's Name (First, Middle, Last)			
Patient's Address			
City	State	Zip	
Date of Birth	Age	Sex	Soc. Sec. No.
Home Phone	Work Phone	Marital Status	
Employer			
Employer's Address (Street)			
City	State	Zip	
Occupation (Indicate if Student)		Number of Children	
Nearest Relative/Friend (local, not in same household)			
Nearest Relative's/Friend's Address			
Phone			
City	State	Zip	
FILL IN FOR HUSBAND OR WIFE			
Spouse's Name			
Employer		Phone	
Employer's Address		City	State Zip
FILL IN IF PATIENT IS A MINOR			
Parent's Name (First, Middle, Last)			
Employer			
Employer's Phone			
Employer's Address			
City	State	Zip	
Parent's Name (First, Middle, Last)			
Employer			
Employer's Phone			
Employer's Address			
City	State	Zip	

INSURANCE			
Primary Insurance		Phone	
Name of Policyholder			
Insurance Address (City, State, Zip)			
Date Last Worked		Date Returned to Work	
Policy Number		Group Number	
Secondary Insurance		Group Number	
Name of Policyholder		Policy Number	
Insurance Address (City, State, Zip)			
Reason for Visit		Date of Injury	
INDUSTRIAL			
Employer at Time of Injury		Phone	
Street Address		City	State Zip
Claim Number		Reported Injury <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Injury		Date Last Worked	Date Returned to Work
State Accident Occurred		County Accident Occurred	
Industrial Insurance Carrier			
Street Address		City	State Zip
Type of Injury			
AUTO RELATED?			
Automobile Insurance			
Claim Number			
Street Address		City	State Zip
Name of Insured			
Date of Accident		State of Accident	
Date Last Worked		Date Returned to Work	
Type of Injury			

The Salt Lake Orthopaedic Clinic (SLOC) Financial Policy

Patient Name _____

It is our office policy to inform you of our patient payment procedures. SLOC bills insurance as a courtesy. **The contract you have with your insurance is between you and your insurance carrier. That insurance contract is not between your carrier and SLOC.**

Please review the sections below.

1. Patient with Insurance

You are responsible for deductibles, co-pays, non-covered services, co-insurance, and items considered "not a covered benefit" by your insurance company. Please pay co-payments and co-insurance amounts as services are rendered. Any balance unpaid after sixty (60) days from the date services were rendered will be considered "delinquent." If you or your insurance carrier make payments exceeding your balance reimbursement will be remitted. If payment cannot be made at each visit, notify the account coordinator so that other arrangements can be made. **It is the responsibility of the patient to determine that the physician you see is a participating provider on your insurance plan. If your physician is not a participating provider, if you are ineligible for insurance, or have given erroneous information, you will be responsible for the balance.**

2. Workers' Compensation Patient

As a Workers' Compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment.

Patient is ultimately responsible for balance.

3. Personal Injury (Accident)

If you are a personal-injury patient, our office will bill the appropriate insurance companies. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all information needed for billing. **Patient is ultimately responsible for balance.**

4. Medicare/Medicaid

Our office will submit your Medicare/Medicaid charges to Medicare/Medicaid and your secondary insurance. Patient hereby agrees to be responsible for deductibles, co-pays, and any non-covered services.

5. Return Check Charges

A return check handling charge of \$20.00 will be applied to all returned checks.

6. Interest Rate

You are responsible for payment of your bill. 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 \$0.50 per month.

7. Forms

There will be a \$20.00 charge for any type of form (excluding Work Comp. Form 123)

ATTORNEY'S FEES AND COSTS: If any legal action is necessary to enforce the terms of this Agreement, or if it is necessary to employ the services of an attorney, the Patient agrees to pay the Clinic's reasonable attorney's fees and court costs in addition to any other relief to which it may be entitled. If Patient fails to pay any amounts owing hereunder when due, or otherwise breaches any terms of this Agreement, Patient agrees to pay the collection expense incurred by SLOC in attempting to collect such amounts from Patient, in addition to the aforementioned attorney's fees and costs.

RELEASE OF INFORMATION

ASSIGNMENT

_____ I request that payment of authorized Medicare/Medicaid benefits be made on my behalf to the Salt Lake Orthopaedic Clinic for any service furnished me by SLOC.

_____ The Signature below authorizes payment of mandated Medigap benefits to SLOC.

_____ I assign the benefits from my insurance carrier(s) to this clinic for the medical/surgical benefits I am entitled to receive.

_____ I authorize SLOC to release my protected health information for treatment, payment, or operations as defined by HIPPA laws.

X _____
Patient or responsible party signature

Date

Person signing on behalf of patient (print name)

Relationship to Patient

Witness

Name: _____ Today's Date: _____ SS#: _____

Past Medical History

Surgeries/Hospitalizations	Year	Reason

Have you ever had general anesthesia? _____ No _____ Yes
Have any problems with anesthesia? _____ No _____ Yes Describe: _____

Family History

Member	Alive	Deceased	Age	Health status or cause of death
Grandmother (mom's)	A	D		
Grandfather (mom's)	A	D		
Grandmother (dad's)	A	D		
Grandfather (dad's)	A	D		
Father	A	D		
Mother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		
Sister/Brother	A	D		

Social History

_____ Work in the home _____ Employed (occupation _____) _____ Student
_____ Single _____ Married _____ Divorced _____ Separated _____ Widowed
Children _____ No _____ Yes # _____
Do you live alone? _____ No _____ Yes
Exercise? _____ Daily _____ Weekly _____ Monthly _____ Rarely _____ Never
What type of exercise? _____
Are you on a special diet? _____ No _____ Yes Describe _____
History of substance abuse? _____ No _____ Yes What? _____
Smoke currently? _____ No _____ Yes _____ Packs per day for _____ years.
Quit smoking? _____ This year _____ 1 year _____ 5 years _____ 10 years
Previously smoked _____ Packs per day for _____ years.
Drink alcohol? _____ Daily _____ 1-2x/week _____ 1-2x/month _____ 1-2x/year

Reviewed By: _____ MD Date: _____