

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, copays, noncovered services, coinsurance and items considered "not a covered benefit" by your insurance company. Please pay copayments and coinsurance 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 makes 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, copays, and any noncovered 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