SOUTHERN UTAH
Ear, Nose and Throat

PATIENT INFORMATION

Patient Name _____
(Last) (First) (Middle Initial)

Address _____
(Street) (City) (State) (Zip)

Mailing Address _____ Birthdate _____

Home Phone# _____ Work/Cell Phone# _____

SS# _____ Marital Status _____ Age _____ Sex _____

Race _____ Ethnicity _____

Occupation _____ Employer _____

Spouse And/Or Mother's Name _____

SS# _____ Birthdate _____ Employer _____

Emergency Contact _____ Phone# _____ Relation _____

Primary Care Doctor _____ Referred By _____

Email Address _____

Southern Utah ENT is able to contact me via email _____
(Please Initial)

RESPONSIBLE PARTY INFORMATION:

Name _____ Relationship to Patient _____

Address _____

Phone# _____ SS# _____ Birthdate _____

Employer _____ Work Phone# _____

INSURANCE INFORMATION:

Primary Insurance _____ Phone# _____

Claims Mailing Address _____

Policy ID# _____

Secondary Insurance _____ Phone# _____

Claims Mailing Address _____

Secondary ID# _____

Please note SUENT Offices follows HIPAA guidelines and keeps all your information private. No information is shared with any other party, except your personal insurance company or whomever you authorize on your HIPAA privacy form. CANCELLATION POLICY: If you cancel your appointment without 24-hours notice, there is a $50 non-refundable charge.

Southern Utah Ear, Nose, Throat, Allergy, and Facial Plastics
617 E Riverside Dr., Suite 201, St. George, Utah 84790
www.southernutahent.com P- (435) 628-3334 F- (435) 628-2137

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FINANCIAL AGREEMENT

It is your responsibility to call your insurance carrier to determine benefits, eligibility and coverage before coming to our office. We are happy to assist you with any questions you may have, but each patient or responsible party is expected to know their own insurance coverage, rules and benefits.

Consultations, scopes, CT scans, sinus debridements, audiology testing and/or any other procedures performed may require an additional payment beyond your insurance co-pay. These services may be applied to your deductible or co-insurance by your insurance carrier. If you are a self-pay patient, there is an additional charge for any of these services performed _____ (initials).

I hereby assign and authorize payment of insurance benefits directly to Southern Utah Ear, Nose and Throat. I guarantee payment of all charges incurred on my behalf and understand I am financially responsible for any amount remaining after insurance payments and adjustments. A denial from my insurance carrier does not release me from my financial obligations, although our office will assist you the best we can to resolve the processing of the claim. However, I also understand that I am ultimately responsible for providing payment if insurance does not pay.

If this account is sent to collections:

- Terms: Net 30 days. Interest rate of 1 ½ percent per month (18 percent annum) will be charged on all past-due balances. In the event the account is delinquent and satisfactory arrangements have not been made for payment, the undersigned is responsible for all legal fees, attorney fees and court costs, including charges and collection agency fees of up to 35 percent of the balance assigned, with or without suit.

We acknowledge that SUENT Offices, including its attorneys and assignees, may have a legitimate business purpose in calling me to discuss this account and we expressly consent that we may be contacted at any telephone number, including a cellular telephone, by means of automatic telephone dialing system or artificial or pre-recorded voice, or by a live caller, and that we bear the cost of any charges associated with the call.

We have read this agreement and understand its terms. A copy or facsimile of this document shall have the same legal effect as the original.

Printed Name of Patient/Responsible Party	Date
Signature of Patient/Responsible Party	Date
Signature of Witness and Title	Date

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