SOUTHERN UTAH EAR NOSE THROAT ALLERGY AUDIOLOGY AND FACIAL PLASTICS

617 E RIVERSIDE DR SUITE 201 ST GEORGE UTAH 84790 P-435-628-3334

Please print legible

Patient Name:

Last: First: Middle:

Mailing Address: City: State: Zip:

Cell/Preferred Phone# Birthdate: Email:

Social Security# Marital Status: Age: Gender:

Race: Ethnicity: Employer:

Responsible Party: Relation: Birthdate:

Insurance: Insurance Subscriber: Birthdate:

Emergency Contact: Relation: Phone#

Primary Care Provider: Last seen: Referred By:

Notice of Privacy Policy and Authorization to release information (HIPAA): I understand that Southern Utah Ear Nose and Throat Offices cannot release any of my medical records or information unless I consent to it. I hereby authorize this person (s) to have access to my medical records: _____ (spouse or family) _____ (physician/medical facility) This will stay in effect until I send a letter in writing to Southern Utah Ear Nose and Throat stating to terminate this agreement. I automatically authorize my Insurance Company to receive any and all of my medical records.

Financial Agreement and policy: I understand it is my responsibility to know my Insurance benefits, rules, coverage and eligibly. Consultations, scopes, sinus debridement's, audiology testing, CT scans, allergy testing and any other service performed may require an additional co pay or may be applied to my deductible/co insurance by my Insurance Company. I initial stating I understand this. _____ Initial. 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 responsible for any remaining amount after Insurance payments and adjustments. A denial from my Insurance Company does not release me from my financial obligations. I will assist with any appeals or help to get my Insurance Company the needed information to process and pay my claims. I understand that Southern Utah Ear Nose and Throat bills Insurance companies as a courtesy and that I am responsible for providing payment of my claims if the Insurance Company does not pay. If an account is sent to collections the terms are 30 days from the date of service of invoice. Should collection become necessary by legal suit or other means, the patient or responsible party agrees to pay all costs of collection, including agency fee, 35% of the balance assigned with or without suit. I acknowledge that Southern Utah Ear Nose and Throat, including its attorneys and assignees, may have legitimate business purposes in calling me to discuss this account and we will bear the cost of any charges associated with such calls. I understand Southern Utah Ear Nose and Throat has a no show and cancellation policy of $50 dollars if I no show my appointment or cancel within 24 hours of my appointment date.

I have read the above agreement and understand its terms. A copy or facsimile of this document has the same legal effect as the original. Thank you.

_____

Signature of Patient or Responsible Party Date

_____

Witness Date