UTAH SPINE AND JOINT SPECIALISTS

Account # ______________

Patient Information

Patient's Last Name		First	Middle	
Patient Address Street		City	State	Zip
Home Phone	Social Security No.	Sex / Birth Date	Age	Marital Status ☐ Single ☐ Married ☐
Employer Patient's Parent's		Occupation		
Employer's Address		Employer's Telephone	Supervisor's Name	
Emergency Contact Not Living with the Patient		Relative or Friend?		Telephone
Full Name of Primary Care Physician				
Full Name of Referring Physician, Friend, or Other Referrer				
Spouse's Name			Spouse's Contact Telephone Number	

☐ Private Pay/No Insurance

Private Insurance Information

Primary Insurance Carrier			Secondary Insurance Carrier		
Primary Insurance Name	Plan Name	Telephone	Secondary Insurance Name	Plan Name	Telephone
Address			Address		
Policy Holder's Name	Relationship to Patient		Policy Holder's Name	Relationship to Patient	
Policy Holder's Soc. Sec. Number	Policy Holder's Telephone		Policy Holder's Soc. Sec. Number	Policy Holder's Telephone	
Group Number	Policy Number		Group Number	Policy Number	
Policy Holder's Employer and Telephone Number			Policy Holder's Employer and Telephone Number		

Auto/Industrial Insurance Information

Insurance Company Name		Date of Injury	Industrial? ☐ Yes ☐	Auto? ☐ Yes ☐
Address Street City State Zip		Adjuster's Name		Adj.'s Phone
Employer at the Time of Injury	Employer Address Street City State Zip		Employer Telephone	
Claim Number	Attorney Name (If You Have One)	Attorney Telephone		

Please note that liens on settlements are not an acceptable payment arrangement with ISI.

I have read the "Financial Arrangements" and Release of Information" disclosures on the reverse side and, as the patient, or the patient's authorized representative for the purpose of signing this document, I hereby accept its terms.

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Date Patient, or Patient's Agent

(Registration Form Front Side)

Release of Information

The law requires us to make and keep records of each patient's medical treatment. We safeguard those records and their uses and disclose such records and the information they contain only in accordance with state and federal privacy laws. Such uses and disclosures are described in the "Notice of Privacy Practices." You should receive a copy of this notice and you acknowledge such receipt by your signature on the front of this form.

I authorize this facility to release to my insurance company and all parties involved in my treatment any information concerning the diagnosis, treatment plan, professional opinion, and medical or surgical procedure(s) performed, as well as information contained on this form.

I also authorize any physician, practitioner, hospital, or any other medically related facility to release to this facility any and all information regarding my medical history to include: medical, hospital, and other facility records; as well as x-rays, scans, laboratory reports, and any other related testing results.

Financial Responsibility

GENERAL: I understand that I am responsible for the payment of all charges incurred in connection with my treatment and I agree to make full payment for such charges by cash and/or by payment from assigned insurance benefits. I understand that charges known to not be covered by insurance are due in full at the time of service. I certify that the information I have provided is correct.

ASSIGNMENT OF BENEFITS: I hereby assign and transfer to this facility all insurance benefits payable to me by my insurance company(s), as listed on the face of this form, or which may change from time to time, for services and costs incurred in connection with my treatment. I understand that this assignment of benefits shall be exclusively for my insurance company(s) and ISI and/or its associated doctors.

MEDICARE/MEDICAID/TRICARE CERTIFICATION AND ASSIGNMENT: I certify that the information given by me in applying for payment for Medicare, Medicaid and TriCare benefits or any other government program is correct. I authorize any holder of medical or other information about me to release to the TriCare administrator, Social Security Administration or its intermediaries, or other carriers or program administrators, to the State or any other government payer, any information needed to substantiate and process a claim for payment for this or any related service, I request that payment of authorized benefits be made in my behalf directly to this facility for its charges or those of its associated physicians.

OTHER AGREEMENTS: I understand that I will be responsible for any deductibles, co-insurance, or other amounts not paid by my insurance company(s). Balances remaining after insurance benefits have been paid should be paid within 30 days. A finance charge of 1.5 percent per month (18% annually) will be assessed on balances unpaid for 30 days. I further agree to pay a service charge of $20.00 for each check tendered by me but returned to this facility unpaid by my bank or credit union. I further agree to pay all costs and expenses including attorney's fees that are incurred in the collection of such checks or outstanding balances.