Coral Desert Orthopaedics

Revere Health Coral Desert Orthopaedics

PATIENT REGISTRATION Chart No. _____

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name (Last -- First – Middle Initial)	Address		Email Address
City, State	Zip	Primary Phone	Secondary Phone
Patient Birth Date	Patient SSN	Sex ❑ Male ❑ Female	Marital Status ❑ Single ❑ Married ❑ Other_____
Preferred Language:	Ethnicity (Required): ❑ Hispanic ❑ Non Hispanic	Race (Required): ❑ Caucasian ❑ Native American ❑ Asian ❑ African American ❑ Pacific Islander ❑ Other_____	
In Case of Emergency Contact	Relationship		Phone Number

RESPONSIBLE PARTY INFORMATION — **RELATIONSHIP TO PATIENT:** ❑ Parent ❑ Guardian

Name (First -- Last – Middle Initial)	Address (if different from patient)			
Cell Phone	Work Phone	SSN	Birth Date	Employer

INSURANCE INFORMATION

Primary Insurance Name	ID Number		Employer Name and Phone
Subscriber Name	DOB	SSN	Relationship to Patient
Secondary Insurance Name	ID Number		Employer Name and Phone
Subscriber Name	DOB	SSN	Relationship to Patient
Patient Employer Name	Patient Employer Address (Street Address – City, State, Zip)		Employer Phone Number

RELEASE OF INFORMATION

I understand the following:

- **Redisclosure of Information:** Once information is disclosed pursuant to this authorization, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.
- **Right to Refuse to Sign this Authorization:** Generally, the person(s) and/or organization(s) listed below who I am authorizing to use and/or disclose my information may not condition my treatment, payment or eligibility for health care benefits on my decision to sign this authorization.
- **Right to Revoke:** I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or a claim under the policy. To revoke this authorization, I will provide the Privacy Officer at the physician/health care provider's office with a written revocation.
- **Right to Inspect:** I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form.
- **Right to Receive a Copy of Authorization:** If I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.
- **Photocopy:** A photocopy of this authorization, including a copy that is received by fax or electronic transmission, shall be considered as effective and valid as the original.
- **Expiration Date:** Unless I provide a written revocation at an earlier date, this authorization will expire in one (1) year or as otherwise noted below.
- **Release of Information:** I hereby authorize the following person(s) to receive the following information:

EXPIRATION DATE: _____/_____/_____

NAME	RELATIONSHIP TO PT	DOB OR PHONE NO.	AUTHORIZED TO RELEASE:	
			❑ All Records OR ❑ Provider Notes	❑ Verbal Updates ❑ Prescriptions ❑ Billing Records
			❑ All Records OR ❑ Provider Notes	❑ Verbal Updates ❑ Prescriptions ❑ Billing Records
			❑ All Records OR ❑ Provider Notes	❑ Verbal Updates ❑ Prescriptions ❑ Billing Records

Signature of Patient or Legal Representative	Date
If signed by legal representative, relationship to Patient	Signature of Witness (Optional)

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MEDICAL INFORMATION RELEASE

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of Central Utah Clinic, P.C. (the "Clinic") and that the Clinic may release all or portions of my medical record to me, and to people or companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or worker's compensation carriers. I further acknowledge that the Clinic may disclose my patient information to referring or treating health care providers, and for payment and health care operations. I hereby authorize the Clinic to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnostic test reports, films/images, and other clinic information deemed necessary by the Clinic physicians or representatives. I understand that I may inspect my protected health information, request more information, and revoke this authorization, as permitted by the federal privacy regulations and in accordance with the Clinic's privacy policy.

Patient/Responsible Party Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby consent to the medical treatment, diagnostic and laboratory tests, and other procedures, which the physician(s) may deem advisable in treatment of my case (or as legal guardian for patient). The Clinic will determine the proper disposition of any tissues, parts, or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.

Patient/Responsible Party Signature: _____ Date: _____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I hereby authorize any benefits due me to be paid directly to the Clinic,1055 North 500 West, Provo, UT 84604. I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third-party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

A finance charge (1.5% per month/APR 18%) may be added to any amount for which payment has not been receive within 60 days from the date of the statement on which the amount first appears. I hereby agree to pay a service charge of $20.00 for each check or other instrument tendered by me but returned to this facility. Additional service charges may be levied for accounts placed with third-party collection agencies, or failure to make necessary co-payments at the time of service.

It is understood and agreed that if I fail to pay this account in accordance with policy, then I will pay all reasonable attorney fees and other costs incurred for collection of this account.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of the Clinic's financial policy and agree to pay for said medical services according to such terms.

Patient/Responsible Party Signature: _____ Date: _____

MEDICARE PATIENT AGREEMENT
(Required by Medicare for all Medicare Claims)

_____

Entitlee's Name Medicare Subscriber Number

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to CENTRAL UTAH CLINIC, P.C. for any services furnished me by that provider. I authorize any holder of medical information about me to release to Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.
This authorization is in effect until I choose to revoke it in writing.

Signature: _____ Date: _____

Employee Signature: _____ Date: _____