UTAH SPINE MEDICINE / EMIL CHENG, MD

Account #_____ (Please Print Legibly)

Patient Information

Patient's Last Name	First	Middle Initial	Preferred Name

Patient's Mailing Address	Apt #	Zip code	City	State

Sex	Birthdate	Age	Social Security #		Marital Status
					☐Single ☐Married ☐Divorced ☐Widowed ☐Partnered

Home Phone	Cell Phone	Work Phone

Employer	Occupation

Spouse/Partner Name	Spouse/Partner Contact Number

Name of Emergency Contact **NOT** Living with Patient	Phone Number	Relationship

Full Name of Referring Doctor / Provider

Full Name of Primary Care Doctor / Provider

Primary Insurance Carrier			Secondary Insurance Carrier		
Insurance Name	Plan Name	Telephone	Insurance Name	Plan Name	Telephone
Insurance Billing Address			Insurance Billing Address		
Policy Holder's Name	Relationship to Patient		Policy Holder's Name	Relationship to Patient	
Policy Holder's Birth Date	Policy Holder's Telephone		Policy Holder's Birth Date	Policy Holder's Telephone	
Group Number	ID/Member Number		Group Number	ID/Member Number	
Policy Holder's Employer and Telephone Number			Policy Holder's Employer and Telephone Number		

Auto/Industrial Insurance Information (If Applicable)

Insurance Company Name	Date of Injury	Industrial? ☐ Yes ☐ No	Auto? ☐ Yes ☐ No

Address Street	City	State	Zip	Adjuster's Name

Employer at the Time of Injury		Adjuster's Phone

Claim Number		Adjuster Fax

Please Note that liens on settlements are not an acceptable payment arrangement with Dr. Cheng.

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.

_____ _____

Date Patient or Patient's Agent

Utah Spine Medicine

Release of Information

The law requires us to make and keep records of each patient's medical treatment. Utah Spine Medicine safeguards 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 consent 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 procedures (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, scan, laboratory reports, and any other related testing results.

FINANCIAL AGREEMENT

By signing the consent form, I agree to pay all amount(s) owed within 60 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past-due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amount(s) owing is/ are referred to a third-party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today. I further agree to pay a service charge of $30.00 for each check tendered by me but returned to this facility unpaid by my bank or credit union.

I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services. I am responsible for deductibles, co-payments, coinsurance amounts or any other patient responsibility indicated by my insurance carrier or Utah Spine Medicine's FINANCIAL POLICIES, which are not otherwise covered by supplemental insurance. I am responsible for knowing my insurance policy. For example, I will be responsible for any charges if any of the following apply: my health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Utah Spine Medicine, and I have not obtained such an authorization or referral; I receive services in excess of such authorization or referral; my health plan determines that the services I received at Utah Spine Medicine are not medically necessary and/or not covered by my insurance plan; my health plan coverage has lapsed or expired at the time I receive services at Utah Spine Medicine; or I have chosen not to use my health plan coverage. **(If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.)**

I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Utah Spine Medicine or anyone acting on its behalf. I understand and agree that such calls may be initiated by Utah Spine Medicine or any of its affiliates, agents, contractors or assignees, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages - some or all of which may result in data charges.

Utah law requires Utah Spine Medicine to provide the responsible party(ies) with notice, by certified mail, 60 days prior to placing any delinquent balance of the below stated account with a collection agency or reporting any delinquent balance to any credit bureau, which actions may negatively impact my credit score. I understand that I will be charged a fee of $10.00 if any such notice is sent to me.