

HIGHLAND CENTER OFFICE
4252 S. Highland Drive, #200
Salt Lake City, UT 84124

WESTERN UROLOGICAL CLINIC

PATIENT INFORMATION

PHYSICIAN STAMP _____

PLEASE PRINT CLEARLY

DATE _____

PATIENT NAME _____ DATE OF BIRTH _____ AGE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE NUMBER _____ CELL # _____ WK # _____ EXT. _____

SOCIAL SECURITY NUMBER _____ M F | S M D W _____
MARITAL STATUS NAME OF SPOUSE _____

EMPLOYER _____ REFERRING PHYSICIAN _____ PHONE _____

PRIMARY CARE PHYSICIAN _____ PHONE _____

RESPONSIBLE PARTY _____ SELF SPOUSE PARENT

ADDRESS _____ PHONE _____

PERSON TO CONTACT IN AN EMERGENCY _____ RELATIONSHIP TO PT. _____ PHONE _____

RELATIVE NOT LIVING WITH YOU OR FRIEND OR NEIGHBOR _____ RELATIONSHIP TO PT. _____ PHONE _____

MEDICAL INSURANCE:

1. PRIMARY INSURANCE _____ ID # _____ GROUP # _____

POLICY HOLDER _____ RELATIONSHIP TO PT. _____ DOB _____ CO-PAY AMOUNT _____

INSURANCE ADDRESS _____ EMPLOYER _____

PHONE # OF THE INSURED _____

2. SECONDARY INSURANCE _____ ID # _____ GROUP# _____

POLICY HOLDER _____ RELATIONSHIP TO PT. _____ DOB _____

INSURANCE ADDRESS _____

PHONE # OF THE INSURED _____ CO-PAY AMOUNT _____

FEE POLICY AND AGREEMENT

It is our policy to require payment of all office services at the time they are rendered. If you are unable to make payment in full, please discuss it with our office personnel in order to help you make arrangements for payment. A PAYMENT equal to any amount which will not, or may not be covered by medical insurance will be required at the time of the first visit. A "Repeat Billing Charge" will be added to all accounts 60 days old to defray the cost of sending repeat statements. We also reserve the right to charge interest at 1.5% per month (18% per annum) on balances 60 days and older. In the event that any balance due hereunder is not paid as agreed, the undersigned jointly and severally agree to pay all costs incurred by said unpaid balance including reasonable attorneys' fees and costs of court along with any fees for the cost of collection up to 40%.

ASSIGNMENT OF BENEFITS:

I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to: WESTERN UROLOGICAL CLINIC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I HEREBY AGREE to the terms stated herein and authorize said assignee to release all information necessary to secure the payment.

DATE _____

SIGNED _____

DATE _____

CO-SIGNER _____