

OGDEN CLINIC

FAMILY REGISTRATION RECORD

Responsible Party					
First Name	Middle	Last	Account Number (internal use)		
Address		City	State	Zip	
Home Phone	Social Security Number	Sex	Birthdate		Marital Status
Employer	Position		How Long Employed	Work Phone	
Primary Care Doctor		E-Mail Address		How did you hear about us?	
Spouse of Responsible Party					
First Name	Middle	Last	Account Number (internal use)		
Address		City	State	Zip	
Home Phone	Social Security Number	Sex	Birthdate		Marital Status
Employer	Position		How Long Employed	Work Phone	
Primary Care Doctor		E-Mail Address			
Patient #1					
First Name	Middle	Last	Account Number (internal use)		
Address		City	State	Zip	
Home Phone	Social Security Number	Sex	Birthdate		Marital Status
Employer	Position		How Long Employed	Work Phone	
Primary Care Doctor		E-Mail Address			
Patient #2					
First Name	Middle	Last	Account Number (internal use)		
Address		City	State	Zip	
Home Phone	Social Security Number	Sex	Birthdate		Marital Status
Employer	Position		How Long Employed	Work Phone	
Primary Care Doctor		E-Mail Address			
Contact					
Name of Person or Nearest Relative (Not Living with You)				Relationship	
Address		City	State	Zip	Home Phone
				Work Phone	
Insurance Co.	Group#	ID#	Policy Holder	Relationship to Insured	Effective Date
Primary					
Secondary					
Other					

The information provided is complete and accurate to the best of my knowledge.

Patient or Guarantor's Signature

Date

Witness

Date

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Patient #3					
First Name	Middle	Last	Account Number		
Address		City	State	Zip	
Home Phone	Social Security Number	Sex	Birthdate		Marital Status
Employer	Position		How Long Employed	Work Phone	
Primary Care Doctor			E-Mail Address		

Patient #4					
First Name	Middle	Last	Account Number		
Address		City	State	Zip	
Home Phone	Social Security Number	Sex	Birthdate		Marital Status
Employer	Position		How Long Employed	Work Phone	
Primary Care Doctor			E-Mail Address		

Patient #5					
First Name	Middle	Last	Account Number		
Address		City	State	Zip	
Home Phone	Social Security Number	Sex	Birthdate		Marital Status
Employer	Position		How Long Employed	Work Phone	
Primary Care Doctor			E-Mail Address		

Patient #6					
First Name	Middle	Last	Account Number		
Address		City	State	Zip	
Home Phone	Social Security Number	Sex	Birthdate		Marital Status
Employer	Position		How Long Employed	Work Phone	
Primary Care Doctor			E-Mail Address		

Patient #7					
First Name	Middle	Last	Account Number		
Address					
Home Phone	Social Security Number	Sex	Birthdate		Marital Status
Employer	Position		How Long Employed	Work Phone	
Primary Care Doctor			E-Mail Address		

The information provided is complete and accurate to the best of my knowledge.

Patient or Guarantor's Signature

Date

Witness

Date

Payment Policy Acknowledgment

Patient Name: Insurance: 1. 2.

Welcome to Ogden Clinic. We appreciate your business and strive to maintain the highest quality of care. Please review the following information carefully.

Release of Information Consent and Payment Terms

- 1. Your signature authorizes payment of medical benefits to go directly to the Ogden Clinic or its agents for any services furnished. Your signature requests that payment be made and authorizes release of any information necessary to process the claim. In case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers compensation, or other insurance which is responsible to pay for the services for which the Medicare claim is made.
2. Your signature authorizes the Ogden Clinic to release medical information that may be necessary to request claim reimbursement from insurance companies or other payers to whom claims have been submitted and to release credit information to appropriate information gathering agencies.
3. The clinic cannot accept responsibility for collection of insurance, or other claims. The patient or guarantor is responsible for payment on the account in accordance with our policy. We anticipate payments on your account even though you may have an insurance claim pending per our contractual agreement with the plan. Accounts that are not paid in full or set up on a mutually agreed upon payment arrangement, will be charged a late fee of 1.5%. The fee will be based upon the patient's monthly balance over 30 days.
4. In the event the account is sent to an outside collection agency the patient or guarantor agrees to pay costs of collections, court cost and reasonable attorney's fees. A collection cost of 21% to 50% of the original balance may be assessed to your account should the matter be referred to an attorney.
5. In the event of suit the patient or guarantor agrees that Weber County is the county of proper venue.
6. Your signature transfers all rights and benefits contained in your insurance policy to the provider, including the right to act as the authorized representative during an appeal and the right to file suit for payment from the insurance company. The patient also has the right to pursue the appeal.

If you have no insurance:

- 1. Our average office visit cost is \$83 for a new patient and \$67 for follow-up visit, and \$156 for a consultation /routine checkup, this is just an estimate. Actual charges cannot be determined until you see the provider, and your charges are added to your account by our data processing team. The amount listed above is due prior to your appointment. You will receive a 10% discount on your exam by paying the amount listed above. If you have a more extensive exam than normal, lab work, radiology tests, or any other medical care you will incur additional charges. Please be aware that it is impossible to estimate your total charges prior to your exam. Therefore, it may become necessary to bill you for additional charges. If you receive a statement from us, payment is due 15 days from the date of your statement.

If you have insurance:

- 1. Ogden Clinic will submit the charges to your insurance company(s) as a courtesy to you if:
a) You bring a current insurance card with you to each visit.
b) You pay any required co-payment at the time of service.
2. Your insurance company may require a co-payment from you. Your contract requires this to be paid at the time of service. Your co-payment may not be your only liability. If your insurance carrier applies the billed charges to your deductible, denies the services, or considers the services non-covered, you may be responsible for payment of the service. Your insurance may charge a higher copay for specialists or visits after 5:00 pm, weekends, or on holidays.
3. If your insurance plan requires a referral to authorize this visit, we require that you bring a written referral from your primary care physician or verification that the referral has been called in to your insurance company. If you do not have the referral when you come, payment for the visit becomes your responsibility until the referral is provided to Ogden Clinic.
4. Some insurance companies do not cover Routine Services (i.e. Routine Physical Exam). A normal Routine Exam may include Lab Tests and/or X-ray Tests in addition to the Exam and could result in a charge of more than \$200.00. If your insurance does not cover Routine Services, please be aware that you will be required to pay for any denied services.
5. It may become necessary to bill you for additional amounts due by you. If you receive a statement from us, payment is due 15 days from the date of your statement.

Medicare and Medicaid Patients:

- 1. Routine Procedures for patients older than 18 years of age are not covered. If you are over 18 years old and have routine procedures performed that are denied by Medicare and Medicaid, you will be expected to pay for these services.
2. Medicaid requires you to present your Medicaid Card at each visit. Failure to present your card may result in you being financially responsible for the charges.
3. Medicare will only allow \$1740 per year for physical therapy service. Any physical therapy charges above \$1740 allowed is the patient's responsibility.

I have read and understand all of the above information. I agree to pay for all charges incurred including any collection costs and reasonable attorney's fees and other fees as described above.

Guarantor Signature _____

Date _____

Account # _____

Receptionist _____