Mountain West Surgical

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PATIENT INFORMATION

Patient Name_____
Last Name First Name Initial

Sex M F Marital Status M S D W Age_____ Birthdate_____ SS No._____

Spouse/Parent (if minor) Name:_____Birthdate:_____

Home Address _____ Apt.#_____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____ Work_____

Employer _____Address_____

Person Financially Responsible_____

Emergency Contact(not living with you)_____ Phone# _____

INSURANCE COVERAGE

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber's Name _____	Subscriber's Name _____
Ins. Co. _____	Ins. Co. _____
Ins. Phone_____	Ins. Phone _____
Employer _____	Employer _____
SS No. _____ Birthdate _____	SS No. _____ Birthdate _____
ID# _____ Group# _____	ID# _____ Group# _____
Co-Pay _____ Deductible _____	Co-Pay _____ Deductible _____

CONSENT TO TREAT

I consent to any medical or surgical treatment rendered the patient under the general or special instruction of the Physician.

_____ _____
Patient Signature or If Minor, Parent/Guardian Date

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ and assign directly to Mountain West Surgical all medical benefits, if any, including those otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian Date

PATIENT BALANCE POLICY

I understand that any balance on my account which is determined to be my responsibility must be paid in full within 30 days from the date the balance became my responsibility. If the balance is not paid in full within 30 days, I understand I will be charged interest in the amount of 3% per month as long as the balance remains unpaid. I further understand that should I be allowed to make monthly payments on my unpaid balance, there is no grace period on the monthly due date and I will be charged a $15.00 late fee if my monthly payment is not received by the close of business on the agreed upon due date. I further understand that should I fail to make payment on my account as agreed upon, my account will be sent to an outside collection agency and may affect my credit rating. I understand that there is a $20.00 charge on all returned checks.

_____ _____
Signature of Patient/Responsible Party Date