

Physician Group

OF UTAH, INC.

Patient name: Last, First, MI	Date of birth mm/dd/yyyy	Medical Record #
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As either the Patient or the legally authorized representative of the Patient, on behalf of the Patient receiving care in this Physician Group of Utah (PGU) Facility, I make the following consents, understandings, and agreements on my own behalf and on behalf of the Patient. In partial consideration of health care services to be provided to the Patient in the PGU Facility, including IASIS Healthcare and its affiliates.

Consent for Services: I hereby give consent to the Facility, its contractors, physicians, and employees to provide health care services to the Patient and to administer physician orders for the benefit of the Patient for this visit and any subsequent visits. I understand this consent may be revoked in writing at any time. I understand that there is a risk of substantial and serious harm involved in such health care services, and I accept such risk in the hope of obtaining beneficial results from such services. No promises of any particular outcome or successful result have been made. I understand and accept that there is some uncertainty involved in the health care services for which this consent is given. I understand that physicians are separately responsible to explain what they do and, in some cases, to obtain separate consent for services they perform.

Independent Contractors: I understand that some physicians and other health care providers furnishing service to the Patient, including residents, interns and other persons in training may be independent contractors and not employees of PGU; and such employees are subject to provisions of the Utah Governmental Immunity Act, UCA 63-30-1, et seq., U.C.A. 1953 as amended, which controls all procedures and provisions with respect to any claim of liability or malpractice involving such individuals.

Assignment of Benefits: Any and all benefits from insurance companies and other third party payors that are payable to the Patient or on behalf of the Patient for health care services and related payments for services rendered or provided to the Patient are hereby transferred and assigned to the Facility for the exclusive purpose of paying for charges associated with the health care services provided to the Patient in the Facility. I understand and intend that all insurance companies and other third party payers will pay benefits directly to the Facility in payment of the Facility's charges and the charges of any other health care providers for whom the Facility is authorized to bill in connection with health care services provided to the Patient.

Financial Responsibility: Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay for all the health care services rendered to the Patient in the Facility including but not limited to any amounts not paid by any insurance company or other third party payor (excluding contract discounts). Patient and the undersigned, if other than the Patient, remain responsible for all copayments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by insurance or third party payor. I understand and agree that any amounts not paid within 30 days of the date of the Facility's bill or statement for payment shall accrue interest at the rate of 1.5 % per month (18% per year) on the unpaid balance. In the event that any unpaid balance is placed with a collection agency or attorney for collection, Patient and the undersigned, if other than the Patient, each jointly and severally agree to pay a 20% collection fee, all costs and reasonable attorney's fees in connection with the collection process. As a courtesy to our personal pay patients, a discount is extended for specified services. The largest discount is available when services are paid in full on the date of service. Please ask about any discounts that may be available.

Medicare/Medicaid/Tricare Patient's Certification: I certify that the information given by me in applying for payment under the titles XVIII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, other intermediaries or carriers, or the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the Facility for its charges and for any charges of physicians or other providers for whom the Facility is authorized to bill in connection with its service.

Release of Information: The Facility is required by law to make and keep records of the Patient's medical treatment. The Facility safeguards those records and it uses and discloses such records and information they contain only in accordance with the State and Federal privacy laws. Such uses and disclosures are described in detail in the Facility's Notice Of Privacy Practices, which may be amended from time to time. I understand that either the Patient or I may ask to see a copy of the current notice at any time.

Blood or Blood Product Opt Out:

The following applies if initiated at the end of this paragraph: Because of the Patient's strongly held religious beliefs, this consent does not include consent to administer blood or other blood products unless the Patient subsequently agrees otherwise. The Patient understands that this limitation may cause some health care providers to decline to provide care, and may, in the opinion of some providers, adversely affect the outcome of the care.

DATE: _____ INITIALS: _____

The undersigned signs this document either as the Patient or the agent or representative of the Patient authorized to execute this document and to accept and agree to its terms on behalf of the Patient. I have read the foregoing and have had the opportunity to ask any questions I may have about the foregoing. Such questions have been answered to my satisfaction, and I indicate my understanding by signing below. I understand that I am entitled to request and obtain a copy of this document, as well as a copy of my billing rights according to the Fair Credit and Billing act. This document will remain in effect unless revoked in writing.

DATE: _____ SIGNATURE: _____

WITNESS TO SIGNATURE: _____ RELATIONSHIP IF OTHER THAN PATIENT: _____

I HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED OR BEEN OFFERED A COPY OF PGU'S NOTICE OF PRIVACY PRACTICE.

DATE: _____ INITIALS: _____

STAFF USE ONLY: IF UNABLE TO OBTAIN ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES, A DOCUMENTED REASON BY THE PGU STAFF MEMBER MUST BE ENTERED BELOW IN ACCORDANCE TO PGU POLICY:

PGU001-0411

PATIENT INFORMATION

Date	Patient Last Name	First Name	Middle Name
Address			City
State		Zip	
Gender	DOB / /	Status: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated	Home phone
Social Sec.#	Occupation	Employer	Business Phone
Employer Address			City
State		Zip	
Driver License #	E-mail Address	Cell Phone	

RESPONSIBLE PARTY INFORMATION

Relationship To Patient	Last Name	First Name	Home Phone	DOB / /
Home Address			City	State
Zip				
Social Sec.#	Occupation	Employer Name	Business Phone	
Company Address			City	State
Zip				
Spouse First Name (and last if different)		Employer	Phone	

INSURANCE INFORMATION (MUST BE FILLED OUT COMPLETELY FOR VERIFICATION PURPOSES) Check here if you have NO insurance

Primary Insurance Company	Co-pay Amount	Policyholder Name	Policyholder DOB / /	Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
Insurance Company Address			Effective Date: / /	Phone
Group	Policy #	Medicare #	Medicaid #	
2nd Insurance Company	Co-pay Amount	Policyholder	Policyholder Date of Birth / /	Patient Relationship to Insured <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____
Insurance Company Address			Effective Date:	Phone

INJURY INFORMATION (Must be filled out completely)

Reason for visit?	What type of injury are we seeing you for? (indicate right or left if appropriate)		
Was this an: <input type="checkbox"/> Accident <input type="checkbox"/> Injury	Date of accident or Injury / /	Place of Accident: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Home <input type="checkbox"/> School <input type="checkbox"/> Other: _____	
Name of School	Sport/Activity	How was injury sustained?	
Is this employment related? Yes <input type="checkbox"/> No <input type="checkbox"/> If so, who is your company's industrial carrier?			
NAME AND ADDRESS OF PLACE OF INJURY:			

Name and address of Referring Physician:	Phone (REQUIRED)
Emergency Contact Information (Full Name /Relationship to Patient):	Phone (REQUIRED)

I declare that the above answers and statements are true and correct to the best of my knowledge. I hereby acknowledge that I have read this entire section front and reverse, and agree to all of the terms herein.

_____ Date

X _____
Signature of Responsible Party/Patient

NEW PATIENTS: Please indicate how you heard about us.

SEE REVERSE SIDE

Newspaper Radio TV Yellow Pages Mailer Internet Physician _____ Friend Other _____