ASPEN FAMILY MEDICINE

Patient Information **Date:**_____

Name:_____ Preferred Name:_____

Mailing Address:_____Apt#_____City_____State____ Zip_____

Street Address:_____Apt#_____City_____State____Zip_____

Preferred Phone:( )_____ Alternate Phone:( )_____ DOB:___/___/___

Sex: M F Email:_____ Marital Status: Married Single Other

Preferred Language:_____ Ethnicity: Hispanic Non-Hispanic

Race: Caucasian Native American Asian African American Pacific Islander Other_____

Social Security #:_____ Employer:_____Employer Phone: ( )_____

Primary Care Physician:_____

Whom We Can Thank for Referring You to Us:_____

RESPONSIBLE PARTY INFORMATION (*If different from patient.*)

Name:_____

Relationship to Patient: (circle one) Spouse Father Mother Other:_____

Mailing Address:_____ Apt#_____City_____State___ Zip_____

Preferred Phone:( )_____ DOB: ___/___/___ Social Sec. No.:_____

Employer:_____ Employer Phone: ( )_____

PERSON TO CONTACT IN CASE OF EMERGENCY (*If possible, list someone with a different phone number than your own.*)

Name:_____ Relationship: (Circle one) Spouse Father Mother Other:_____

Home Phone:_____ MobilePhone:_____

INSURANCE INFORMATION

1. Primary Insurance Company:_____
   Claims Address:_____ City:_____ State____ Zip_____
   Group No. _____ ID No. _____
   Relationship of Patient to Insured: (circle one) Self Spouse Child Other_____
   Policy Holder:_____ DOB: ___/___/__

2. Secondary Insurance Company:_____
   Claims Address:_____ City:_____ State____ Zip_____
   Group No. _____ ID No. _____
   Relationship of Patient to Insured: (circle one) Self Spouse Child Other_____
   Policy Holder:_____ DOB: ___/___/__

MEDICAL INFORMATION RELEASE

I acknowledge that I have been provided a copy of the NOTICE OF PRIVACY PRACTICES of Aspen Family Medicine and that Aspen Medicine may release all or portions of my medical record to me, and to people of companies responsible to pay the charges for my care, such as my insurance or health benefits companies, or worker's compensation carriers. I further acknowledge that Aspen Family Medicine may disclose my patient information to referring or treating healthcare providers, and for paymentand health care operations. I hereby authorize Aspen Family Medicine to obtain my medical information from other health care entities and providers, including but not limited to, copies of lab results, diagnostic test reports, films/images, and other clinic information deemed necessary by Aspen Family Medicine physicians or representatives. I understand, as permitted by the federal privacy regulations and in accordance with Aspen AFamily Medicine privacy policy.

Patient/ Responsible Party Signature:_____Date:_____

CONSENT FOR TREATMENT

I hereby consent to the medical treatment, diagnostic and laboratory tests, and other procedures, which the physician(s) may deem advisable in treatment of my case (or as legal guardian for patient). Aspen Family Medicine will determine the proper disposition of any tissues, parts, or body fluids consistent with state and federal laws. This agreement will remain in effect until I choose to revoke it in writing.

Patient/Responsible Party Signature:_____Date:_____

CREDIT AND FINANCE CHARGE POLICY AND AGREEMENT

I hereby authorize any benefits due for me to be paid directly to Aspen Family, 36 N 1100 E, American Fork, Utah 84003. I understand and agree that I am financially responsible for all deductible amounts, co-insurance, non-covered services or services deemed as "non-medically necessary" by my third party insurance carrier. I agree that I am responsible for satisfying any conditions necessary for insurance or health benefits.

A finance charge (1.5% per month/APR 18%) may be added to any amount for which payment has not been received within 60 days from the date statement on which the amount appears. I hereby agree to pay a service charge of $20.00 for each check or other instrument tendered by me but returned to this facility. Additional service charge may be levied for accounts placed with third party collection agencies (TSI), or failure to make necessary co-payments at the time of service.

It is understood and agreed that if I fail to pay this account in accordance with policy, then I will pay all reasonable attorney fees and other costs incurred for collection of this account.

In consideration for medical services rendered, I (we) acknowledge that I (we) have received notice of Aspen Family Medicine financial policy and agree to pay for said medical services according to such terms.

I hereby expressly consent to receiving voice and SMS (text) messages (including pre-recorded messages) on my mobile phone number and any other telephones number(s) that I provide (either directly or through an intermediary) to Aspen Family Medicine or any of its affiliates, agents or contractors (including third-party billing and/or collection companies). I understand and agree that such messages may be sent by Aspen Family Medicine and/or by affiliates, agents or contractors and may be sent via automated dialing technology (i.e. auto dialer) and may consist of such things as offers, advertisements, solicitations for business, and/or collection efforts.

Patient/Responsible Party Signature:_____Date:_____

MEDICARE PATIENT AGREEMENT

(Required by Medicare for all Medicare claims)

Entitlee's Name Medicare Subscriber Number

I hereby request that payment of authorized Medicare benefits be made either to me or on my behalf to Aspen Family Medicine for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

This authorization is in effect until I choose to revoke it in writing.

Signature:_____Date:_____

Employee Signature:_____Date:_____

Tyson Boltz FNP-C | Joey McGovern DNP | Jerry Graves FNP-C

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB:_____

I,_____,
authorize_____
(Patient or Legal Representative (s)) (Name of physician / health care provider releasing records) to disclose to:

Name:_____
Phone:_____
Address:_____
Fax:_____
City, State, Zip:_____

The following protected health care information:
Entire medical record (NOTE: This may include records from other health care providers, patient history forms, insurance information, correspondence, etc. It is NOT strictly limited to records generated by the physician/health care provider indicated above.)
Entire medical record for specified date (s) of service: From:_____To:_____
ONLY the following specific information:
_____
_____
_____

I understand that information disclosed pursuant to this authorization may include information relating to the following, unless specifically restricted below:
- Psychological / psychiatric conditions - Drug and/or alchol abuse diagnosis and/or treatment
-HIV/AIDS diagnosis and/or testing - Sexually transmitted disease(s) and/or testing
-Genetic testing
List any
restrictions:_____
The purpose of the disclosure
is:_____

Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from redisclosing it. Other laws, however, may prohibit redisclosure.
Right to Refuse to Sign this Authorization: I understand that generally the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition my treatment, payment, or eligibility for health care benefits on my decision to sign this authorization.
Right to Revoke: I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on it, or unless this authorization is given as a condition of obtaining health insurance coverage and the insurer has a legal right to contest the policy or claim under the policy. To revoke this authorization, I will provide the Privacy Officer at the above listed physician/health care provider's office with a written revocation.
Right to Inspect: I understand that I have the right to inspect the health information I have authorized to be used or disclosed by this authorization form.
Right to Receive a Copy of Authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.
Expiration Date: I understand that unless I provide a written revocation at an earlier date, this authorization will expire in one year or as otherwise noted. Expiration Date:___/___/___

Signature of Patient or Legal
Representative(s):_____
(Note: if patient is a minor child, both parents may require by law to sign)
Printed Name(s):_____Date:___/___/___

Relationship to
Patient:_____
(if signed by other than patient)