



**Patient Information**

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Gender M/F

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Marital Status: M/S/Other

E-mail address: \_\_\_\_\_ DL# & State: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Responsible Party**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ M.I. \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Mailing Address: : \_\_\_\_\_ City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Gender M/F  
(If Different)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Marital Status: M/S/Other

E-mail address: \_\_\_\_\_ DL# & State: \_\_\_\_\_ SSN: \_\_\_\_\_

Employer: \_\_\_\_\_ Work #: \_\_\_\_\_

**Insurance Information**

Insurance Name & Address: \_\_\_\_\_

Policy Holder: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Relationship to insured: \_\_\_\_\_ Co-pay \$ \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Medical Consent, Credit Policy and Financial Agreement**

This is to certify that the undersigned consents to examination and treatment by the staff of Park City Healthcare, and is aware of Park City Healthcare's financial policy

I authorize such treatments, which may be recommended by my doctor and agreed upon by the doctor and myself.

1. I, (patient or responsible party), **not the insurance company**, am responsible for payment of all the charges incurred during my visit unless special arrangements are made in advance. Patient is responsible for payment of any and all letters requested by the insurance company.
2. All billed patient balances are due within 30 days from the date of service, and thereafter are subject to an 1 1/2 % monthly finance charge (18% A.P.R) Minimum finance charge is \$1.00.
3. I authorize and request that payments under my medical insurance program be made directly to the physician for including patient information to ancillary (such as Laboratory) providers of service. I further permit copies of this to be used in place of the original.
4. Urgent Care- if I am seen in Urgent Care Center, I may be assessed a \$50.00 urgent care fee. Most insurance companies honor and reimburse this fee; however, if this service is not covered is not reimbursed by my insurance, I am responsible for payment.

**I /We agree to pay all collections of costs & reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit.**

Print Patient's Name

Signature

Date Signed

**\*\*PLEASE CONTINUE ON BACKSIDE\*\***