Intermountain Neurology, Skyline Pain Clinic, Hormone Specialists Clinic

Jahan Imani, MD   Danna Schow, FNP-C   Jared Abrams, PA   Marinda Paskett, ANP-C

PATIENT INFORMATION

Last Name:		First:	Middle:	
Marital status: Single / Married / Divorced / Separated / Widow		Birth date:	Age:	Sex: ❑ Male ❑ Female
Street Address:		Social Security # (required):	Phone Number:	
City:	State:		ZIP Code:	

INSURANCE INFORMATION

Is the patient covered by insurance? ❑ Yes ❑ No					
Primary Insurance Name:					
Subscriber's Name:	Subscriber's S.S. #	Birth Date:	Policy Number:	Group Number:	Co-Pay:
Patient's relationship to subscriber: ❑Self ❑ Spouse ❑Child ❑ Other					
Address (if different):				Phone Number:	
Name of secondary insurance (if applicable):	Subscriber's Name:		Policy Number:	Group Number:	

IN CASE OF EMERGENCY

Name of Contact:	Relationship to Patient:	Phone Number:

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Intermountain Neurology and Skyline Pain Clinic or insurance company to release any information required to process my claims.

____

Signature   Date

5315 South Adams Ave Pkwy, Suite A & B   Washington Terrace, UT 84405

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722 W Shepard Lane, Suite 102 Farmington, UT 84025

Phone: 801.475.7707 or 801.476.4448

Fax: 801.475.7322 or 801.476.4449

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Beneficiary Signature on File Form

I authorize any holder of information about me, medical or otherwise, to release necessary information to my Insurance Company or its intermediaries or Carriers if needed for any related claim. I permit a copy of these authorizations to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to the Insurance company assignment of benefits apply.

Signature Required: ___________________________________ Date: ________________

Financial Policy

Our providers are participants in most health plans. However, ultimately it is the insured's responsibility to determine if the provider and/or services are covered on their plan. Both primary and secondary insurance will be billed. If no payment is received within 30 days, the patient is then responsible for the balance. Co-pays are due at the time of service. There is a $25 charge for not keeping a scheduled appointment if our office is not notified within 24 hours of your appointment. We do not accept checks. If payment arrangements are necessary, we will try to work with you and set up a plan that meets your needs. Delinquent accounts are turned over to a collection agency, at which time additional fees and interest will accrue.

Signature Required: ___________________________________ Date: ________________

Collection Fee

By signing below I agree to pay all amount(s) owed within 30 days. In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court cost and reasonable attorney's fees, ECT.) I will also be responsible for a collection fee of up to 40% of the principal amount owing as allowed by Utah Code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today of after today.

Signature Required: _________________________________ Date: __________________

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