**Jordan River Family Medicine**

**1868 W. 9800 S., Suite 100 South Jordan, Utah 84095**

**Phone (801) 433-2873 Fax (801) 433-5734**

**PATIENT INFORMATION (Please print clearly & fill out all that apply)**

PATIENT NAME : Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Middle\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX: M / F SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MARITAL STATUS: S / M / D / W

Preferred Phone # : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home **□** or Cell **□** Employer Name & # :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \*Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BILLING INFORMATION** (If Patient is over 18 the Patient is the responsible party)

(Excluding insurance)

RESPONSIBLE PARTY (**Person/Guardian signing paperwork**):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP TO PATIENT: □Self □Parent □Spouse □Legal Guardian

MAILING ADDRESS (if different from above):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHO CAN WE CONTACT IN CASE OF AN EMERGENCY? Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you give our office permission to discuss medical & billing information with emergency contact?** **□Yes □No**

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL & BILLING INFORMATION WITH FAMILY MEMBERS?

**□YES □NO** IF YES, PLEASE PROVIDE THEIR NAMES AND PHONE NUMBERS BELOW.

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION** DOYOU HAVE HEALTH INSURANCE? □YES □NO

IF YES, PLEASE PRESENT YOUR PHOTO ID WITH YOUR CARDS TO THE FRONT DESK TO TAKE A COPY. (PLEASE BE

AWARE THAT IF WE DO NOT HAVE YOUR CURRENT INSURANCE INFORMATION, WE WILL BE UNABLE TO BILL

YOUR CLAIM)

**PRIMARY INSURANCE:** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **IDENTIFICATION#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF INSURED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECONDARY INSURANCE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_IDENTIFICATION# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME OF INSURED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Do you have an Advance Directive? Y / N If yes please make sure we have an up dated copy in your chart.

(Please check appropriate boxes)

**LANGUAGE:** English/Spanish/Other ETHNICITY: □ Hispanic/Latino, □ Not Hispanic/Latino, □ Refuse to report

RACE: (select one) □ African American, □ White, □ Hispanic, □ Native American, □ Native Hawaiian, □ Pacific Islander, □ Asian □ Other

**Notice of Privacy Acknowledgement – By signing this form, you acknowledge having reviewed the “Notice of Privacy Practices” for Jordan River Family Medicine, either hard copy or online @ www.jrodanriverfamilymedicine.com**

**HIPAA approved AI may or may not be used to help scribe your visit properly.**

**I have read and agreed to financial agreement on back. I release JRFM and its physicians from any liability involving Covid 19 illness or exposure.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Signature Date**

**PLEASE READ AND SIGN FRONT AND BACK OF FORM**

**Financial Policy and Agreement**

Thank you for choosing us as your Health Care Provider. We are committed to excellent patient care. The following is an explanation of our Financial Policy and Agreement which you must read and sign prior to any current and future medical evaluation or treatment in this office. All patients must also complete the information and insurance form before seeing a provider.

**1**. I understand that I am financially responsible for all charges whether paid or not paid by my insurance. I am aware that if I do not provide current insurance information Jordan River Family Medicine will be unable to bill my claim.

**2.** Payment of all insurance co-payments and deductibles are required at the time medical services are rendered.

**3.** Patients who have no insurance are required to pay 100% of services rendered each visit. If this is impossible you will need to make payment arrangements with our billing office prior to any medical evaluation or treatment. We accept cash, checks, Visa, and Master Card.

**4.** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to your insurance carrier. In order to facilitate claims processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance company pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.

**5.** You are responsible for knowing what your insurance covers and the providers and networks covered under your health insurance plan. Any service provided, but not covered by your insurance company, you will be responsible to pay.

**6.** If your insurance company has not paid your full account within 60 days, the outstanding balance must be paid by you without further delay.

**7.** Monthly payments are required on all accounts with outstanding balances. A monthly finance charge of 1-3/4% per month (21% annual rate) will be charged to the amount not paid after 60 days, with a minimum charge of $.50 per month. By signing below, you acknowledge receipt of this Financial Policy and Agreement. If collection is made by suit or otherwise, patient and or responsible party agrees to pay interest until paid, collection costs up to 50% of the remaining balance, all attorney’s fees and court cost. Patient is responsible for payment, interest and any collection cost.

**8.** A $25.00 fee will be charged on all return checks.

**9.** Patients who fail to appear for their scheduled appointments may be charged a fee up to $60.00 unless the patient cancels the appointment at least 24 hours before the scheduled appointment time. Amount is subject to doctor review.

**USUAL AND CUSTOMARY RATES**

Our rates for medical services reflect the usual and customary rates in the community. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates for medical services.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize this office to release all information concerning my medical treatment to my insurance carriers and to any requesting referring provider (if any).

**AUTHORIZATION TO PAY BENEFITS**

I further and direct said agency, attorney, or insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my case, directly to the providers of this office for their professional services rendered. I understand this in no way relieves me from my personal responsibility for paying my provider when a statement, e-mail or text message is rendered. It is understood that signing of this form does not prohibit customary monthly billings.

A photocopy of this assignment will be considered as valid as an original.

**SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Responsible Party**