▪ **Canyon Medical Group** ▪ 1325 North 600 East, Suite 101 ▪ Logan, UT 84341 ▪ 435.750.5599

How did you hear about us? ☐ other physician ☐ friend/relative ☐ advertisement ☐ other _____

PATIENT INFORMATION → PLEASE FILL OUT COMPLETELY

Preferred **PHARMACY** (specify location, if necessary) _____

Full LEGAL Name _____ Sex _____ Date of Birth _____
Last First Middle

Preferred Name _____ Home Phone _____ SSN _____

Mailing Address _____ City, State _____ Zip _____

☐ Single ☐ Married ☐ Separated Race _____ Ethnicity _____ Religion _____

MOTHER: Name _____ Date of Birth _____ SSN _____

Cell Phone _____ Work Phone _____ Email _____

☐ Single ☐ Married ☐ Separated Race _____ Ethnicity _____ Religion _____

FATHER: Name _____ Date of Birth _____ SSN _____

Address (if different) _____ City, State _____ Zip _____

Cell Phone _____ Work Phone _____ Email _____

☐ Single ☐ Married ☐ Separated Race _____ Ethnicity _____ Religion _____

OTHER (step parent / legal guardian / **SPOUSE**) **:**

Name _____ Date of Birth _____ SSN _____

Address (if different) _____ City, State _____ Zip _____

Cell Phone _____ Work Phone _____ Email _____

☐ Single ☐ Married ☐ Separated Race _____ Ethnicity _____ Religion _____

Immediate Family Members who are also Canyon Medical Group Patients:

Name	Date of Birth	Name	Date of Birth
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

INSURANCE INFORMATION → PLEASE ALSO PROVIDE ACTUAL CARD TO BE SCANNED

Primary Insurance Company _____ Employer _____

Policy Holder Name _____ Relationship to Patient _____

Policy Holder Date of Birth _____ ID/Policy # _____ Group # _____

Insurance Claims Address _____ City, State _____ Zip _____

Secondary Insurance Company _____ Employer _____

Policy Holder Name _____ Relationship to Patient _____

Policy Holder Date of Birth _____ ID/Policy # _____ Group # _____

Insurance Claims Address _____ City, State _____ Zip _____

CONTACT INFORMATION ✓ CHECK ALL THAT APPLY

Do we have permission to leave appt. information: ☐on your answering machine/voice mail ☐w/ family member _____
Do we have permission to leave test results: ☐on your answering machine/voice mail ☐with family member _____
If no, how would you like us to contact you? _____

Emergency Contact: _____ Phone _____ Relationship to Patient _____

Other person(s) who may accompany my child to his/her appointment:

Name _____ Relationship _____ Name _____ Relationship _____

_____ _____
***Signature** of Patient (or representative if patient is under 18)* *Date*

WE APPRECIATE THE OPPORTUNITY TO SERVE YOU.
WE PLEDGE TO GIVE YOU OUR VERY BEST MEDICAL CARE.

In consideration for the professional services rendered to you, or at your request for your child or ward, by the doctor you agree to pay the reasonable value of said services to said doctor or his assignees at the time said services are rendered, or within thirty (30) days of billing if credit shall be extended. You further agree that the reasonable values of said services shall be as billed unless objected to by you, in writing, within the time for payment thereof. You further agree that a waiver of any breach of terms or conditions hereunder shall not constitute a waiver of any further term or condition, and you further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder to collect monies owed by you, including interest charges, processing fees, or commissions that may be assessed by any collection agency retained to pursue the matter.

Interest will be charged at the rate of $5.00 per month on the unpaid balance on all accounts. The interest shall be accrued both before and after a judgment, if any is entered.

Insurance provides for your reimbursement on ***allowed*** medical charges. As a courtesy to you, we will provide an itemized statement you may send to your insurance company for payment. We will be happy to submit to most insurance carriers if you have provided us, within all timely filing parameters, with policy numbers, insurance company address, place of employment, and any other pertinent information. You are responsible for all deductibles and charges not covered by insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations. This is YOUR responsibility.

I authorize the release of any medical information necessary to process any claim. I authorize payment to be made directly to the provider from my insurance company. I grant my permission to you or your assignee to telephone me at home, on a cell phone, or at my workplace to discuss matters relating to this form.

I certify that I have answered all questions on the form accurately and I hereby agree to abide the conditions outlined therein.

NOTE: The person signing below will be financially responsible for all charges incurred, for today's visit and all future visits, including any and all collection costs.

Please sign below if you agree to the above financial policy.

_____
Printed Name of Patient

_____ _____ _____
Signature of Patient (or representative if patient is under 18) *Date* *Relationship to Patient*

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I hereby acknowledge that a copy of *Canyon Medical Group's Notice of Privacy Practices* was made available to me. I further acknowledge and understand that if I have any questions about Treehouse's privacy practices or my rights with regard to my personal health information, I may contact their office manager for further information as set forth in the notice.

_____
Printed Name of Patient

_____ _____
Signature of Patient (or representative if patient is under 18) *Date*

For office use only

Patient _____ Date of Birth _____

I hereby certify that on ____/____/_____ (mm/dd/yyyy), I made a good faith effort to obtain the above patient's written acknowledgment of receipt of *Canyon Medical Group's Notice of Privacy Practices*, but was unable to do so for the following reason(s):

_____

_____

_____
Printed name of Canyon Medical Group Pediatric Staff Member

_____ _____
Signature of Staff Member *Date*