Patient ID#_____

Patient Information

→ Please fill out completely

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

Full LEGAL Name_____ Gender_____ Date of Birth_____
Last First Middle

Preferred Name _____ Primary Phone_____ SSN_____

Mailing Address_____ City, State_____ Zip_____

Cell Phone_____ Work Phone_____ Email_____

☐ Single ☐ Married ☐ Separated Race_____ Ethnicity_____ Religion_____

SPOUSE/PARTNER/OTHER: Name_____ Date of Birth_____ SSN_____

Cell Phone_____ Work Phone_____ Email_____

☐ Single ☐ Married ☐ Separated ☐Widowed Race_____ Ethnicity_____ Religion_____

SPOUSE/PARTNER/OTHER: Name_____ Date of Birth_____ SSN_____

Address (if different)_____ City, State_____ Zip_____

Cell Phone_____ Work Phone_____ Email_____

☐ Single ☐ Married ☐ Separated ☐Widowed Race_____ Ethnicity_____ Religion_____

Immediate Family Members who are also Canyon Medical Patients:

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

Contact Information

→ Check all that apply

Do we have permission to leave appt. information on your answering machine/voice mail or with a family member? ☐ Yes ☐ No

Do we have permission to leave test results or medical info on your ans. machine/voice mail or with a family member? ☐ Yes ☐ No

If no, how would you like us to contact you?_____

Emergency Contact: _____ Phone_____ Relationship to Patient_____

Other person(s) who may schedule my appointments or access medical records:

Name_____ Relationship_____ Name_____ Relationship_____

_____ _____

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

Insurance Information

→ Please also provide actual card to be scanned

Primary Insurance Company_____ Employer_____

Policy Holder Name_____ Relationship to Patient_____

Policy Holder Phone Number_____ Policy Holder Address_____

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

Insurance Claims Address_____ City, State_____ Zip_____

Secondary Insurance Company_____ Employer_____

Policy Holder Phone Number_____ Policy Holder Address_____

Policy Holder Name_____ Relationship to Patient_____

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

Insurance Claims Address_____ City, State_____ Zip_____

Canyon Medical Group – Notice of Privacy Practices (NPP)
Effective May 1, 2025

Your Rights Regarding Your Health Information:
As our patient, you have the right to:
Access and obtain a copy of your medical records.

Request corrections to your medical records if you believe information is incomplete or incorrect.

Request confidential communication (e.g., using a different phone number or mailing address).

Request restrictions on how your information is used or shared.

Get a list of certain disclosures we have made of your health information.

File a complaint if you feel your privacy rights have been violated, without fear of retaliation.

Our Responsibilities:
Canyon Medical Group is required to:
Maintain the privacy and security of your protected health information (PHI).

Provide you with this Notice describing our legal duties and privacy practices.

Notify you if a breach occurs that compromises the privacy or security of your information.

Follow the terms of this Notice and obtain your written authorization for certain uses and disclosures.

How We May Use and Share Your Information:
We typically use or share your health information in the following ways:

Treatment: To provide and coordinate your healthcare.

Payment: To bill and obtain payment from insurance companies and other payers.

Healthcare Operations: For office management, quality assurance, and administrative purposes.

Other uses and disclosures may include:
Public health and safety activities.

Required reporting to health oversight agencies.

Legal proceedings, law enforcement, or as otherwise required by law.

We will not sell your information or use your information for marketing purposes without your written authorization.

Contact Information:
If you have questions or concerns about this Notice or your rights, please contact:
Canyon Medical Group
1624 North 200 East, Suite 160
Logan, Utah
84341
Acknowledgment of Receipt
I acknowledge that I have received or had access to Canyon Medical Group's Notice of Privacy Practices.

Patient Name (Print): _____
Signature: _____
Date: _____
If applicable, Representative Name and Relationship to Patient: _____