# Utah Addiction Medicine (UAM)

## FINANCIAL POLICY AND AGREEMENT

Thank you for choosing us as your healthcare 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 the provider.

- Each patient is responsible for his or her own bill. Payment of all insurance co-payments and deductibles/ coinsurance is required at the time medical services are rendered. It is a courtesy for UAM to balance bill you for your patient portion after the insurance has processed the services rendered.
- Your insurance policy is a contract between you and your insurance company. We are not 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 immediately. 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.
- You are responsible for knowing what your insurance covers and the providers and network(s) covered under your health insurance plan. UAM strives to communicate with our patients which carriers we are or are not participating with. Yet, it is the patient's responsibility to ensure that the rendering provider(s) are in network with your insurance plan. You understand that you are responsible any services rendered, even when processed out of network by your carrier.
- If your insurance company has not paid your full account within 90 days you are responsible to pay the outstanding balance without further delay.
- Monthly payments are required on all accounts with outstanding balances. Payment plans may be set up for balances over 100.00. A credit card will be kept on file for payment towards balances. Your signature below authorizes UAM to withdraw payments to be applied toward any outstanding balances. If at any time the credit card on file is declined or no payment is received within thirty (30) days, the payment plan will be voided and the total balance is due upon receipt.
- A monthly finance charge of 11/2% monthly (18% annual rate) will be charged to the amount not paid after 30 days. By signing below, you agree to pay collection costs and/or attorney's fees on any delinquent balance, if referred to any agency or attorney for collection or suit, per Utah State Statutes.
- A $35.00 fee will be charged on all returned checks. Cash payments will be required for future payments if you have two (2) or more returned checks.
- Patients who fail to appear for their scheduled appointments may be charged a fee of $30.00 unless the patient cancels the appointment at least 24 hours before the scheduled appointment time.

**USUAL AND CUSTOMARY RATES**

Our rates for medical services reflect the usual and customary rates in the community. Unless we have accepted an alternate fee schedule from your insurance company, 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 requesting referring providers (if any). I also acknowledge that I have been provided a copy of the HIPAA Policies and Practices.

**AUTHORIZATION TO PAY BENEFITS**

I further authorize and direct said agency, attorney, or Insurance Company to pay from the proceeds of benefits of any recovery of 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 is rendered. It is understood that the signing of this form does not prohibit customary monthly billings.

______________________________________________________________________

Signature of Patient or Responsible Party                                   Date

______________________________________________________________________

Printed Name of Patient or Responsible Party

# PATIENT MEDICAL HISTORY FORM

Name:_____________________________________ Age:_________ Date of Birth______/______/__________

How did you find Utah Addiction Medicine (doctor, counselor, lawyer, friend, therapist, Internet)? _____________________________

How long have you had an addiction? ☐ less than 1 year ☐ 1-2 years ☐ 2-5 years ☐ 5 or more years

Briefly describe the primary reason for your visit today: ______________________________________________________

**MEDICAL HISTORY**: *Check if you have a history of…*

- ☐ Headache
- ☐ Seizures
- ☐ Sleep apnea
- ☐ Stomach ulcers
- ☐ Skin infection/abscess
- ☐ HIV/AIDS
- ☐ Asthma or other lung disease
- ☐ Tuberculosis
- ☐ Cancer *(list type)*___________
- ☐ Obesity
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Kidney disease
- ☐ Venous thrombosis/PE
- ☐ STDs
- ☐ Hepatitis C or B
- ☐ Pancreatitis
- ☐ Cirrhosis or other liver disease
- ☐ Heart attack or rhythm problems
- ☐ Infected heart valve (endocarditis)
- ☐ Other heart disease _________________
- ☐ Chronic pain (*where?*) _______________

**LIST any other DIAGNOSED MEDICAL CONDITIONS:**

____________________________________________________

**LIST ALL PREVIOUS SURGERIES:**

____________________________________________________

**LIST CURRENT MEDICATIONS & SUPPLEMENTS:**
*(use back of this form for more space)*

| Name | Dose | Frequency | Route |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Preferred Pharmacy:**__________________________________
*(Name, City)*

**LIST ALLERGIES TO MEDICATIONS:** ☐ No Known Allergies

____________________________________________________

____________________________________________________

**FEMALE PATIENTS ONLY:**

Date of last menstrual period ______/______/________

Currently using contraception? ☐ Yes ☐ No

Number of pregnancies? ____________

**PSYCHIATRIC HISTORY:** *Check if you have a history of…*

- ☐ Depression
- ☐ OCD
- ☐ Schizophrenia
- ☐ Personality disorder
- ☐ Insomnia
- ☐ Anxiety
- ☐ Bipolar disorder
- ☐ Psychosis
- ☐ ADHD
- ☐ Eating disorder (bulimia/anorexia)
- ☐ Are you currently suicidal/history of attempts? ______________
- ☐ Other self harming behaviors
- ☐ Hospitalized for psychiatric diagnosis? _____________________

**SOCIAL/DEVELOPMENTAL HISTORY:**

- Educational level: ☐ Less than high school diploma ☐ High school diploma ☐ Some college ☐ College diploma
- Learning disability? ☐ Yes ☐ No
- Dyslexia or difficulty with reading? ☐ Yes ☐ No
- Dysgraphia or difficulty with writing? ☐ Yes ☐ No
- Who lives at home with you? ___________________________
- Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
- Number of children: ______________________
- Employed? ☐ Yes ☐ No How long? ____________________
- Criminal justice problems (felonies, DUI, possession)? ☐ Yes ☐ No
- Have you experienced traumatic events? ☐ Yes ☐ No
- Engaged in risky sexual behavior (unprotected sex, sex with strangers, sex for money or drugs)? ☐ Yes ☐ No
- Smoking Status: ☐ Current If current: ____ packs per day ☐ Former (when quit: _______) ☐ Never smoked

**FAMILY HISTORY:** *Check if blood relatives have the following…*

| DISEASE | RELATIONSHIP TO YOU |
|---|---|
| ☐ Alcoholism | ______________________ |
| ☐ Nicotine addiction | ______________________ |
| ☐ Other drug addiction | ______________________ |
| ☐ Asthma/COPD | ______________________ |
| ☐ Obesity or eating disorder | ______________________ |
| ☐ Blood Clots/PE | ______________________ |
| ☐ Bleeding problems | ______________________ |
| ☐ Cancer | ______________________ |
| ☐ Depression/anxiety | ______________________ |
| ☐ OCD/Tourette syndrome | ______________________ |
| ☐ Schizophrenia/BPD | ______________________ |
| ☐ Psychosis | ______________________ |
| ☐ Diabetes | ______________________ |
| ☐ Heart disease/stroke | ______________________ |
| ☐ Liver disease | ______________________ |
| ☐ Tuberculosis | ______________________ |

# UTAH ADDICTION MEDICINE – PATIENT INFORMATION FORM

Please Print Clearly and Fill Out Completely

Patient Name ____________________________________________
Last Name First Name M.I Maiden

Mailing Address ____________________________________________
Street City State Zip

Home Phone (___ ___)____________________

Work Phone (___ ___)____________________

Cell Phone (___ ___)____________________

Preferred Phone:
☐ Home
☐ Work
☐ Cell

Email ______________________________________

Employer ______________________________________

Physician who sent you (First & Last Name) ____________________________

Primary Care Physician (First & Last Name) ____________________________

Gender - ☐ Male ☐ Female

Marital Status ______________

Date of Birth _____ / _____ / _________

SSN# ________________________

Preferred Language (if not English) ______________

**PARENT or RESPONSIBLE PARTY** (if patient is under the age of 18 or under the guardian care of a third party)

Name ____________________________________________
Last Name First Name M.I. Maiden

Address ____________________________________________
Street City State Zip

Home Phone (______)____________________

Work Phone (___ ___)____________________

Cell Phone (___ ___)____________________

Patient's Relationship to the Responsible Party ______________________

Gender - ☐ Male ☐ Female

Date of Birth _____ / _____ / _________

SSN# ________________________

Employer ____________________________

Employment Status - ☐ Full-time or ☐ Part-time

Other Parent's Name ______________________

**INSURANCE INFORMATION** (Despite our scanning your insurance card, please fill in all fields)

**Primary Insurance:**

Insurance Company ____________________________
Ins. Address ____________________________
Subscriber's Name ____________________________
Subscriber's Date of Birth _____ / _____ / _________
Subscriber's ID# ____________________________
Group# ____________________________
Patient's Relationship to Subscriber ______________

**Secondary Insurance:**

Insurance Company ____________________________
Ins. Address ____________________________
Subscriber's Name ____________________________
Subscriber's Date of Birth _____ / _____ / _________
Subscriber's ID# ____________________________
Group# ____________________________
Patient's Relationship to Subscriber ______________

**EMERGENCY CONTACT** (Not living with you)

Name ______________________________ Relationship ______________ Phone (______)______________

Address ____________________________________________

**RELEASE OF MEDICAL INFORMATON –** By signing below, I authorize the doctors and staff at Utah Addiction Medicine and its affiliates to disclose my protected health information, including but not limited to office notes, diagnostic tests, and lab results, to the below-named persons (e.g., spouse or parent). This authorization shall be effective until I revoke it in writing.

Individual #1 ______________________________ Individual #2 ______________________________

Relationship to Patient ______________________ Relationship to Patient ______________________

**FINANCIAL POLICY & ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES** – I am responsible, regardless of insurance coverage, for payment of all rendered services. I am responsible for copayments, deductible amounts, co-insurance, non-covered services, or services deemed as "non-medically necessary" by my insurance carrier. **I understand co-payments are due at time of service.** I am responsible for providing correct/updated insurance information so this office can bill my insurance. I understand that interest will accrue on all amounts 30 days and older at the rate of 18% annually until paid in full. If any amounts are referred to a third party collection agency, I am responsible for a collection fee of up to 40% of the principal amounts owing as allowed by Utah Code Annotated, sec. 12-1-11 in addition to any other amounts, such as interest or court costs. **I understand that some medical services performed in the office (blood/urine lab tests, injections, etc.) are billed separately from the office visit.**

By signing below, I acknowledge that I have received and had an opportunity to ask questions concerning the Notice of Privacy Practices. Furthermore, I have read the Financial Policy above and agree to abide by its guidelines.

____________________________________________

Patient or Patient's Representative Signature Date

If signed by Representative, state name of: Representative ______________________ Relationship to Patient ______________________

# UTAH ADDICTION MEDICINE

*HIPPA Privacy Authorization Form *Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 42 C.F.R. Parts 160 and 164) **

1. I authorize ***UTAH ADDICTION MEDICINE*** and ______________________________**to share and disclose** the protected health information described below for coordination of care.

2. Effective Period: This authorization for release of information covers the period of healthcare form: a. ____________________ to ____________________. **OR**
   b. all past, present and future periods.

3. Extent of Authorization: I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.)

4. This medical information may be used by the person I authorize for the coordination of care, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until ______________ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to consent a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name:_________________________________DOB:____________________

Signature:_________________________________ Date:_______________________

Relationship:_______________________

OFFICE (801)-852-9440 FAX (801)-852-9449 4659 S. Highland Dr.
Salt Lake City, UT 84117

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