PEDIATRIX
Specialty Care of Utah
Part of the Mednax® Family

Date: _____

Patient is accompanied by: _____
Primary Care Physician: _____

COMPLETE **ALL** INFORMATION (PLEASE PRINT)

Patient Information

Name (First)	(Middle)	(Last)	Date of Birth	Age	Gender
					M

Home Address	City	State	Zip Code

Home Phone	Cell Phone	Email Address

Responsible Party Information:

1. Name (First) (Middle) (Last) Social Security # Date of Birth Relationship to Patient

Home Address (If different from patient's)	City	State	Zip Code

Home Phone	Cell Phone	Email Address

Employer	Employer's Address	Work Phone

2. Name (First) (Middle) (Last) Social Security # Date of Birth Relationship to Patient

Home Address (If different from patient's)	City	State	Zip Code

Home Phone	Cell Phone	Email Address

Employer	Employer's Address	Work Phone

Name of nearest relative (or friend) not living with the patient	Phone	Relationship to Patient

Insurance Information

Primary Insurance	Claims Address (include city, state, zip)	Phone

Insured's Name	Group Number (if applicable)	ID Number

Insured's Date of Birth	Relationship to Patient	Copay Amount	Referral/Pre-Auth?

Secondary Insurance	Claims Address (include city, state, zip)	Phone

Insured's Name	Group Number (if applicable)	ID Number

Insured's Date of Birth	Relationship to Patient	Copay Amount	Referral/Pre-Auth?

Authorization to Bill and Agreement to Pay

I, the undersigned, certify that the information provided by me above is true and give permission to release information to 3rd party carrier(s) and do assign all insurance benefits for treatment to the above named provider and request that this assignment remain on file with my insurance carrier. I certify that a copy of this statement shall be as valid as the original. I also recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. I also agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection, including agency and attorney fees and court costs incurred as permitted by laws governing these transactions. A finance charge of 1.5% per month (18% annually) will be charge on all balances over 30 days, regardless of pending insurance claims.

Print Name of Responsible Party _____ Signature of Responsible Party _____ Date

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Patient Name: _____

The government now requires that we ask you about your race, ethnicity, and preferred language. Please take a moment and fill out this quick form. Thank you.

Ethnicity (culture, ancestry):

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

Race (physical appearance):

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Island
- ☐ White
- ☐ Other Race: _____

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other: _____

We would also like to update your child's record with:

Preferred Pharmacy: _____

Approx. Address/Location: _____

_____

Any known drug allergies:

- ☐ No
- ☐ Yes

If yes, please specify: _____

_____

Reactions: _____

_____

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Pediatrix Specialty Care of Utah
Ph #: 435-216-3590
Fax #: 435-237-0241

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby authorize ***Pediatrix Specialty Care of Utah*** to use and/or disclose health information of (***patient***) , which specifically identifies him/her or which can reasonably be used to identify him/her to carry out treatment, payment, and or health care operations. I understand that while this consent is voluntary, if I refuse to sign this consent, ***Pediatrix Specialty Care of Utah*** can refuse to treat the patient.

I have been informed that ***Pediatrix Specialty Care of Utah*** has prepared a notice (Notice of Privacy Practices) which more fully describes the uses and disclosures that can be made of my identifiable health information for treatment, payment, and health care operations. I understand that I have the right to review such Notice prior to signing this consent.

I understand that I may revoke this consent at any time by notifying ***Pediatrix Specialty Care of Utah*** in writing, but if I revoke my consent, such revocation will not affect any actions that ***Pediatrix Specialty Care of Utah*** took before receiving my revocation.

I understand that ***Pediatrix Specialty Care of Utah*** reserved the right to change its privacy practices and that I can obtain such changed notice upon request.

I understand that I have the right to request that ***Pediatrix Specialty Care of Utah*** restricts how my individually identifiable health information is used and/or disclosed to carry out treatment, payment, or health operations. I understand that ***Pediatrix Specialty Care of Utah*** does not have to agree to such restrictions, but that once such restrictions are agreed to ***Pediatrix Specialty Care of Utah*** must adhere to such restrictions.

_____ _____

Signature of patient or minor patient's representative **Date**
(Form MUST be completed before signing)

_____

Printed name of person signing

_____

Relationship to the patient

Print