MOUNTAIN STATE MEDICAL SPECIALTIES, INC.

***Patient Name** ____
Last First Middle

***Mailing Address**____
Street City State Zip

*** Date of Birth** _____ /_____ /_____ **SS #** ____________________ *** Gender** M F **Marital Status :** SG M W D SP

*** Home phone (   )**____________________ **Cell # (   )** ____________________

*** Race** ______________*** Ethnicity** ______________*** Preferred Language** ______________

E-mail Address: ______________________________*** Best form of contact** : Phone E– Mail

Employer ______________________________ **Phone (   )**____________________

Spouse's Name ______________________ **Best # to contact them: (   )**____________________

Nearest friend/relative not living with you :____________________**Best # to contact them: (   )**____________

Reason for Appointment (Optional)________________ **Referring Physician** ____________________

Guarantor Name ______________________________ **Relation to Patient**______________
Last First Middle

Address: ____
Street City State Zip

Home Phone (   )______________ **SS#**______________ **Date of Birth** ____/____/____ **Sex :** M F

Cell Phone # (   ) ______________ **E-Mail Address** ______________________________

Employer ______________________ **Phone #** (   ) ______________ **Marital Status:** SG M W D SP

Insured's Name : ______________________________**Relation to Patient** ______________
Last First Middle

Address :____
Street City State Zip

Home Phone (   ) ______________ **SS#** ______________ **Date of Birth**____/____/____ **Sex :** M F

Cell Phone # (   ) ______________ **E-Mail Address** ______________________________

Employer ______________________**Phone # (   )**______________ **Marital Status:** SG M W D SP

Primary Ins Name ______________________Secondary Ins ______________________

PLEASE NOTE: PAYMENT FOR SERVICES IS REQUIRED AT THE TIME OF SERVICE, AT WHICH YOUR PRIMARY INSURANCE WILL BE BILLED. INSURANCE CO-PAYMENTS AND DEDUCTIBLES MUST BE PAID WHEN SERVICES ARE RENDERED. IF YOU HAVE ANY QUESTIONS ABOUT YOUR FINANCIAL RESPONSIBILITY, PLEASE ASK A MEMBER OF OUR STAFF. THANK YOU FOR ALLOWING MOUNTAIN STATE MEDICAL SPECIALTIES TO CARE FOR YOU . **ALL INFORMATION IS CONFIDENTIAL. THE FOLLOWING NOTICE IS REQUIRED AND IMPERATIVE FOR YOUR RECORDS. THIS IS A LIFETIME AUTHORIZATION UNLESS REVOKED IN WRITING.**

I authorize Mountain State Medical Specialties, Inc. and its physicians and providers to diagnose and provide medical care for the above named patient. I am aware that this consent includes all procedures including treatment and surgery. I am aware that if I have a surgical procedure my specimen will be sent for histopathology and I consent to the release of my information for this purpose.

☆ Patient /Guarantor Signature ______________________________Date:______________

I authorize payment of medical benefits to the above mentioned provider(s) for all services rendered. Please accept a photocopy of my signature as the original on file. I am aware that any changes by my insurance are my responsibility. I authorize the release of my medical information for the processing of my claims. I understand that if I have a surgical procedure I will have additional charges for the pathology. I am aware that if I have an HMO/MC plan that I am responsible for any obtaining authorization for my visits. If I do not follow the guide-lines set by my insurance company I will be fully responsible for any and all charges. I understand that I am responsible for any remaining balance. I understand that payment is due in full within 90 days of the date of my first statement (REGARDLESS OF INSURANCE) unless other financial arrangements have been made. As a courtesy, your statement will be mailed to you free of charge, any additional statements will incur a $1.50 statement processing fee. Workers Compensation is not accepted.

☆ Patient /Guarantor Signature______________________________Date: ______________