FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

PATIENT NAME _____

I authorize treatment of the person named above as patient, and as the responsible party I agree to pay all fees and charges for treatment as shown by statements promptly upon presentment thereof, unless credit arrangements are agreed upon in writing. Charges shown by statements are deemed to be correct and reasonable unless protested in writing within (3) days of the billing date. If this account becomes delinquent, I agree to pay all court costs and collection fees. It is agreed that payments will not be delayed or withheld due to pending of insurance claims thereon, and the proceeds of insurance are assigned to Moab Regional Hospital. I hereby authorize Moab Regional Hospital to furnish information to insurance carriers concerning illness, injuries and treatments and I hereby assign to Moab Regional Hospital all payments for medical services rendered by myself or my dependents. I UNDERSTAND I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE.

Signature _____ Date _____

IF YOU DO ***NOT*** HAVE YOUR INSURANCE CARD WITH YOU IN ORDER FOR US TO PHOTOCOPY, PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME OF INSURANCE _____

POLICY # _____

ADDRESS OF INSURANCE _____

PHONE NUMBER OF INSURANCE _____

PLEASE COMPLETE THE FOLLOWING ONLY IF THE POLICY HOLDER (PERSON PROVIDING INSURANCE COVERAGE) IS NOT THE PATIENT.

NAME OF POLICY HOLDER _____

BIRTHDATE OF POLICY HOLDER _____

ADDRESS OF POLICY HOLDER _____

EMPLOYER OF POLICY HOLDER _____