Patient Information

Confidential Record: Information contained here will not be released unless you have authorized us to do so.

Scott A.Leckman M.D., 1220 East 3900 South, #3G, Salt Lake City, Utah 84124 (801)268-4924

Name of Patient:_____ Date of Birth:_____ Age:_____

Home Address:_____ City/State/Zip_____

Home Phone:_____ Work/Cell:_____ SS#_____

Please Circle Sex: M F Single Married Widowed Divorced

Employer:_____ Occupation:_____

Address:_____ City/State/Zip:_____

Person responsible for paying the bills or person insured

Responsible Party Name: _____ SS#_____

Address: _____ City/State/Zip_____

Relationship to Patient: _____Date of Birth: _____

Employer: _____ Business Phone: _____

Employer Address: _____ City/State/Zip: _____

Emergency Contact:_____ Phone Number:_____

Your Pharmacy:_____ Phone Number:_____

Insurance- If you have a subscriber card with you, information need not be entered

1st Insurance Company_____ Subscriber: _____

Insurance Address: _____ City/State/Zip_____

Policy #: _____Group #:_____

2nd Insurance Company_____ Subscriber: _____

Insurance Address: _____ City/ State/Zip: _____

Policy #:_____ Group#:_____

As a service to you, we will bill Insurance if proper information is given. Otherwise, you are responsible for billing your insurance. However, you are responsible for full payment of you account within 90 days.
A statement will be mailed to you at the beginning of each month as long as there is an outstanding balance on your account.

Any accounts still outstanding after 90 days and if no payment arrangements were made, will be sent to a collection agency. After an account has been sent to collection services will be provided on a cash basis only. The patient will be responsible for any expenses related to the collection of the amount owed.

I agree with the terms and conditions for payment stated above and, if applicable authorize Scott A. Leckman M.D. to furnish designated insurance carrier any information they may request regarding my illness or injuries.

Patient Signature_____ Date_____