

J. Gregory Kjar, M.D.415 South Medical Dr. Suite #B-200
Bountiful, UT 84010 801-295-9105**Premier Plastic Surgery Group of Utah, LLC**

Patient's Name:			Age:	Date of Birth:
Male	Female	Single	Divorced	Married
Home Phone:				
Street Address:			Work Phone:	
City:	State:	Zip:	Cell Phone:	
Social Security #:			E-mail address:	
Employer:				
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Guarantor's Name:			Age:	Date of Birth:
Relationship to Patient:	Self	Spouse	Parent	Other:
Home Phone:				
Street Address:			Work Phone:	
Cell Phone:				
City:	State:	Zip:	E-mail address:	
Social Security #:			Employer:	
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Primary Medical Insurance Co.:			Address of Primary:	
Name of Insured:		DOB:		
Relationship to Patient:	Self	Spouse	Parent	Other:
ID#:		Group#:		
<hr/>				
Secondary Medical Insurance Co.:			Address of Secondary:	
Name of Insured:		DOB:		
Relationship to Patient:	Self	Spouse	Parent	Other:
ID#:		Group#:		
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Referred by:				
Reason for visit:				
Notify in emergency:			Phone:	

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. We reserve the right to charge for collection fees on balances 90 days or older. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and costs of collection. THIS OFFICE CANNOT HOLD ANOTHER PARTY RESPONSIBLE FOR PAYMENT OF SERVICES YOU RECEIVE. If you pay your account it does not in any way prevent or delay you from collecting from the responsible party.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled to: Premier Plastic Surgery Group of Utah, LLC or Intermountain Plastic Surgery Associates, PC. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

I also understand that photographs may be taken in the management of my case and I give my permission for their use in patient education, presentations, and publications.

Signature _____ Date _____