



Welcome to Alpine Family Medicine!

ALPINE FAMILY MEDICINE

Peter V. Sundwall Jr., M.D.

Daniel W. Egan, M.D.

Thank you for choosing us to care for your family. Our goal is to treat you like we would want to be treated.

Circle your doctor's name: Egan/Sundwall

Patient Name: _____
 Street Address: _____
 City: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 Patient SSN: _____ Birth Date: _____
 E-mail _____ Pharmacy & Location: _____
 Emergency Contact Name and Relationship: _____
 Emergency Contact Phone: _____

Responsible Party (Guarantor Primary Insurance):

Guarantor Name: _____ Date of Birth: _____
 Guarantor SSN: _____ Insurance Name: _____
 Policy number: _____ Relationship to Patient: _____
 Guarantor Address: _____ City: _____ Zip: _____
 Guarantor Phone: _____

Responsible Party (Guarantor Secondary Insurance):

Guarantor Name: _____ Date of Birth: _____
 Guarantor SSN: _____ Insurance Name: _____
 Policy number: _____ Relationship to Patient: _____
 Guarantor Address: _____ City: _____ Zip: _____
 Guarantor Phone: _____

I hereby give my consent for Alpine Family Medicine to use and disclose my protected health information (PHI) to carry out treatment, payment and health care operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Alpine Family Medicine reserves the right to revise its notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Alpine Family Medicine, 38n East Red Pine Drive, Alpine Utah, 84004.

With this consent, Alpine Family Medicine may call my home, leave messages, send me regular mail, or e-mail in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls or communications pertaining to my clinical care, including laboratory test results, among others.

By signing this form, I am consenting to allow Alpine Family Medicine to use and disclose my PHI to carry out TPO.

I also agree to be responsible for any fees not covered by insurance and any collection charges, interest charges, or legal fees on accounts past due.

I authorize Alpine Family Medicine to use and disclose my health information to the following persons: _____

Print Patient's Name

Date

Print Name of Legal Guardian (if applicable)

Signature of Patient or Legal Guardian

