Intermountain Medical Group

Clinic Reinstatement Application

Date of Application: _____

Patient Name:_____ SSN:_____

Address:_____

Home Phone: (___)_____ Work Phone:_____

Guarantor Name: _____ SSN:_____

Address:_____

Home Phone: (___)_____ Work Phone:_____

Date of Birth: _____

Explanation of why you feel you should be reinstated:

_____

_____

_____

_____

Additional Family Members to be Reinstated: _____

_____

I agree to the following terms upon approval of reinstatement:

- All past due balances have been paid in full.
- Patient agrees to notify the provider 24 hours in advance of a cancellation.
- Patient agrees that the discharge will be reinstated if they miss another appointment without notifying the clinic in advance.

_____ _____
Signature of Guarantor/Patient Date

FOR OFFICE USE ONLY

Date of Discharge: _____(Reinstatement cannot be approved until one year after discharge)

_____ _____ _____ _____
Signature of Clinic Manager Date Signature of Physician Date

Request t50092