Northern Utah Dermatology
Medical Surgical Cosmetic

Patient Name:_____ Date of Birth: _____

HIPAA

Patients are protected under the Federal Health Insurance Portability and Accountability Act (HIPAA). This Federal Law prohibits any staff member of Northern Utah Dermatology from discussing appointments, medications, test results or other treatment plans with anyone other than the patient, unless patient is a minor.

According to this Federal Law, if your spouse or adult children assist with making appointments for you or if you are an adult college student away at school and your parents assist with prescriptions and appointments, you need to have their name listed below. If you would like to permit someone to discuss your personal medical condition, confirm an appointment, or obtain any results please list their name(s) below.

Please check mark the following methods Northern Utah Dermatology can contact you for medical information and appointments

You may leave a message regarding appointments

- ☐ Home answering machine
- ☐ Cell phone voice mail
- ☐ Work phone voice mail
- ☐ With another person that answers the phone
- ☐ Information through mail

You may leave a message regarding medical information

- ☐ Home answering machine
- ☐ Cell phone voice mail
- ☐ Work phone voice mail
- ☐ With another person that answers the phone
- ☐ Information through mail

Name of Individual	Relationship to Patient	Phone

Patient or Guardian Signature:_____ Date: _____

I acknowledge and understand the above HIPAA policies and understand I may request a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act.

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Cancellation Policy

Out of respect for all patients waiting to see a provider, Northern Utah Dermatology has a 24-hour cancellation policy. I will be charged a **$25.00** no show fee for regular appointments and **$100.00** fee for and surgical appointments **if I do not call to cancel within 24 hours or show up to my appointment.** Prior to scheduling a filler appointment, a **$100** deposit will be required that will be applied to your service. **If you cancel after the 24 hours and/or no show your appointment the $100 deposit will not be refunded.**

Financial Policy

Fees are due at the time of service including all co-payments and charges for cosmetic care. I realize that any services deemed a non-covered benefit by the physician or insurance company will be the patients' responsibility.

Minor Patients

A legal guardian MUST ACCOMPANY children under the age of 18 to their initial appointment so that proper forms can be completed and your child can be treated. Children without a legal guardian at their initial visit will be rescheduled. Signed forms in lieu of parent/ legal guardian's attendance are not acceptable. Grandparents, babysitters, older sibling etc. are not considered legal guardians

Insurance/Referral Policy

If my insurance plan requires a referral to see a specialist, it is my responsibility to obtain a referral from my Primary Care Physician and will obtain updated ones as needed. I understand that should I fail to have a valid referral for my visit, I am completely responsible for all charges incurred.

Insurance Policies

I will confirm my insurance is current at each visit. If there is a change I will provide a valid insurance card or a temporary print out at the time of my visit. My insurance carrier may consider certain routine services in dermatology to be surgical in nature and separate co-insurance, deductibles or co-payments may apply. I understand it is my responsibility to understand my policy and what will be covered. If insurance information I present at the time of my visit is not correct, I will be responsible for all charges incurred.

Insurance Inquires

From time to time I may receive a letter from my insurance company requesting information about my coverage. I understand that claims will not be paid without my providing this information, and the balance will become my responsibility.

Account Balances

All balances are due in full when statements are received. It is my responsibility to contact the office to arrange for an acceptable payment plan should I be unable to pay my balance in full. Any balance left unpaid after 120 days will be considered for collections. Should my account be sent to collections, I understand I will be responsible for an additional administrative collection fee plus any attorney/court fees which may be added to my account during efforts to obtain payment. I am responsible for any bank fees associated with returned check fees plus a $25.00 administrative processing.

Billing Authorization

Northern Utah Dermatology is a participating provider for Medicare/Medicaid and a variety of other insurances. I permit a copy of this signature authorization to be used in place of the original and request payment of medical insurance benefits to Northern Utah Dermatology. Regulations pertaining to Medicare assignment of benefits apply.

Consent to Medical Care

I hereby give consent to the providers at Northern Utah Dermatology for medical evaluation and treatment. This permission includes injections and/or treatment of lesions requiring minor surgical procedures in the office. I consent to the procedures standard to the care of Dermatology. My signature authorizes the providers to release medical information to the primary care or referring physician. To consultants if needed and as necessary to process insurance claims, insurance application, and prescriptions.

I hereby acknowledge that I have read, understand, and agree with the policies set forth by Northern Utah Dermatology and any change made by me will be in writing.

Patient or Legal Guardian Signature:_____**Date**:_____