PATIENT INFORMATION

JORDAN VALLEY DERMATOLOGY

DOUGLASS W. FORSHA, M.D.

PLEASE COMPLETE ALL INFORMATION

Last Name	First Name	Middle	D.O.B	Sex	Marital Status M S D W	Social Security No.

Home Address (Apartment No.)	City	State	Zip	Home Phone

Name of Patient's Employer	Address	City	State	Zip	Work Phone

E-mail Address	May we E-mail personal medical info to you? **YES or NO**	Cell Phone

May we leave personal medical info on your answering machine or cell phone? **YES or NO** If yes, which # listed would you prefer we call and/or leave info on?	Best Phone

	Phone Number

(PERSON ACCOMPANYING THE PATIENT IF UNDER 18)

Last Name	First Name	Middle	D.O.B	Sex	Marital Status M S D W	Social Security No.

Home Address (Apartment No.)	City	State	Zip	Home Phone

Relationship to Patient	Work Phone

INSURANCE COVERAGE – #1 (PRIMARY) *WE MUST HAVE COPIES OF INSURANCE CARDS*

Insurance Company #1	Phone

Address of Insurance Company #1	City	State	Zip

Primary Insured Person	Insurance Subscribers Date of Birth	Relationship to Patient

Social Security No.	Insurance ID No.	Group No.

Employer Name

INSURANCE COVERAGE – #2 (SECONDARY)

Insurance Company #2	Phone

Address of Insurance Company #2	City	State	Zip

Insured Person	Insurance Subscribers Date of Birth	Relationship to Patient

Social Security No.	Insurance ID No.	Group No.

Employer Name

Consent for Treatment

Patient Name:_____

I, the undersigned, give permission to release information to your insurance carrier(s) and do assign all insurance benefits for treatment to be paid directly to the Jordan Valley Dermatology Center provider(s) and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be as valid as the original.

I, the undersigned, consent to the procedure(s) rendered by Jordan Valley Dermatology Center provider(s) for the treatment of my case, including but not limited to the following: Warts, Photo–Dynamic Therapy Treatment, Seborrheic Keratosis, Keloid Scarring, Skin-tag removal, and other surgical procedures. I also understand that Jordan Valley Dermatology Center office policy requires that **ANY and ALL** lesions removed **WILL BE** sent off for review by a Pathologist. Pathology fees may be billed separately.

*Signature _____ Date _____

Financial and Insurance Policy

As a service to you and in an effort to keep costs down, we have established some basic policies and guidelines. We have found that our patients have different financial needs and many of them vary depending upon the insurance company with which they are contracted. Please find the type of insurance policy listed below that applies to your situation and make arrangements accordingly, ***It is also important for you to understand that your contract with an insurance company is between you and them; therefore, the ultimate responsibility for payment belongs to you.***

1. If your insurance policy is a COMMERCIAL PLAN with which we are contracted, we will adhere to the written insurance policy. You must have a current medical card at the time of your appointment; otherwise, you are considered a cash patient and must pay in full at the time of service.
2. If you are a **CASH PATIENT** and establish yourself as such with our office, payment in full is always required at the time of service.
3. It is your responsibility to make sure that all services rendered in the office fall under your policy guidelines. If your insurance requires a referral from your primary care physician, these arrangements must be made prior to your appointment. If you do not provide our office with a referral, you will be responsible for the charges incurred. If you are unsure of what your policy covers, please contact the Customer Service number on the back of your insurance card.
4. ***If you are an established patient and miss an appointment without notifying us 24 hours in advance, your account may be charged $25.00 for each missed appointment.***
5. ***Specialist Co-pays are required to be paid in full at each office visit including Follow-Up appointments.***

I, the undersigned, recognize that if my account/co-payment is not paid in full or payment arrangements are not made within 30 days, Jordan Valley Dermatology Center may send any unpaid balances to collections which may also be reported negatively to the credit bureau. I agree that, if my unpaid account is sent to collections, I will be responsible for any balance due, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee equal to 40% of the past due balance. For your convenience, we accept VISA, MasterCard, American Express and Discover Card.

I understand the terms of these Financial and Insurance Requirements and agree to remit payment accordingly.

*Signature _____ Date _____

MEDICAL AND FINANCIAL AUTHORIZATION RELEASE

Patient Name:_____ Today's Date:____/____/_____

Do you give our office permission to discuss your medical or financial information with family members?
YES or NO

If Yes, please provide their names and phone numbers below.

Name:_____ Relationship:_____

Phone # (day): ( )_____ Phone # (evening): ( )_____

HIPPA PATIENT CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient understands that:

* Protected health information may be disclosed or used for treatment, payment, or health care operations.
* The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
* The Practice reserves the right to change the Notice of Privacy Practices.
* The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
* The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
* The Practice may condition receipt of treatment upon the execution of this Consent.

Printed Name-Patient or Representative/Relation if other than Patient: _____

Signature: _____

Witness:

Printed Name – Practice Representative:_____

Signature: _____