Integrated Dermatology Group – Patient Information

Amy V. Curtis, M.D. Jennifer Walker, PA-C
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Date _____

PATIENT NAME_____ Date of Birth _____ Age ___Sex__

Mailing Address_____City_____State___Zip_____

Home Phone # (___) _____Cell Phone # (___) _____

E-Mail Address_____

Contact me by E-mail regarding promotions and newsletters Yes ___ No___

Responsible Party Name (if patient is a minor) _____

Mailing Address_____City_____State_____Zip_____

Home Phone # (___) _____ Cell Phone # (___) _____

INSURANCE INFORMATION

Insurance Name_____ ID or Policy Number _____

INSURED NAME (if different then patient or responsible party) _____

Date of Birth _____ Relationship to patient _____

Mailing Address_____City_____State___Zip_____

Home Phone # (___) _____Cell Phone # (___) _____

EMERGENCY CONTACT_____ Relationship to Patient _____

Home Phone # (___) _____ Cell Phone # (___) _____

How did you hear about us?

Patient Referral___ Insurance Directory___ Internet Search ___ Doctor Referral___ Phone Book ____

*** Preferred Pharmacy** _____

*** Primary Care Physician** _____

FINANCIAL POLICY FOR INTEGRATED DERMATOLOGY OF BOUNTIFUL

Thank you for choosing Bountiful Dermatology for your Dermatology and Skin care needs. We are committed to providing you with quality and affordable health care. Our staff will work very hard to make ensure your insurance paperwork is filed accurately and promptly.

Please read and initial all of the following

___ I understand that insurance is a contract between me the patient and health insurance company.

___ I understand that if there are referrals or pre-authorizations that are required for my evaluation or treatment it is my responsibility to obtain such prior to receiving treatment. It is not the responsibility of Dr. Curtis or staff.

___ I understand that if my insurance does not cover a specific procedure treatment or diagnosis it is my responsibility to resolve such with my insurance company and not the responsibility of the staff of Bountiful Dermatology or Dr. Curtis

___ I understand that Bountiful Dermatology will file claims to my insurance company as a convenience to me and that any unpaid balances are my responsibility and will be paid by me in a timely manner.

___ I understand that some dermatological concerns and procedures are deemed “cosmetic” by the insurance company and are therefore not covered by my health insurance.

___ I understand that Co-pays and other out of pocket payments are due on the day of my appointment.

___ I understand some dermatological concerns will not resolve after one visit and that I will be required to pay a copay for each and all follow up appointments (the only exceptions are suture removals and bandage changes).

1- Insurance is a method of reimbursement to the patient for fees paid to the doctor and is not considered a substitute for payment. We are willing to extend credit for a period of 45 days, allowing your insurance time to pay your claim. If your insurance has not paid within this amount of time, payment in full is expected from the patient or, in the case of a minor, the responsible party.

2- ALL CO-PAYMENTS AND DEDUCTIBLES are due AT THE TIME OF SERVICE. A $5.00 billing fee may be charged each billing cycle for any balances not made at the time of service.

3- There is a $25.00 charge for all checks returned by your bank.

4- It is the responsibility of the patient, or in the case of a minor, the responsible party, to obtain any and all referral or authorizations required by your insurance. Failure to obtain referrals or authorizations DOES NOT release the patient or the responsible party from payment of services not covered by your insurance.

5- Payment in full is expected at the time of service for all CASH-PAY ACCOUNTS. Surgical charges may be eligible for payment arrangements with authorization from the provider in advance.

6- There is a $35.00 charge for all appointments not cancelled at least 24 hours in advance.

7-There is a $75.00 charge for all procedures not cancelled at least 24 hours in advance.

I hereby consent to any medical treatment rendered to me, or in the case of a minor, for whom I am legally responsible (hereafter known as "the minor”), the minor, and guarantee payment of charges incurred on my or the minor's behalf.

Regardless of insurance coverage, I know that I am responsible for payment of this account.

I hereby assign and authorize payment of all medical and/or surgical benefits to which I or the minor are entitled for these services, including major medical benefits, Medicare, private insurance and all other health plans to: Dermatology and Aesthetics Center of Utah, 1222 W Legacy Crossing Blvd, Suite 200, Centerville, UT 84010. This assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary to secure the payment of this account. I agree to pay a "repeat billing fee" of $5.00 per month for balances more than 60 days or more overdue. I also agree to pay an interest charge of 1.5% per month (18% per annum) on balances 60 days and older. In the event that any balance is not paid, I, the undersigned, jointly and severally agree to pay all costs incurred in collection of the unpaid balance, including a collection fee of 33% of the unpaid balance, any attorney's fees, and court costs.

Patient Name (Print)_____Date of Birth_____

Signature_____Date_____

Printed Name (if signing for a minor) _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you

- Most uses and disclosure of psychotherapy notes
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations
- Disclosures that constitute a sale of PHI under HIPAA
- Other uses and disclosures not described in this notice

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health
- Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of (Date): _____and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with our office and with the State of Utah. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

The undersigned acknowledges that they have received, read, and understand this notice of privacy practices.

Printed Name of Patient or Representative: _____

Signature: _____ Date: _____

Relationship to Patient (if other than Patient) _____

Witnessed by (if required) _____

PERMISSION TO SHARE LIMITED HEALTH INFORMATION WITH FAMILY/FRIENDS

Patient Name _____ DOB _____

By signing this paper below, I give permission to the person(s) listed in the table documented to receive limited information about my care. I understand my healthcare provider will use their professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information that does not pertain to assisting with my health care and any copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state in writing otherwise.

Date of Permission	**Name of Individual & Relationship to Patient**	**Comment/Instructions** *(i.e. may pick up meds, may disclose test results, etc.)*	**Patient/Guardian Initials**

THE PHYSICIANS/STAFF HAS MY PERMISSION TO: (Please check all boxes that apply)

☐ Leave message on cell phone Cell phone number: _____

☐ Leave message at work Work phone number: _____

☐ Leave a message on voicemail Phone number: _____

☐ Leave a detailed message on answering machine Phone number: _____

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Printed name of Patient or Legal Guardian Relationship (*if not self)*