West Valley Dermatology
Dr. Jesse Jensen, D.O.
3465 S 4155 W, Suite 1
West Valley City, UT 84120
801-966-1403
(Please print clearly in BLACK INK only)

Today's Date _____

Email Address _____ Okay to email statement ____ YES ____ NO

Patient Information

Name _____ Birthdate _____ SSN# _____

If Under 18 Parents Name _____Birthdate_____SSN#_____

Address _____ City _____ State _____ Zip _____

If PO Box, Physical Address_____

Home Phone (____)_____ Work Phone (____)_____

Cell Phone (____)_____ Preferred Language_____

Sex: M F Marital Status: S M W D Ethnicity/Race _____

Occupation _____ Responsible Party Employer _____

How did you hear about us (phonebook, signage, insurance co., another patient)? _____

Or Name of Physician referred by _____

Insurance Information

Primary Insurance Name_____ ID # _____

Subscribers name if different than above_____ Birthdate _____

Relationship to patient_____

Address (if different than above) _____

City _____ State _____ Zip _____

Secondary Insurance Name_____ ID # _____

Subscribers name if different than above_____ Birthdate _____

Relationship to patient_____

Address (if different than above) _____

City _____ State _____ Zip _____

Patient Name _____

PLEASE READ AND FILL OUT THE NEXT 3 SECTIONS AS THEY APPLY TO THE PATIENT

Section 1

IN CASE OF EMERGENCY

Please give name, address and phone number of a friend or a relative NOT LIVING AT YOUR ADDRESS.

Name _____

Address _____ City _____ State _____ Zip _____

Phone (____)_____

Relation to Patient_____

Section 2

Release of Information

If you are 18 OR OLDER we are unable to discuss your medical condition with other individuals in your family without your permission. Do you give us permission to discuss your confidential medical information with someone other than yourself? YES NO

If yes, name of person _____

Relation to Patient _____

Signature _____

Section 3

Preferred Pharmacy

Name _____

Address _____

City _____ State _____ Zip _____

Phone (____)_____

Patient's name_____ Date_____

Medication List

Medication	Dose	Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Notice of Privacy Practices

Jesse Jensen, D.O.

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 and 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 protected 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 is providing your primary care doctor with clinical information about your treatment in our office.
- Payment means such activities as obtaining reimbursement of services, confirming coverage, billing of collection 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 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 services.
- The Practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may contact you by phone or in writing to provide appointment reminders, lab results, or information about your treatment and health related benefits and services.

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 exempt 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 communication of Protected Health Information by alternative means of 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 in advance, 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 PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of September 1, 2014 and it is our intention to abide by the term of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of your Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy 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 the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer, Angela Lind at 801-966-1403 or office@westvalleyderm.com for more information, in person or in writing.

_____ _____

Sign Date

West Valley dermatology

Payment Policy

Thank you for choosing West Valley Dermatology; we are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon your request.

Methods of payment. Our practice accepts the following methods of payment: cash, personal checks, and most major Credit Cards. Checks returned to our office by your financial institution will incur a $25.00 fee, which is added to your account balance.

Balances. You are expected to pay your balance in full within 30 days. Should special circumstances arise, we ask that you please contact our billing department to set up a payment plan.

Insurance. West Valley Dermatology will bill your insurance company as a service to you as long as you have provided complete and accurate information. Having an insurance policy does not guarantee payment. You are responsible for all incurred charges. We participate with select insurance plans. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility; you are responsible for confirming your coverage based on your individual plan. If your insurance plan requires a referral you will be responsible for obtaining a current referral. Please contact your insurance company with any questions you may have regarding your coverage. Should your insurance reject your claim for any reason, you are financially responsible for all incurred charges. That is, if your insurance denies payment you agree to be personally and fully responsible for payment.

Self-Pay. We do accept cash pay patients, payment in full is due at the time of service.

Co-payments, deductibles, co-insurance, and self-pay. If you have a co-pay, it will be due at the time of service. If you have not met your deductible or if your insurance requires a patient responsibility percent, this could result in a balance in addition to your co-pay. Failure on our part to collect co-payments, deductibles, and co-insurance from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. If you do not have health insurance (self-pay patients), you will be required to pay in full for all services at the time they are received.

Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers.

Cosmetic procedures. Payment in full for all cosmetic procedures are due at the time of service. No exceptions will be made.

Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit your claim and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you.

Nonpayment. If your account goes delinquent, you agree to pay processing fees, interest at the rate of 15% annually on all past due balances from the original due date, plus court costs and reasonable attorney's fees, with or without suit, incurred in collecting any past due balance, and a collection fee if the account is assigned to a collection agency.

Payment plans. If you are set up on a payment plan by our billing department and are unable to make your monthly payment, it is your responsibility to contact the billing department and inform them. Not doing so will result in your account possibly being referred to an outside collections agency.

Missed appointments. Our policy is to charge for missed appointments not canceled within 24 hours of the scheduled appointment. A missed appointment fee of $25 for office visits, and $50 for surgery's and cosmetic procedures, will be your responsibility and billed directly to you. This fee will need to be paid before your next scheduled appointment. Please help us to serve you better by keeping your regularly scheduled appointment.

Accurate information. You must supply West Valley Dermatology with accurate information regarding your address, phone number, and insurance information. Promptly notify us of any changes.

Agreement. I, the undersigned, acknowledge that I have read and understood this account policy. I agree to make payments to West Valley Dermatology according to the above terms. I authorize my insurance carrier to send payments directly to West Valley Dermatology according to the above terms and on my behalf. I also agree that in the event my account goes delinquent that I will pay for processing fees, interest at the rate of 15% annually on all past due balances from the original due date, plus collection fees if my account is assigned to a collection agency.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

_____ _____

Signature of Responsible Party **Date**

_____

Printed Name

West Valley dermatology

Written Explanation of Arbitration

- A binding arbitration agreements requires patient to submit all future claims to arbitration instead of having the claim heard in court by a judge or jury.

- An Arbitrator is a person chosen to resolve disputes after hearing the information presented by both sides. You select one arbitrator, your doctor selects one and you and the doctor agree on a third arbitrator selected from a list of persons trained and approved as arbitrators for the State and Federal courts of Utah.

- You pay for the fees and expenses of your arbitrator, the doctor pays for his or her arbitrator and the fees and expenses of the third arbitrator are shared equally.

- You have the right, at your expense, to be represented in arbitration by an attorney.

- By choosing arbitration, you also have the right to require mediation. Mediation occurs before arbitration. Mediation is a process by which a neutral person tries to help the parties reach a mutually agreeable resolution of their dispute. The cost of mediation is shared equally.

- Whether you sign the arbitration agreement or not is up to you. You will not be treated any differently if you choose not to sign the agreement.

- You have the right to rescind the agreement within ten (10) days of signing the agreement.

- The arbitration agreement is renewed each year unless it has been canceled by letter sent by certified mail before the renewal date.

- You have the right to have all of your questions about arbitration answered.

Date: _____

Signed: _____

Patient received a copy of this document _____ (initials of staff member)

ARBITRATION AGREEMENT

Alpine Valley dermatology

Article 1 Dispute resolution

By signing this Agreement ("Agreement") we are agreeing to resolve any claim for medical malpractice by the dispute resolution process described in this Agreement. Under this Agreement, you can pursue your Claim and seek damages, but you are waiving your right to have it decided by a judge or jury.

Article 2 Definitions

A. The term "we," "parties" or "us" means you, (the Patient), and the Provider.

B. The term "Claim" means one or more Malpractice Actions defined in the Utah health Care Malpractice Act (Utah Code 78-14-3(15)). Each party may use any legal process to resolve non-medical malpractice claims.

C. The term "Provider" means the physician, group or clinic and their employees, partners, associates, agents, successors and estates.

D. The term "Patient" or "you" means:

(1) you and any person who makes a Claim for care given to YOU, such as your heirs,

(2) your unborn child or newborn child for care provided during the 12 months immediately following the date you sign this Agreement, or any person who makes a Claim for care given to that unborn or newborn child.

Article 3 Dispute Resolution Options

A. Methods Available for Dispute Resolution. We agree to resolve any Claim by:

(1) working directly with each other to try and find a solution that resolves the Claim, OR

(2) using non-binding mediation (each of us will bear one-half of the costs); OR

(3) using binding arbitration as described in this Agreement.

You may choose to use any or all of these methods to resolve your Claim.

B. Legal Counsel. Each of us may choose to be represented by legal counsel during any stage of the dispute resolution process, but each of us will pay the fees and costs of our own attorney.

C. Arbitration – Final Resolution. If working with the Provider or using non-binding arbitration. We both agree that the decision reached in binding arbitration will be final.

Article 4 How to Arbitrate a Claim

A. Notice. To make a Claim under this Agreement, mail a written notice to the Provider by Certified mail that briefly describes the nature of your Claim (the "Notice"). If the Notice is sent to the provider by certified mail it will suspend (toll) the applicable statute of limitations during the dispute resolution process described in this Agreement.

B. Arbitrators. Within 30 days of receiving the Notice, the Provider will contact you. If you and the Provider cannot resolve the Claim by working together or through mediation, we will start the process of choosing arbitrators. There will be three arbitrators, unless we agree that a single arbitrator may resolve the Claim.

(1) Appointed Arbitrators. You will appoint an arbitrator of your choosing and all Providers will jointly appoint an arbitrator of their choosing.

(2) Jointly-Selected Arbitrator. You and the Provider(s) will then jointly appoint an Arbitrator (the "Jointly-Selected Arbitrator"). If you and the Provider (s) cannot agree upon a Jointly-Selected Arbitrator, the arbitrators appointed by each of the parties will choose the Jointly-Selected Arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah. If the arbitrators cannot agree on a Jointly-Selected Arbitrator, either or both of us may request that a Utah court select an individual from the lists described above. Each party will pay their own fees and costs in such an action. The Jointly-Selected Arbitrator will preside over the arbitration hearing and have all other powers of an arbitrator as set forth in the Utah Uniform Arbitration Act.

C. Arbitration Expenses. You will pay the fees and costs of the arbitrator you appoint and the Provider(s) will pay the fees and costs of the arbitrator the Provider(s) appoints. Each of us will also pay one-half of the fees and expenses of the Jointly-Selected Arbitrator and any other expenses of the Jointly-Selected Arbitrator and any other expenses of the arbitration panel.

D. Final and Binding Decision. A majority of the three arbitrators will make a final decision on the Claim. The decision shall be consistent with the Utah Uniform Arbitration Act.

E. All Claims May be Joined. Any person or entity that could be appropriately named in a court proceeding ("Joined Party") is entitled to participate in this arbitration as long as that person or entity agrees to be bound by

the arbitration decision ("Joinder"). Joinder may also include Claims against persons or entities that provided care prior to the signing date of this Agreement. A "Joined Party" does not participate in the selection of the arbitrators but is considered a "Provider" for all other purposes of this Agreement.

Article 5 Liability and Damages May Be Arbitrated Separately

At the request of either party, the issues of liability and damages will be arbitrated separately. If the arbitration panel finds liability, the parties may agree to either continue to arbitrate damages with the initial panel or either party may cause that a second panel be selected for considering damages. However, if a second panel is selected, the Jointly Selected arbitrator will remain the same and will continue to preside over the arbitration unless the parties agree otherwise.

Article 6 Venue/ Governing Law

The arbitration hearing will be held in a place agreed to by the parties. If the parties cannot agree, the hearings will be held in Salt Lake City, Utah. Arbitration proceedings are private and shall be kept confidential. The provisions of the Utah Uniform Arbitration Act and the Federal Arbitration Act govern this Agreement. We hereby waive the prelitigation panel review requirements. The arbitrators will apportion fault to all persons or entities that contributed to the injury claimed by the Patient, whether or not those persons or entities are parties to the arbitration.

Article 7 Term/ Rescission/ Termination

A. Term. This Agreement is binding on both of us for one year from the date you sign it unless you rescind it. If it is not rescinded, it will automatically renew every year unless either party notifies the other in writing of a decision to terminate it.

B. Rescission. You may rescind this Agreement within 10 days of signing it by sending written notice by registered or certified mail to the Provider. The effective date of the rescission notice will be the date the rescission is postmarked. If not rescinded, this Agreement will govern all medical services received by the Patient from Provider after the date of signing, except in the case of a Joined Party that provided care prior to the signing of this agreement (see Article 4(E)).

C. Termination. If the Agreement has not been rescinded, either party may still terminate it at any time, but termination will not take effect until the next anniversary of the signing of the Agreement. To terminate this Agreement, send written notice by registered or certified mail to the Provider. This Agreement applies to any Claim that arises while it is in effect, even if you file a Claim or request arbitration after the Agreement has been terminated.

Article 8 Severability

If any part of this Agreement is held to be invalid or unenforceable, the remaining provisions will remain in full force and will not be affected by the invalidity of any other provision.

Article 9 Acknowledgement of Written Explanation of Arbitration

I have received a written explanation of the terms of this Agreement. I have had the right to ask questions and have my questions answered. I understand that any Claim I might have must be resolved through the dispute resolution process in this Agreement instead of having them heard by a judge or jury. I understand the role of the arbitrators and the manner in which they are selected. I understand the responsibility for arbitration related costs. I understand that this Agreement renews each year unless cancelled before the renewal date. I understand that I can decline to enter into the Agreement and still receive health care. I understand that I can rescind this Agreement within 10 days of signing it.

Article 10 Receipt of Copy I have received a copy of this document.

Provider **West Valley Dermatology**

Name of Patient (Print) _____

Signature of Patient or Patient's Representative _____

Date: _____

Signature of Physician or Authorized Agent _____

I DO NOT wish to sign _____