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		

Medication Prior Authorizations

Prior Authorizations for medications are an unfortunate effect of the changes in some, but not all, health plans. Prior authorizations require a considerable amount of time and will incur a **$25** service charge. We appreciate your understanding.

As an alternative to a prior authorization, you may choose to have your prescription sent to Meier's Pharmacy or HRx Pharmacy and use the cash price or you may use the Good Rx Card to get a discount on your medication. The doctor will also research preferred alternatives, if medically favorable.

initial_____

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

Updated 12/2015