

Joseph D Jensen M.D.

Patient Legal Name	Gender M F	Marital Status S M D W	Date of Birth	Age
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BASIC POLICY: The patient is responsible for all medical bills in our office. If you have insurance, please give your card to the receptionist to copy. It is the patient's responsibility to provide all the necessary and correct insurance information at the time of your appointment. Please realize we may not participate with your insurance. If this is the case, payment is required at the time of service. We will be glad to give you a form to submit for your reimbursement. Your insurance is a contract between you, your employer, and the insurance company. It is the patient's responsibility to know his/her insurance contract benefits, assure collection of insurance payments, and to negotiate with the insurance company over any disputed claims. Some insurance companies arbitrarily select certain services that they will not cover. It is the patient's responsibility to know their co-pay, deductible, or percentage amounts. If your insurance requires a referral, it is your responsibility to make sure it received by our office prior to your appointment.

NO SHOW FOR APPOINTMENT WITHOUT CANCELLATION will be subject to a \$20.00 fee (\$40.00 for surgery appointment) charged to your account.

RETURNED CHECK POLICY: There is a \$20.00 fee on all returned checks.

A "repeat billing charge" may be added to all accounts 60 days old to defray cost of sending repeat statements. We reserve the right to charge interest at 1 1/2% per month (18% per annum) on balances 30 days and older. In the event any balance due is not paid as agreed, the undersigned jointly and severally agree to pay all costs incurred in collecting said unpaid balance including reasonable attorney's fees, court costs and a collection fee of up to 50 % of the unpaid balance.

RECORDS RELEASE: To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient record. For records to be transferred to another provider, a signed record release must accompany request. When records are being released to the patient, parent, or guardian, a clerical fee payable in advance of \$20.00 is required. Account must also be paid in full and photo ID is required to protect patient confidentiality.

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Dermatology Center of Salt Lake. The assignment will remain in effect until revoked by me in writing. A photocopy of assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure payment. I authorize you to give me, or the person I have signed for as parent or guardian, reasonable and proper medical care by today's standards.

BIOPSY: I understand that if a biopsy and/or pathology is necessary that it may be sent to and read by either ProPath, PO Box 678175, Dallas, TX 75267 or Skin Pathology Consultants, 168 East 5900 South #C-104, Murray, UT 84107. An administrative fee is added to each specimen. If insured, insurance will typically cover the fee.

HIPPA: With my consent, Dermatology Center of Salt Lake may contact me by phone or mail regarding any items that assist the practice in carrying out my clinical care, including, but not limited to, laboratory and biopsy results, appointment reminders, statements etc...

Signature _____ Date _____