Patient Legal Name: _____Date of birth_____

BASIC POLICY: The patient is responsible for all medical bills in our office. It is the patient's responsibility to provide all the necessary and correct insurance information at the time of your appointment. Your insurance is a contract between you, your employer, and the insurance company and we will bill your insurance as a courtesy to you. 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 is received by our office prior to your appointment.

NO SHOW & CANCELLATION POLICY: A fee of $50.00 per appointment and $100.00 per surgery appointment will be charged if a 48 hour notice of cancellation is not given.

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

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 $0.50 per page is required. Account must also be paid in full and photo ID is required to protect patient confidentiality.

HIPAA: With my consent, Dermatology Center of Salt Lake may contact me by phone or email 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..

By signing below I agree to pay all amounts owed within 30 days of when such amounts are incurred. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past due amounts at the rate of 18% per annum (1.5% per month) until paid in full. In the event any amounts are referred to a third party debt collection agency, I agree that in addition to any other amount for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 40% of the principal amount owing as allowed by Utah Code Annotated, sec 12-1-11. I will also be responsible for $6.25 certified mail charge if my account is sent to collections. The terms of this paragraph shall apply to all amounts incurred by me or by any individual for whom I have legal responsibility whether such amounts are incurred today or after today. I hereby consent to being contacted by telephone at any number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Dermatology Center of Salt Lake or anyone acting on its behalf. I understand and agree that such calls may be initiated by Dermatology Center of Salt Lake or one of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third party collection agencies, and that the methods of contact may include using pre-recorded/artifical voice messages and/or the use of automated dialing device and/or the use of text messages-some or all of which may result in data charges. I also consent to receiving emails at any email address provided by me or anyone associated with me or acting on my behalf.

BIOPSY: I understand that if a biopsy and/or pathology is necessary that it may be sent to and read by either Skin Pathology Consultants, 168 East 5900 South #C-104, Murray, UT 84107 or U of U, 417 S. Wakara Way #2151, SLC UT 84108. An adminstrative fee is added to each specimen.

Signature_____ Date_____