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PATIENT INFORMATION

PATIENT INFORMATION – *PLEASE COMPLETE ALL INFORMATION.

Last Name	First Name	Middle	Date of Birth / /	Sex	Marital Status M S D W	Social Security No. - -
Home Address (Apartment No.)			City	State	Zip	Home Phone
Name of Patient's Employer		Address		City	State	Zip
E-mail Address						Cell Phone

Name of Nearest Relative Not Living with You (excluding spouse)						Phone Number
Address of Nearest Relative listed above City State Zip						Relationship To Patient

PERSON RESPONSIBLE FOR PAYMENT (PERSON ACCOMPANYING THE PATIENT IF UNDER 18)

Last Name	First Name	Initial	Date of Birth / /	Sex	Marital Status M S D W	Social Security No. - -
Home Address (Apartment No.)			City	State	Zip	Home Phone
Name of Employer		Address		City	State	Zip
						Work Phone

REFERRING PHYSICIAN

Name	Address	City	State	Zip	Phone	Written Referral? <input type="checkbox"/> Yes <input type="checkbox"/> No
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OR REFERRED BY:

Yellow Pages Newspaper Magazine Family/Friend Internet Mailing

INSURANCE COVERAGE – #1 (PRIMARY) *WE WILL NEED COPIES OF INSURANCE CARDS*

Insurance Company #1					Phone
Address of Insurance Company #1			City	State	Zip
Primary Insured Person		Date of Birth of Primary Insured Person		Relationship to Patient	
Social Security No.		Insurance ID No.		/ Group No.	
Employer Name					

INSURANCE COVERAGE – #2 (SECONDARY)

Insurance Company #2					Phone
Address of Insurance Company #2			City	State	Zip
Insured Person		Date of Birth of Insured Person		Relationship to Patient	
Social Security No.		Insurance ID No.		/ Group No.	
Employer Name					

Are you interested in cosmetic procedures or over-the-counter skin care products? Yes No

I understand that any phone quotes are subject to change depending upon the level of service and upon the type of procedure(s) performed.

I, the undersigned, give permission to release information to 3rd party carrier(s) and do assign all insurance benefits for treatment to be paid directly to the above-named provider and request that this assignment remain on file with my insurance carrier. I certify that a copy of this assignment shall be as valid as the original.

I, the undersigned, recognize that the provider cannot accept responsibility for collecting any insurance claim or negotiating any settlement on a disputed claim. I also agree that in the event of default in the payment of any amount due, and if this account is placed in the hands of an agency or attorney for collection or legal action, to pay an additional charge equal to the cost of collection including agency and attorney fees plus court costs incurred and permitted by laws governing these transactions.

I, the undersigned, consent to the procedure(s) rendered by the above-named provider(s) for the treatment of my case.

Signature of Responsible Party (over) _____
Date

FINANCIAL AND INSURANCE REQUIREMENTS OF SOUTH VALLEY DERMATOLOGY

As a service to you and in an effort to keep costs down, we have established some basic policies and guidelines. We have found that our patients have different financial needs and many of them vary depending upon the insurance company with which they are contracted. Please find the type of insurance policy listed below that applies to your situation and make arrangements accordingly. ***It is also important for you to understand that your contract with an insurance company is between you and them; therefore, the ultimate responsibility for payment belongs to you.***

1. If your insurance policy is a **MANAGED CARE PLAN** with which South Valley Dermatology is contracted, we will adhere to the written insurance policy. We require all co-payments to be made in full at the time of service and payment in full to be made at the time of service for any services not covered by your policy. *We reserve the right to charge a monthly \$10.00 billing fee if a co-payment is not paid at the time of service.* It is your responsibility to make sure that all services rendered in the office fall under your policy guidelines. If your insurance requires a referral from your primary care physician, these arrangements must be made prior to your appointment. Please understand that if you do not provide our office with a referral, you will be responsible for the charges incurred. If you are unsure of what your policy covers, do not hesitate to ask. We may be able to answer your questions.
2. If you have **PRIVATE INSURANCE** and you supply us with the correct billing information, we will submit an itemized claim to your insurance company for you free of charge. *We reserve the right to charge a monthly \$10.00 billing fee on accounts that have not been paid within 60 days.*
3. If you are a **CASH PATIENT** and establish yourself as such with our office, payment in full is always required at the time of service unless other arrangements are made. *We reserve the right to charge a monthly \$10.00 billing fee on accounts that have not been paid within 60 days.*
4. If you are receiving state assistance through **MEDICAID**, you must have a current medical card and referral at the time of your appointment. Otherwise, you are considered a cash patient and must pay in full at the time of service. We are NOT a provider for Healthy U, Select Value, University of Utah, Molina or PCN Network. We will not bill to any of these Medicaid plans. You are responsible for the charges.
5. If you are an established patient and miss an appointment without notifying us 24 hours in advance, your account may be charged \$20.00 for each missed appointment. If you are a new patient and you miss a second appointment without notifying us 24 hours in advance, your account may be charged \$20.00.

If your account is more than 90 days delinquent, it may be turned over to a collection agency and reported to the credit bureau. This will take place if no arrangements are made to settle your account. For your convenience, we accept VISA, MasterCard, American Express and Discover.

I understand the terms of these Financial and Insurance Requirements and agree to remit payment accordingly.

Signature _____ Date _____