

BILLING INFORMATION
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PATIENT INFORMATION

PATIENT NAME: _____ DATE: _____

HOW WOULD YOU LIKE TO BE ADDRESSED? (first name, Mr., Mrs., etc.) _____

DATE OF BIRTH: _____ AGE: _____ SEX (please circle): Male Female

MARITAL STATUS (please circle): Single Married Widowed

PHONE #: Home: (____) _____ Work: (____) _____ Cell: (____) _____

HOME ADDRESS: _____

City _____ State _____ Zip _____

WHO CAN WE CONTACT IN CASE OF EMERGENCY? Name: _____

Phone #: _____ Relationship: _____

DO YOU GIVE OUR OFFICE PERMISSION TO DISCUSS YOUR MEDICAL INFORMATION WITH FAMILY MEMBERS?

YES NO IF YES, PLEASE PROVIDE THEIR NAMES AND PHONE NUMBERS BELOW.

NAME: _____ RELATIONSHIP _____ PHONE # _____

NAME: _____ RELATIONSHIP _____ PHONE # _____

HOW DID YOU HEAR OF OUR OFFICE? Friend or family member? _____

Phone book Website Dr. referral Other _____

WHO IS YOUR FAMILY PHYSICIAN ? (first and last name please) _____

BILLING INFORMATION

RESPONSIBLE PARTY (excluding insurance): _____

DATE OF BIRTH: _____ RELATIONSHIP TO PATIENT: Parent Spouse Legal Guardian

MAILING ADDRESS (if different from above): _____

City _____ State _____ Zip _____

INSURANCE INFORMATION DO YOU HAVE HEALTH INSURANCE? YES NO

IF YES, PLEASE PRESENT YOUR CARD(S) TO THE RECEPTIONIST TO TAKE A COPY.

(PLEASE BE AWARE THAT IF WE DO NOT HAVE CURRENT INSURANCE INFORMATION WE WILL BE UNABLE TO BILL YOUR CLAIM.)

PRIMARY INSURANCE: _____

NAME OF INSURED: _____ DATE OF BIRTH: _____

SECONDARY INSURANCE: _____

NAME OF INSURED: _____ DATE OF BIRTH: _____

PLEASE SEE OTHER SIDE

I understand that I am financially responsible for all charges whether paid or not paid by my insurance. I am aware that if I do not provide current insurance information Dr. Woseth and Dr. Swinyer's office will be unable to bill my claim.

ANY ACCOUNTS OVER THIRTY DAYS OLD WILL ACCRUE INTEREST OF 1.5% PER MONTH (18% PER YEAR) UNTIL THE ACCOUNT IS PAID IN FULL. In the event that full payment for charges incurred in my medical care is not made, I agree to pay all cost of collection, including a 50% Collection Agency Commission and reasonable attorney's fees. I also agree to submit myself to the jurisdiction of the courts of Salt Lake County, Utah.

I understand that in the event that I cannot make a scheduled appointment I must cancel within 24 hours prior to that appointment time. Failure to do so will result in a \$50.00 charge to my account (per incident).

I consent to medical treatment as provided by Swinyer - Woseth Dermatology, P.C.

This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment will be considered as valid as an original.

SIGNATURE: _____ DATE: _____
(Responsible Party)

I have received a copy of the Notice of Privacy Practices for Swinyer - Woseth Dermatology, P.C.

SIGNATURE: _____ DATE: _____
(Responsible Party)