ASPEN DERMATOLOGY

Patient Information

Name (last, first, MI)____ Nick Name________________________

Marital Status _______________ Previous Name____________________ Social Security Number_____________________

Date of Birth__________________ Birth Sex (select one): M F Language_______________________________

Ethnicity______________________ Gender Identity______________________Race______________________________

Preferred Contact Method (select one): Phone Email Patient Portal Fax Letter Decline to receive reminders

Emergency Contact____ Phone #_____________________________

Spouse Name____ Phone #_____________________________

Caretaker Name____ Phone #_____________________________

Patient Home Phone____________________ Work Phone_____________________ Mobile Phone____________________

Preferred Phone (select one): Home Work Mobile

May we leave a detailed message and/or biopsy and/or lab results on your voicemail (select one)? Yes No

Please specify which phone # we may use for the message ____

Patient email __________________________________ Alternate email____

Would you like to opt in to email notifications (select one)? Yes No

Patient Address____ City__________________ State_______ Zip________

Seasonal Address____ City__________________ State_______ Zip________

Employer____ Occupation____

Guarantor Information – Financially Responsible Party

Guarantor____ Patient's Relationship to Guarantor____________________

Last First MI

Date of Birth___________________________________ Social Security Number_________________________________

Contact Information (if same as Patient's, check here ☐)

Country______________________ Street Address____

City__________________________________ State____________________________ Zip____________________________

Contact Home Phone_____________________ Work Phone____________________ Mobile Phone___________________

Contact Email____

Insurance

Primary Insurance

Payer____

Policy Number_______________________________________

Patient's Name on Card_______________________________

Policy Holder Name___________________________________

Policy Holder Date of Birth______________________________

Patient's Relationship to Policy Holder_____________________

Secondary Insurance

Payer____

Policy Number_______________________________________

Patient's Name on Card_______________________________

Policy Holder Name___________________________________

Policy Holder Date of Birth______________________________

Patient's Relationship to Policy Holder_____________________

Preferred Pharmacy ____ **City**______________________________

By signing below, I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. 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 amount(s) is/are referred to a third-party debt collection agency, I agree that in addition to any other amount(s) allowed 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(s) owing as allowed by Utah Code Annotated, sec.12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s)are incurred today or after today.

I hereby consent to being contacted by telephone at any telephone number (including but not limited to wireless/cellular phone numbers) provided by me or anyone associated with me or acting on my behalf to Aspen Dermatology or anyone acting on its behalf. I understand and agree that such calls may be initiated by Aspen Dermatology or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an 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 e-mails at any e-mail address provided by me or anyone associated with me or acting on my behalf.

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Signature of Patient or Legal Guardian/Representative **Date** **Staff Initial**

Medicare Patients Only

I authorize any holder of medical or other information about me to release to any carrier or the Social Security Administration and CMS or its intermediaries any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts the assignment. Regulations pertaining to Medicare assignment of benefits apply.

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Signature of Patient or Legal Guardian/Representative Date