

Acknowledgement of receipt of Information Practices Notice (9164.520(a))

I understand that as part of my healthcare, Aspen Dermatology originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that Aspen Dermatology’s Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that:

I have the right to review Aspen Dermatology ‘s Notice of Privacy Practices prior to signing this acknowledgement I

Aspen Dermatology reserves the right to change their Notice of Privacy Practices and before implementation will mail a copy of any revised notice to the address I have provided if requested.

Signature of individual or legal representative witness: _____

Printed name or individual or legal representative witness: _____

Please list the name of person you consent to disclose your health information (spouse, child, etc.) including phone numbers per HIPPA regulations:

Name: _____ Phone number: _____

Agreement of financial responsibility and methods of being contacted.

By signing, I agree to pay all amount(s) owed within 30 days (about 4 and a half weeks) 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 a rate of 18% per annum (1.5% per month) until paid in full. In the event any amounts j 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. I authorize payment of insurance benefits, otherwise payable to me, directly to Aspen Dermatology. I authorize Aspen Dermatology to release any information required to secure the payment of benefits. 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 (so are incurred today or after today.

I hereby consent to being contacted by telephone and or email at any telephone number/email 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 affiliate, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ices), and that 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.

Signature of individual or legal representative witness: _____

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.

Date: _____

Signature of individual or legal representative witness: _____

Date: _____