Dr. Michael W. Peterson, DO
732 N Main St. / Springville, UT 84663
P: (801) 704-7001 / F: (801) 210-7012
Email: springvillederm@gmail.com

SPRINGVILLE DERMATOLOGY

Patient Information

Patient Name: _____Preferred Name:_____

Address: _____ Email:_____
Street Address City State Zip

Phone: _____ DOB : _____/_____/_____ SS#:__ __ __ - __ __ - __ __ __ __

Gender: M / F Marital Status: S / M / Other Race:_____ Hispanic: Y / N Language: _____

(The above are required to comply with Federal Government requirements.)

Primary Physician: _____ Emergency Contact: _____(_____)_____
Name Phone Number

Responsible Party

(If different than patient.)

Name: _____ SS#: __ __ __ - __ __ - __ __ __ __ DOB: ____/____/_____

Address:_____

Email:_____ Phone:_____ Alt Phone:_____

Insurance & Pharmacy Information

Primary Carrier: _____ Mem ID#: _____ Effective Date: _____

Secondary Carrier: _____ Mem ID#: _____ Effective Date: _____

Guarantor:_____ DOB: ____/____/_____ SS#: __ __ __ - __ __ - __ __ __ __

Pharmacy Name:_____ Pharmacy Address: _____

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 any related Medicare claims. 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.

Signature: _____ Date: _____/_____/_____

I authorize payment of insurance benefits, otherwise payable to me, directly to Springville Dermatology. I understand that I am financially responsible for all charges, whether or not paid by the insurance, and for all services rendered on my behalf, or my dependents. I authorize Springville Dermatology to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. In the event that payment in full for charges is not made, I agree to pay for all costs associated with the collection of said fees.

_____ _____ ____/____/_____

Signature of Patient or Responsible Party **Printed Name** **Date**

Dr. Michael W. Peterson, DO
732 N Main St. / Springville, UT 84663
P: (801) 704-7001 / F: (801) 210-7012
Email: springvillederm@gmail.com

SPRINGVILLE DERMATOLOGY

Medical History Questionnaire

Patient: _____ **Date of Birth** _____/_____/_____

Today's Date: _____/_____/_____ Reason for visit: _____

Do you have any medical allergies? (circle one) **Y / N Please list:** _____

Below please list any medications (and dosages) that you are currently taking (including prescriptions, over-the-counter meds, vitamins & herbals).

1._____ **4.**_____ **7.**_____

2._____ **5.**_____ **8.**_____

3._____ **6.**_____ **9.**_____

Do you now, or have you ever had diseases or conditions of: (Please check all that apply)

Lungs:
- Bronchitis _____
- Emphysema _____
- Asthma _____
- Shortness of Breath _____
- Wheezing _____

Cardiovascular:
- High Blood Pressure _____
- Heart Attack _____
- Heart Murmur _____
- Irregular Heart Beat _____
- Phlebitis _____
- Blood Clots _____

Endocrine:
- Diabetes _____
- Thyroid _____
- Menstrual Irregularities _____

Urinary:
- Kidney _____
- Bladder _____
- Yeast Infections when Taking antibiotics _____

Gastrointestinal:
- Diarrhea, Bleeding _____
- Constipation _____

Musculoskeletal:
- Arthritis/Joint deformity _____

Neurological:
- Convulsions, Epilepsy or Seizure, Fainting _____

Pace Maker: _____
Valve Replacement: _____
Artificial Joint: _____
Cancer History:_____
Bleeding Disorder: _____
Hepatitis (Type): _____
Transplant: _____

Surgeries/Procedures:_____

Skin:
Have you ever had skin cancer? _____ If yes, _____
Has anyone in your family had skin cancer? _____
Do you have a history of any specific skin disease? _____ If yes, _____
Do you have problems with healing? _____
Do you develop keloids (scars) after surgery? _____
Do you bleed easily? _____
Do you develop skin rashes in reaction to: ____ Medications ____ Food ____ Environment ____ Bandages ____ Topical Products ____ Other: _____

Social History:
Occupation? _____ Hobbies? _____
Do you drink alcohol? _____ Do you smoke? _____ Have you ever been exposed to HIV (AIDS)? _____
Are you pregnant? _____ Due Date: ____/____/____ Are you breast feeding? ____

Patient Signature (or parent/guardian): _____ **Date**: ____/____/____

Office Use Only **Updated** ___/____/____ **MA Initials** _____ **Updated** ___/____/____ **MA Initials** ____

Dr. Michael W. Peterson, DO
732 N Main St. / Springville, UT 84663
P: (801) 704-7001 / F: (801) 210-7012
Email: springvillederm@gmail.com

Patient Notice of Privacy Practices

This notice describes how medical information about you may be disclosed. ***Please review it carefully.***

Springville Dermatology will use your medical information for the following:

- **Treatment:** Including providing your medical records to consulting clinicians and insurance companies.
- **Payment:** We will file necessary claims with insurance companies in your name to obtain payment. They may request part or all of your medical record to pay the claim.
- **Health Care Operations:** Any others involved in your health care

The entire *"Private Policy Notices of Springville Dermatology"* is available for your perusal.

In conjunction with these privacy practices you will need to provide us with the following information:

- Name of person(s) we may speak to regarding your health (i.e. Spouse, Child, etc..) including a contact number.

_____(_____)_____

Name of Authorized Person(s) Contact Phone Number

_____(_____)_____

Name of Authorized Person(s) Contact Phone Number

- May we leave a message regarding your health, or an upcoming appointment, on your answering machine? Y / N

_____ _____

Signature of Patient or Parent or Legal Guardian Relationship to Patient

_____ _____/_____/_____

Print Name (of above party) Patient's Date of Birth

_____ _____/_____/_____

Witness-Office Staff Date

Dr. Michael W. Peterson, DO
732 N Main St. / Springville, UT 84663
P: (801) 704-7001 / F: (801) 210-7012
Email: springvillederm@gmail.com

SPRINGVILLE DERMATOLOGY

Patient Financial Policy

Welcome, and thank you for choosing Springville Dermatology for your dermatology care. Your clear understanding of your **Patient Financial Policy** is important to our professional relationship. Carefully review the following information, and return this form with your signature and today's date. Please don't hesitate to ask any questions about our fees, our policies, and/or your responsibilities.

Insurance:

When making an appointment with your physician it is **your responsibility** to confirm with your insurance company that the physician is currently under contract with the plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you have the **referral at the time of your appointment**. If you do not have your referral at the time of your appointment, you will need to reschedule your appointment, or you may choose to be seen **without the insurance benefit, and pay for your visit in full.**

You are responsible for knowing your insurance benefit coverage. We will gladly file your insurance claim on your behalf. We allow 60 days from the date the claim is filed for the insurance company to pay. If the insurance company does **NOT** pay within this time, **you will be** responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and/or policy benefit criteria, i.e. deductibles, non-covered service, co-insurance, coordination of benefits, or pre-existing conditions. **You are responsible for all co-payments and deductibles at the time of service.** Co-payments will be required on all visits at the time of service, including follow-up appointments.

Check-In:

Please bring your current insurance card with you to **each** visit. Without the insurance card, we will be unable to file your insurance claim, and you **will be responsible** for the entire balance. On follow-up visits you will be asked to verify all demographic and insurance information, so that our records remain up-to-date.

Check-Out:

Please be **prepared to pay** for the current visit, as well as any past balances on your account. Payments and co-payments, deductibles, or fees for non-covered services will be required at the time of service. For your convenience we take cash, check, and all major credit cards.

Non-Covered Services (Including Cosmetic Procedures):

In dermatology, there are many procedures that are considered by Medicare and private insurers as **non-covered**, including removal of skin tags, cosmetic treatments such as Laser Treatments, Botox injections, and fillers such as Restalyn. If you are coming in for a non-covered service, **please be prepared to pay for the service in full**.

Return Check Fees:

Any returned check from the bank for non-payment shall result in the patient's or Guarantor's account being assessed a **$25.00 fee per check**.

Dr. Michael W. Peterson, DO
732 N Main St. / Springville, UT 84663
P: (801) 704-7001 / F: (801) 210-7012
Email: springvillederm@gmail.com

SPRINGVILLE DERMATOLOGY

Patient Financial Policy

Pathology Fees & Lab Tests:

If your visit includes biopsies or lab tests, there will be additional fees related to the processing of these. If the specimens require processing outside of our lab, you will receive a separate billing from the laboratory performing the service. **You are responsible** to notify us if your insurance company requires particular labs for coverage of the processing.

By signing below you acknowledge you have read, understand, and agree to the Springville Dermatology Patient Financial Policy.

Printed Patient Name: _____

Signature of Patient/Insured/Guardian: _____Date: _____

Printed Name of Party Above: _____

Signature of Office Representative: _____ Date: _____