SWINYER WOSETH DERMATOLOGY

RACE: ❑White ❑American Indian/Alaska Native ❑Asian ❑Black/African American ❑Hawaiian/Pacific Islander ❑Other ❑Decline to specify

ETHNICITY: ❑Hispanic/Latino ❑Not Hispanic/Latino ❑Decline to specify

PREFERRED LANGUAGE:_____

HOW DID YOUR HEAR OF OUR OFFICE?_____

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

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According to the Centers for Medicare and Medicaid Services, a provider is to bill a Medicare beneficiary for his/her yearly deductible and coinsurance. In addition, a provider may bill Medicare beneficiaries for noncovered services and services that are considered to be not medically necessary as long as an Advanced Beneficiary Notice has been signed by the patient.

I agree that I am financially responsible for charges as outlined above. I am aware that if I do not provide current insurance information Swinyer-Woseth Dermatology will be unable to bill my claim. I give Swinyer-Woseth Dermatology and it's representatives permission to appeal insurance claim determinations on my behalf.

As a service to our patients, we provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message. If you have provided us with a cell phone number as your primary contact number, you consent to receiving such calls at this number.

It is the responsibility of the patient to keep track of all scheduled appointments. **I understand that in the event that I cannot make a scheduled appointment I must cancel at least 24 hours prior to that appointment time. Failure to do so will result in a $50.00 charge to my account (per incident). This fee is not billable to Medicare.** Reminder calls are simply a courtesy.

In the event that full payment for the above charges is not made, I agree to pay all cost of collection, including 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 consent to medical treatment as provided by Swinyer-Woseth Dermatology.

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)

A copy of the Notice of Privacy Practices for Swinyer-Woseth Dermatology has been made available to me.

SIGNATURE:_____DATE:_____
(Responsible Party)

SWINYER WOSETH
DERMATOLOGY
GENERAL, SURGICAL AND COSMETIC DERMATOLOGY

1548 East 4500 South #202 Salt Lake City, Utah 84117
4040 W. Daybreak Parkway, # 200 South Jordan, Utah 84009
phone 801-266-8841 • fax 801-266-0449
E-mail: doctor@swinyer.com • Website: www.dwoseth.com

Douglas M. Woseth, M.D., FAAD
Angela K. Brimhall, D.O., FAOCD, FAAD
Breton A. Yates, M.D., FAAD
Elena M. Hadjicharalambous, M.D., FAAD
Michael R. Swinyer, P.A.-C.
Alisa Seeberger, F.N.P.
Shane M. Farr, P.A.-C.

RELEASE OF INFORMATION

I authorize any holder of medical or other information about me to release to the Society Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carrier any information needed fir this or a related Medicare claim. I permit a copy of this authorization to be used in placed of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Patient's signature _____ Date _____

Name (Please Print) _____ Date of Birth _____

Douglas M. Woseth, M.D., FAAD
Woseth Dermatology, P.C.

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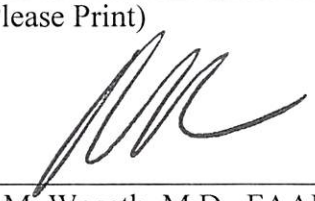
_____ _____

Patient's signature Date

_____ _____

Name (Please Print) Date of Birth



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