Patient and Billing Information

Patient Information

Acct# (office use): _____

Patient Name: _____ Date: _____

Date of Birth: _____ Age: ____ SS# _____

Marital Status ▫Single ▫Married ▫Widowed Sex: ▫Male ▫Female

Home phone (_____) _____ Cell phone (_____) _____ Work phone (_____) _____

Home Address: _____

City: _____ State: _____ Zip: _____

Who may we contact in case of emergency? _____

Phone #:_____ Relationship: _____

Billing Information

Responsible party (if different from patient): _____

Date of birth: _____ Relationship to patient: ▫Spouse ▫Parent ▫Legal Guardian

Mailing address (if different from above): _____

City: _____ State: _____ Zip: _____

Insurance Information **Do you have health insurance? ▫Yes ▫No**

Primary Insurance: _____ **Policy Holder**: _____

Date of birth: _____ Relationship to patient: ▫Spouse ▫Parent ▫Legal Guardian

ID # _____ Group # _____

Secondary Insurance: _____ **Policy Holder**: _____

Date of birth: _____ Relationship to patient: ▫Spouse ▫Parent ▫Legal Guardian

ID # _____ Group # _____

As a service to our patients, we provide a courtesy appointment reminder call the day before the scheduled appointment. If you have provided us with a cell phone number, you consent to receiving calls and or text from our office.

Reminder calls are simply a courtesy

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 charge to my account (per incident).

Co-pays must be made at time of service.

I acknowledge that the above information give to Dr. R. Ralph Bradley is correct and true. I hereby authorize Dr. Bradley to release all information concerning my medical treatment to my insurance company and/or my referring physician. I also authorize any physician, hospital, or medical care facility to provide all information on my medical history and treatment to Dr. Bradley. I authorize photocopies of this form to be as valid as the original.

Signature: _____ Date: _____

R. RALPH BRADLEY, M.D.
KIRK STEPHENS, PA-C

OFFICE POLICY ON PAYMENT

It is our policy to require payment at the time services are rendered for self-pay, large deductibles or for out of network insurance plans. We accept cash, checks, and all major credit cards. Any patient responsibility balance remaining after 60 days may be charged an interest rate of 1.75% per month (22% per annum). In the event the balance due is not paid as agreed, the undersigned will be assessed all fees necessary to employ the service of a collection agency on the unpaid balance. The patient agrees to pay up to a 40% collection expense incurred by the office of R. Ralph Bradley, M.D. in attempting to collect such amounts from the patient.

A 24 HOUR CANCELLATION NOTICE IS NEEDED TO AVOID A $50 "NO-SHOW" CHARGE.
RETURNED CHECKS ARE ASSESSED A $25 FEE.

INSURANCE POLICY

You must present your current insurance card(s) at the time of service. **Failure to provide your insurance card may result in your appointment being rescheduled.** We will provide your insurance company with information necessary to determine the medical and/or surgical care you receive. **We cannot be responsible for determining your actual medical eligibility for benefits**, e.g. pre-existing clauses, exclusion clauses, disallowed service, etc. You should carefully review your health insurance policy, especially before diagnostic testing or surgery, e.g. blood work, pathology, laboratory use, etc. Many policies require a pre-authorization for procedures performed in our office. Our office will be glad to help with prior authorizations needed for services and prescriptions generated within our office. If your insurance requires a referral to see a specialist or obtain services outside your network, please contact your insurance company and/or your primary care provider. Referrals from your primary care provider are now filed online or by phone for use by your insurance company in consideration of payment. We do not receive notification of authorization; it is solely the **responsibility of the patient** to insure that is done.

Be prepared to pay your co-payment at the time of your visit if you belong to an insurance that requires a co-payment. Many insurances have fixed allowances or percentages based on your contract with them. It is your responsibility to pay your deductible, co-insurance, and any other balances not paid by your insurance. **Failure to make your co-payment at time of service will result in a $10 billing charge.**

We will be happy to provide you with an estimate for the fee for any service you require. The final fee for the service may vary somewhat from our estimate due to unforeseen factors or complications that may occur. We base our fees on the complexity of the actual problem, the level of medical expertise, as well as the amount of time we devote to your care. Our insurance and billing staff members are familiar with the extent of our office policies and are here to help you with any problems you may have.

I HAVE READ AND UNDERSTAND THE ABOVE INSURANCE POLICIES. I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION CONCERNING MY PRESENT ILLNESS TO MY DESIGNATED INSURANCE CARRIER. I ALSO AUTHORIZE THE BENEFITS UNDER THIS CLAIM TO BE MADE DIRECTLY TO THE ATTENDING DOCTOR FOR SERVICE RENDERED.

PATIENT OR RESPONSIBLE PARTY SIGNATURE _____ DATE_____

PATIENT NAME (IF PATIENT IS A MINOR) _____

Medical History

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Age: _____ Sex: ▫M ▫F Are you: ▫Married ▫Single ▫Widowed ▫Other

What is today's problem? _____
How long has it been a problem? _____
What areas are involved? _____
Has your problem or lesion changed in appearance since starting? _____
Are you allergic to any medications, metals, food etc.? ▫Yes ▫No If yes, please list: _____
_____

Please list all medications you are currently taking (including prescriptions, over-the-counter medications, supplements, and herbals):_____
_____

Do you have now, or have you ever had any of the following diseases or conditions?

	Yes	No		Yes	No
Lung problems _____	▫	▫	Arthritis/Joint deformity	▫	▫
Tuberculosis	▫	▫	Artificial heart valves	▫	▫
Asthma/wheezing	▫	▫	Artificial joints	▫	▫
Hay fever	▫	▫	Convulsions/Epilepsy/Seizures	▫	▫
Oxygen use	▫	▫	Fainting	▫	▫
High blood pressure	▫	▫	Eye problems	▫	▫
Heart attack	▫	▫	Bleeding tendency	▫	▫
Heart murmur	▫	▫	Blood clots	▫	▫
Irregular heartbeat	▫	▫	Anemia	▫	▫
Pacemaker	▫	▫	Depression	▫	▫
Stroke	▫	▫	Anxiety	▫	▫
Circulation problems	▫	▫	Changing moles/lesions	▫	▫
Cancer	▫	▫	Dysplastic moles	▫	▫
AIDS/HIV	▫	▫	Keloids	▫	▫
Diabetes	▫	▫	Melanoma	▫	▫
Thyroid disease	▫	▫	Skin cancer (non- melanoma)	▫	▫
Kidney disease _____	▫	▫	Warts	▫	▫
Hepatitis A, B, or C	▫	▫	Yeast infections	▫	▫
Stomach/digestive problems	▫	▫	Athlete's foot	▫	▫

List any other diseases or conditions: _____
List surgical procedures you have had: _____

Skin: Have you ever had skin cancer? ▫ Yes ▫No
Has anyone in your family had skin cancer? ▫ Yes ▫No
Do you have a history of any specific skin disease? ▫ Yes ▫No If yes, _____
Do you have any problems healing? ▫ Yes ▫No
Do you develop keloids (scars) after surgery? ▫ Yes ▫No
Do you bleed easily? ▫ Yes ▫No
Do you develop skin rashes in reaction to ▫Medications ▫Food ▫Environment ▫Bandages ▫Neosporin ▫Adhesives ▫Latex ▫Other_____

Social History: Do you drink alcohol? ▫ Yes ▫No If yes, how much? _____
Do you smoke? ▫Yes ▫No If yes, how much? _____
Do you use IV Drugs? ▫Yes ▫No
What is your occupation? _____ Hobbies? _____

Is there a family history of any of the following? ▫ eczema ▫psoriasis ▫hay fever ▫asthma ▫diabetes ▫heart disease ▫cancer ▫tuberculosis ▫peptic ulcer ▫hypertension ▫hepatitis ▫thyroid disease ▫arthritis ▫male pattern hair loss ▫alopecia areata ▫skin cancer (non-melanoma) ▫malignant melanoma ▫dysplastic moles ▫psoriasis ▫vitiligo ▫keloids ▫other _____

NOTICE OF PRIVACY AND AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

By signing, I authorize the medical practice of Dr. R. Ralph Bradley, MD to use and/or disclose certain protected health information (PHI) about me for the following purposes:

_____ for use in treatment and coordination of care with other physicians and facilities involved in my medical treatment

_____for use to obtain payment from insurance companies and other entities that are involved in payment of/for my medical treatment as required

_____for certain operational disclosures as permitted by law

_____with this consent Dr Bradley or his staff may call my home or other alternative location and leave a message on voice mail or in person in reference to items that assist the practice in carrying out my care, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory test results, among others.

You may have and review a copy of our policies and procedures concerning how we may use your protected health information before signing this authorization.

You have my permission to release my protected health information to the following persons:

Name:_____Relationship:_____
Name:_____Relationship:_____
Name:_____Relationship:_____

I do not have to sign this authorization in order to receive treatment from this practice. I have the right to request that my information not be disclosed to certain entities or parties. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer: Glenna Levorsen, 166 E 5900 South, Ste B-111, Murray Utah 84107

Date:_____

Signed by: _____

Print name: _____ _____

Signature of Patient or Legal Guardian: _____

Name of Patient
(print)_____Relationship_____

Patient/guardian must be provided with a signed copy of this authorization form.