DERMATOLOGY AND LASER CENTER NW

905 Squalicum Way, Ste. 101 **(360) 676.1470**

PATIENT INFORMATION:

Last name: _____ First name: _____ Middle Initial: _____

Date of birth: _____ Sex: M F U Address: _____ Apt/Ste #: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Preferred phone: _____ Alt phone: _____

Employer: _____ Work phone: _____ Social Security: _____

ALLOWING ACCESS TO YOUR MEDICAL INFORMATION (PHI):

I consent to allow secure access to my Electronic Health Record to the following people: (Does not include medical professionals involved in your coordination of care). Communication may include phone access, delivering lab results verbally or in person, discussing my medical condition, picking up copies of electronic medical record, and/or my appointment information. This information will remain current unless you alert us of a change. **Initial:** _____

_____	_____	_____	_____
_____	_____	_____	_____
Name	Relationship	Phone	Date

I consent to allow providers and staff at Dermatology and Laser Center NW to leave a detailed message at the following phone number and/or email (PHI). I understand this may include information regarding appointments as well as personal medical or financial information related to my medical care. (Optional). _____ _____ **Initial:** _____

Phone Date

INSURANCE:

PRIMARY: _____ ID# _____ SECONDARY: _____ ID# _____

RESPONSIBLE PARTY INFORMATION (Complete if patient under 18 **OR** spouse or parent provides insurance)

Last name: _____ First: _____ Middle Initial: ____ DOB: _____

Address: _____ Apt/Ste #: _____City: _____ State: ___ Zip: _____

Preferred phone: _____ Alt phone: _____Employer: _____

Relationship to patient: _____ SS# _____

If we are billing an insurance carrier the printed name on the card must match EXACTLY to what is above.

HOW DID YOU HEAR ABOUT OUR OFFICE?_____

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT **Initial: ___**

Dermatology & Laser Center NW has a responsibility to protect the privacy of your health care information and to provide a NPP that describes how your health care information may be used and disclosed, how you can access your health care information, and whom to contact if you have concerns. We may change NPP at any time if required by HIPAA. You may contact our Privacy Officer at 360-676-1470x104. I agree that I have received the NPP.

CONSENT TO TREAT **Initial: ___**

I agree to have lower-risk, common procedures performed at this facility; to include skin biopsy, skin lesion destruction/removal, and injection of skin lesions. The procedure and the most common risks will be fully explained to me prior to treatment. Rarely occurring risks include bleeding, reoccurrence, scarring to the skin, infection, nerve damage, and skin discoloration. I have read, understand, and consent to treatment.

TERMINATING THE PROVIDER-PATIENT RELATIONSHIP POLICY **Initial: ___**

It is the policy of this practice to maintain a cooperative and trusting provider-patient relationship with its patients. When such a provider-patient relationship has not been formed or a provider-patient relationship is no longer proceeding in a mutually productive manner, it is the policy of this practice to terminate the provider-patient relationship within the bounds of applicable state and federal laws, rules, and regulations; the American Medical Association guidelines, and this policy so that the patient can develop the type of trusting relationship with another provider that is essential to successful continued care and treatment. The types of circumstances that can result in termination include, but are not limited to, the following: Noncompliance with treatments recommended by the practice, physician, or other healthcare provider, failure to pay, consistent with our financial policy, consistent failure to keep appointments, threatening or abusive behavior directed at office staff, providers, or patients, patient is deceptive/lies, patient abuses medication, or patient decides to leave the practice.

MEDICARE PATIENTS ONLY **Initial ___**

I authorize any holder of medical or other information about me to release to the Social Security Administration or it intermediaries or carrier any information needed for this or a 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 either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

FINANCIAL POLICY **Initial ____**

Payment due at time of service for **cosmetic visits.** Medical visits may not be covered, or only partially covered, by insurance. Most insurance plans require the patient to pay a portion of the total fees in the form of a deductibles, co-Insurance/cost-sharing, and co-pays. **Your remaining balance will be billed as your responsibility; due upon receipt.** There may be additional charges for biopsies, lab tests, and other procedures done on the day of your visit**.** You will receive a separate bill from the laboratory for their fees; our billing department is not involved in this process and cannot address questions regarding their charges. We accept debit cards, Visa, MasterCard, Discover, and Care Credit (OAC). **Co-pays are due day of service; if not paid a $10 statement fee will be added to your account. Accounts past 90 days will be sent to an outside collection agency**.

Surgical procedures: 100% of estimated insurance cost-share amount is due at the time of surgery. Our accounts receivable department will contact you with the amount due prior to your surgery.

Phototherapy and Patch-testing: A portion of insurance cost-share amount is due at the time of treatment.

Short-Notice Cancellation or No-Show Appointment: If you fail to show OR do not cancel with at least 24 hours' notice you will be charged a **$100.00 missed appointment fee**. As a courtesy, our office will place a reminder call to your phone number on file prior to your appointment. **Esthetician procedures & nurse visits $25.00. Surgery, Pulse Dye or Vascular Laser, & Infini Skin Tightening-$250**. (72 hours required for cancellation).

Non-insured patients/Non-covered services: This section applies to patients with no insurance & insured patients paying for NON-COVERED services. (Medicare, Medicare Advantage, & DSHS patients required to sign waiver). Payment due at the time of service; 25% discount for MEDICAL treatment only. We will not bill your insurance.

Printed name of patient or responsible party (party/guardian): _____

Signature: _____ Date: _____

PATIENT HEALTH HISTORY INTAKE FORM (Complete Yearly)

Name: _____Date: _____

Preferred Pharmacy: _____ Pharmacy location/address: _____

Primary Care Physician _____ Referred by: _____

- **Ethnicity: *REQUIRED*** ( )Hispanic or Latino ( )Not Hispanic or Latino ( )Unknown
- **Race: *REQUIRED*** ( )American Indian or Alaska Native ( )Asian ( )Black or African American ( )Native Hawaiian or Other Pacific Islander ( )White ( )Other Race **Preferred Language: *REQUIRED*** _____

(OPTIONAL) Sexual Orientation & Gender Identify Questions

Sexual Orientation

- Do you think of yourself as:
- __ Straight
- __ Lesbian, gay, or homosexual
- __ Bisexual
- __ Something else
- __ Don't know
- __ Choose not to disclose

What sex were you assigned at birth on your original birth certificate?

- __ Male __ Female
- __ Choose not to disclose

Gender Identity

- What is your current gender identity? (check one):
- __ Male __Female
- __ Transgender Male/Trans Man/Female-to-Male (FTM)
- __ Transgender Female/Trans Woman/Male-to-Female (MTF)
- __ Genderqueer, neither exclusively male nor female
- __ Additional Gender Category/(or Other), please specify: _____
- __ Choose not to disclose

Past Medical History (Circle all that apply)

Anxiety	Depression	Hypothyroidism
Arthritis	Diabetes	Leukemia
Asthma	End stage renal disease	Lung cancer
Atrial fibrillation	GERD	Lymphoma
Bone marrow transplant	Hearing loss	Prostate Cancer
BPH	Hepatitis	Radiation Therapy
Breast Cancer	Hypertension	Seizures
Colon cancer	HIV/AIDS	Stroke
COPD	High Cholesterol	Other: _____
Coronary artery disease	Hyperthyroidism	NONE OF THE ABOVE _____

Past Surgical History (Circle all that apply)

Appendix removed	Biological valve replacement	Kidney transplant
Bladder removed	Coronary artery bypass surgery	Kidney removal: Nephrectomy
Breast biopsy	Heart transplant	Liver removal: Hepatectomy
Lumpectomy (R, L, Bi)	Mechanical valve replacement	Liver transplant
Mastectomy (R, L, Bi)	Percut trans. Coronary angio	Liver shunt
Colectomy: Cancer resection	Joint replacement, hip (R, L, Bi)	Ovaries removed: Endometriosis
Colectomy: Diverticulitis	Joint replacement, knee (R, L, Bi)	Ovaries removed: Cancer
Colectomy: IBD/IBS	Kidney biopsy	Ovaries removed: Cyst
Gallbladder removed	Kidney stone removal	Ovaries: Tubal Ligation

MRN:_____

Pancreas: Pancreatectomy
Prostate biopsy
Prostate removed: Prostatectomy
Trans. Resection of Prostate
Rectum: APR
Rectum: Low Anterior Resection
Basal cell cancer surgery
Melanoma surgery
Skin biopsy
Squamous cell carcinoma surg.
Spleen removed
Testicles removed
Hysterectomy: Fibroids
Hysterectomy: Uterine cancer
Hysterectomy: Cervical cancer
Other: _____

Skin Disease History (Circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal cell skin cancer
Blistering sunburns
Dry skin
Eczema
Flaking or itchy scalp
Hay fever/allergies
Melanoma
Poison ivy
Precancerous moles
Psoriasis
Squamous cell skin cancer
Other_____

Do you wear sunscreen? Yes No **Do you tan in a tanning salon?** Yes No
Do you have a family history of Melanoma? Yes No **If yes, which relative**? _____

Medications: Enter **all** current medications (**with name, dosage, frequency, & route of administration**), including topical, over-the-counter, and supplements

_____ _____ _____
_____ _____ _____
_____ _____ None (*Circle if taking none).*

Known allergies? Y N (List): **_____**

Social History: (Circle all that apply)

- Have you ever had a Melanoma? YES NO
- Alcohol Use: None Less than 1 drink a day 1-2 drinks a day 3 or more drinks a day
- Cigarette Smoking: Never Quit/Former Smoker Smoke less than Daily Daily Smoker
  - **Need support to quit? Free support line: 1.800.784.8669**
- New medications/changes to medications since last visit? YES NO
- Immunized for Flu this year: YES NO
  - **It is beneficial, for most patients, to have your shot yearly.**
- Pneumonia Vaccine: YES NO Year _____
- Advanced Directive-Living Will, Power of Attorney, Health care Proxy: YES NO Unknown
- Person who makes decisions (Name/Phone): _____ Phone: _____

Immediate Family Health History (mother, father, sister, brother). Enter who it applies to in blank area.

- Psoriasis _____
- Eczema _____
- Diabetes _____
- Hypertension _____
- Asthma _____
- Cancer_____
- Stroke _____
- Arthritis _____
- Thyroid Disorder _____
- Other condition (list with who it applies to): _____