MRN_____

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: _____

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

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

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, Actinic Keratoses, skin tag removal, milia extractions, hemangiomas, Seborric Keratoses, lentigos, warts, 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.

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FINANCIAL POLICY **Initial:**____

- **ECC (encrypted credit card): We require a credit card upon check in for your appointment.** Please read the "Credit card/Health savings/Flexible spending Authorization" agreement for specific details. Select the Maximum Amount to be charged on your credit card following your insurance paying their portion. Self-pay patients are not required to provide a credit card.
- **Payment due at time of service for cosmetic visits**, cosmetic procedures, and retail purchases.
- **Medical visits may not be covered, or only partially covered, by insurance.** Insurance plans require the patient to pay a portion of the total fees in the form of a deductibles, 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 lab for their fees; our billing department cannot address questions regarding their charge.
- **We accept debit, Visa, MasterCard, Discover, and Care Credit (OAC).**
- **Co-pay due day of service.** If not paid a $10 statement fee will be added.
- **Surgical procedures:** 100% of estimated cost-share amount due at the time of surgery. Our accounts receivable department will contact you with amount due prior to surgery.
- **Phototherapy and Patch-testing:** Your portion of cost-share due at the time of treatment.
- **Short-Notice Cancellation or No-Show:** If you fail to show OR do not cancel with 24 hours' notice you will be charged **$100.00**. As a courtesy, we will deliver a reminder call, text, & email prior to your visit. Failure to receive notifications will not excuse the fee.
    - Esthetician procedures and injections or skin tag removal with a nurse-**$50.00.**
    - Surgery, Pulse Dye or Vascular Laser, Patch Testing, & Infini-**$250.**
        - (72+ hours' notice required to cancel).
- **Non-insured patients/Non-covered services:** Patients with no insurance & insured patients paying for NON-COVERED services. (Medicare, Medicare Advantage, & DSHS required to sign waiver). Payment due at time of service; 25% discount for MEDICAL treatment. We will not bill your insurance.
- **Accounts past 90 days will be sent to an outside collection agency. $25 fee for NSF/returned checks.**

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.

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

Signature: _____ Date: _____

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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 ( )Caucasian ( )Other Race **Preferred Language: *REQUIRED***_____

(OPTIONAL SECTION) 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

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

Skin Disease History (Circle all that apply)

Acne	Dry skin	Poison ivy
Actinic Keratosis	Eczema	Precancerous moles
Asthma	Flaking or itchy scalp	Psoriasis
Basal cell skin cancer	Hay fever/allergies	Squamous cell skin cancer
Blistering sunburns	Melanoma	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 _____ Cancer_____
- Eczema _____ Stroke _____
- Diabetes _____ Arthritis _____
- Hypertension _____ Thyroid Disorder _____
- Asthma _____
- Other condition (list with who it applies to): _____

CREDIT CARD/HEALTH SAVINGS/FLEXIBLE SPENDING CARD AUTHORIZATION

The providers at Dermatology and Laser Center NW are dedicated to providing excellent and affordable care to their patients. Your understanding of our financial policy is important to our ongoing professional relationship.

Due to the healthcare act and high deductible insurance plans which shift cost to the patient, we are experiencing an increased volume in overdue balances. In response we have implemented a credit card agreement policy. We will ask for a credit card upon check-in to be used later to pay your portion of the bill. Debit cards will process as credit. Many patients find this to be a convenient way to pay their member responsibility after insurance has paid. **A separate authorization agreement is required for each family member.**

Your card will be entered in our secure **Pay Junction** portal upon check-in for your appointment and the card number will be encrypted and stored by the bank. ONLY THE LAST 4 DIGITS OF YOUR CARD AND EXPIRATION DATE WILL BE VIEWED ON YOUR ACCOUNT TO CONFIRM THE CARD IS ACTIVE. You ***may*** see a temporary authorization hold on your account for $0.01 which your bank may use for account verification purposes only, it is not a formal transaction.

Please note that all your rights with respect to the use of your card will remain in effect. This policy will in no way prevent you from being able to dispute a charge or question your insurance company's determination of payment.

Co-pays will remain due at the time of your appointment as per the contract you have with your insurance company. We will bill your claim to your insurance company who is required to send us and you an Explanation of Benefits letter, either by mail, or email, which will indicate your total Member Responsibility Due. Your Co-pay payment will be applied to your total Patient Responsibility Due for that claim.

After we have received your Explanation of Benefits indicating your responsibility you will receive 1 statement. If your balance is not paid in 30 days your credit card will be charged for the amount you have agreed to below. If your balance exceeds this amount you will receive a statement showing your additional remaining balance, due upon receipt. Ensure your card account is active and fully funded. Dermatology and Laser Center NW will not be responsible for overdraft fees.

If you have any questions about this policy, or if your credit card information changes, please ask one of our receptionists or call us at 360.676.1470.

CIRCLE selection for Maximum Amount to be charged on your credit card. Last 4 digits: _____

1. Total balance due after insurance. **2. $150.00** **3. $100.00** **4. $50.00**

I have read Dermatology and Laser Center NW's credit card authorization policy and agree to the terms of this policy:

PATIENT NAME (print): _____ DATE: _____

CARDHOLDER NAME (print): _____ CARD HOLDER SIGNATURE: _____

STATEMENT & RECEIPT OPTION (Circle): NO RECEIPT EMAIL MAIL STATEMENT & RECEIPT

EMAIL ADDRESS: (Print clearly): _____

10.1.2019