MRN:_____

DERMATOLOGY AND LASER CENTER NW

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

PATIENT INFORMATION:

Last name: _____First: _____ Middle Initial: ___ Nick name: _____

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.

I consent to allow providers and staff at Dermatology and Laser Center NW to leave a detailed message at my preferred 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

ALLOWING OTHERS 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

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, Seborrheic 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.

FINANCIAL POLICY

- **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. Patients will receive 1 statement. If not paid in 20 days credit card will be charged for the amount specified in authorization. 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 charges.
- **We accept debit, Visa, MasterCard, Discover, and Care Credit (OAC).** Care Credit option must be chosen at the time of treatment.
- **Co-pay due day of service, per your insurance plan.** 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.
    - Phototherapy only: Patients may choose to pay weekly if arrangements are made in advance.
- **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

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.

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

Signature: _____ Date: _____

MRN:_____

PATIENT HEALTH HISTORY INTAKE FORM (Complete Yearly)

Name: _____Height:_____Weight:_____Date: _____

Preferred Pharmacy: _____ Pharmacy location/address: _____

Primary Care Physician (PCP) _____ Referring Medical Provider: _____

- **Ethnicity: *REQUIRED*** ( )Not Hispanic or Latino ( )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***: ( )English ( )Other _____

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	Joint replacement, hip (R, L, Bi)	Prostate removed: Prostatectomy
Bladder removed	Joint replacement, knee (R, L, Bi)	Trans. Resection of Prostate
Breast biopsy	Kidney biopsy	Rectum: APR
Lumpectomy (R, L, Bi)	Kidney stone removal	Rectum: Low Anterior Resection
Mastectomy (R, L, Bi)	Kidney transplant	Basal cell cancer surgery
Colectomy: Cancer resection	Kidney removal: Nephrectomy	Melanoma surgery
Colectomy: Diverticulitis	Liver removal: Hepatectomy	Skin biopsy
Colectomy: IBD/IBS	Liver transplant	Squamous cell carcinoma surg.
Gallbladder removed	Liver shunt	Spleen removed
Colostomy	Ovaries removed: Endometriosis	Testicles removed
Biological valve replacement	Ovaries removed: Cancer	Hysterectomy: Fibroids
Coronary artery bypass surgery	Ovaries removed: Cyst	Hysterectomy: Uterine cancer
Heart transplant	Ovaries: Tubal Ligation	Hysterectomy: Cervical cancer
Mechanical valve replacement	Pancreas: Pancreatectomy	Other: _____
Percut trans. Coronary angio	Prostate biopsy	None of the above: _____

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: **All** current medications (**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 & who it applies to: _____

(OPTIONAL SECTION-NOT REQUIRED TO COMPLETE)

What sex were you assigned on original birth certificate? _Male _Female _ Choose not to disclose

Gender Identity-Optional

Current gender identity?

__Male __Female __Choose not to disclose
__ Transgender Male/Trans Man/Female-to-Male
__ Transgender Female/Trans Woman/Male-to-Female
__ Genderqueer, neither exclusively male nor female
__ Addl. Gender Category/ (or Other), specify: _____

Sexual Orientation-Optional

Do you think of yourself as?

- __ Straight
- __ Lesbian, gay, or homosexual
- __ Bisexual
- __ Something else
- __ Don't know
- __ Choose not to disclose

MRN_____

Dermatology and Laser Center NW ECC Program-2021

For patient convenience we offer our Encrypted Credit Card program (ECC). Many patients find this a convenient way to pay their bill after insurance has paid. Your card will be encrypted in our secure Pay Junction portal and stored by the bank. Only the last 4 digits and expiration date will be visible. After we have received payment from your insurance you will receive a statement. If we do not receive payment in full within 20 days, we will charge your card based on the option below. Card required at check in.

- Option 1: _____ Charge my card for total balance due.
- Option 2: _____ Charge my card monthly until balance paid in full.
    - Circle amount per month: $150 $100
- Circle card: Visa MC Discover HSA FSA
- Credit card information: Last 4 digits: _____ Exp: _____

I agree to the terms of this policy and allow Dermatology and Laser Center NW to charge my credit card as specified above:

Patient Name (print):_____Date:_____

Card holder name (print):_____

Card holder signature:_____

Email for receipt:_____

Please scan and email to: Contactus@dlcnw.com OR Bring to your visit**.** If you have questions, please ask one of our receptionists or call us at 360.676.1470.

* 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.