Eastern Washington Dermatology

Surgery, Skin Cancer, & Clinical Research
228 W Birch St., Walla Walla, WA 99362 (509) 525-9404 FAX (509) 525-9433

PATIENT REGISTRATION

Date: _____

Name _____ / _____
Last First MI Preferred Name

Mailing Address _____
City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

SSN _____ Date of Birth ___/___/___ Sex ☐ M ☐ F Marital Status _____

Preferred Language Spoken: _____ Ethnicity: Hispanic or Latino ☐ Yes ☐ No

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White

Employer Name _____ Employer Phone _____

Pharmacy of choice: _____ / _____
Name Location (City/Street)

Referred by _____ Primary Care Physician _____

Insurance Information: Do you have insurance? ☐ Yes ☐ No

Primary Insurance Carrier: _____ Member ID #: _____ Group #: _____

Name of Insured (Policy Holder): _____ Policy Holder Date of Birth ___/___/___

Secondary Insurance Carrier: _____ Member ID #: _____ Group #: _____

Name of Insured (Policy Holder): _____ Policy Holder Date of Birth ___/___/___

May we leave personal medical information on your answering machine at home? ☐ Yes ☐ No

May we e-mail personal medical information to you? ☐ Yes ☐ No Email: _____

Do you give our office permission to discuss your medical information with family members?

☐ Yes ☐ No If yes, please provide their names and phone numbers below:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Financial Policy/ Release of Information:

All Private Pay Service, Insurance Co-Payments and Non-Covered Services are due at the time of service.

I certify the information given by me is correct and I have read and consent to the terms of the financial agreement. I certify that I am the patient or am otherwise authorized to execute this document and accept its terms on behalf of the patient. I assume individually all financial responsibility by signing below.

It is your responsibility to obtain a referral or prior authorization PRIOR to your appointment, if your medical coverage requires either. If you are unsure, contact your insurance provider for verification.
I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment directly to Eastern Washington Dermatology of all insurance or health plan benefits.

By my signature below, I understand and accept the above policies and consent for medical treatment.

Patient or Responsible Party Signature: _____ Date ___/___/___

Dermatology Medical History

Today's Date: _____

Patient Name: _____ Date of Birth: _____

What is the reason for this visit? _____

Physician/Provider Name: _____ Pharmacy of choice: _____ Location _____

Are you allergic to any medication? ☐ No ☐ Yes

Please list medications you are allergic to: _____

What kind of reaction occurred when taking the medication you are allergic to: _____

_____

Have you had dental anesthesia before (including Novocain)? ☐ No ☐ Yes

Any Bad Reaction to dental anesthesia? Describe. _____

DO YOU HAVE NOW, OR HAVE YOU EVER HAD ANY OF THESE CONDITIONS? (CIRCLE ANY CONDITIONS THAT APPLY)

Acne	Eczema	Irregular Heartbeat	Renal dialysis
Arthritis	Heart Attack	Kidney Disease	Seasonal Allergies
Asthma	Heart Murmur	Lung Disease	Seizure
Bowel Problems	Hepatitis	Melanoma	Skin Cancer
Depression or Anxiety	High Blood Pressure	Phlebitis	Thyroid Disease
Diabetes	HIV/AIDS	Psoriasis	Transplant patient

List any surgeries: _____

DO YOU HAVE PROBLEMS WITH (CIRCLE ANY CONDITIONS THAT APPLY)

Fever/Chills	Changes in your urination	Rash with antibiotic ointments
Recent changes in vision	Enlarged lymph nodes	Rash from bandages or tape
Difficulty with swallowing	Joint stiffness	Form thick scars
Shortness of breath	Prosthetic joint	Antibiotics cause nausea/vomit
Pacemaker/Defibrillator	Thyroid Disease	Aspirin use
Mitral valve prolapse	Type of Transplant: _____	Anticoagulant use
Changes in your bowels	Depression or Anxiety	

FAMILY HISTORY OF PARENTS, SIBLINGS, CHILDREN: (CHECK WHAT APPLIES)

	Father	Mother	Brother	Sister	Son	Daughter
Allergies	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐

	Father	Mother	Brother	Sister	Son	Daughter
Lung Disease	☐	☐	☐	☐	☐	☐
Melanoma	☐	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐

Do you drink alcohol? ☐ No ☐ Yes ☐ Have drank in past and stopped.

How much do you drink and how often? _____

Do you use IV drugs? ☐No ☐ Yes

Do you smoke? ☐ No ☐ Yes ☐ Have smoked in past and stopped.

How much do you smoke per day? _____ How long?_____

Have you had or have you been exposed to HIV (AIDS)? ☐ No ☐ Yes

(WOMEN) Are you pregnant? ☐ No ☐ Yes: Due Date ___/___/___ Occupation? _____Hobbies _____

List all medications you are currently taking (Include prescriptions, over-counter meds, vitamins, & herbal)

_____

_____

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MEDICARE FINANCIAL POLICY AND SIGNATURE ON FILE

MEDICARE PATIENTS ONLY:

Medicare: We are a participating provider for the Medicare program. We accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying the 20% co-payment. We file with secondary and supplemental carriers.

Medicare does not cover cosmetic procedures.

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its 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.

Signature as it appears on Medicare Card

_____DATE_____

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over," we are required to keep a separate signature on file.

Please read and sign the following statement:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release the MEDIGAP carrier any information needed to determine these benefits or the benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP Card

_____DATE_____

Eastern Washington Dermatology
Health Insurance Portability and Accountability Act
Patient Consent Form

Eastern Washington Dermatology provides this Consent to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

This is a summary of and consent for the privacy practices and patient care at Eastern Washington Dermatology and serves as a condensed version of our Notice of Privacy Practices. You have the right to review our Notice before signing this Consent upon request. The terms of our Notice may change and you may obtain a revised copy by contacting our office.

If you ever believe your privacy rights have been violated, you may file a complaint with Eastern Washington Dermatology or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized for filing complaints.

There are circumstances in which Eastern Washington Dermatology will receive remuneration from third party in exchange for using or disclosing patient's Protected Health Information. Information is available regarding these situations upon request.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- How will we use or disclose your information? Here are a few examples:
  - A basis for planning my care and treatment.
  - A means of communication among the many health professionals who contribute to my care.
  - A source of information for applying my diagnosis and surgical information to my bill.
  - A means by which a third-party payer can verify that services billed were actually provided.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to request restrictions
- The right to amend
- The right to a paper copy of this notice
- The right to an accounting of disclosures
- The right to request confidential communication

You do not have to sign this authorization in order to receive treatment from Eastern Washington Dermatology. You have the right to refuse to sign this authorization. When your information is used or disclosed pursuant to this authorization it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. You have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. Written revocation must be submitted to Eastern Washington Dermatology using appropriate form available upon request.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent.

This information and Notice of Privacy Practices is made available on request.

Patient: _____ Date: _____

Signed by: _____
Patient or Representative Relationship (of other than patient)

EWD Witness: _____
Eastern Washington Dermatology Representative

IF REQUESTED, PATIENT/GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION.

Eastern Washington Dermatology
Financial Policy

Our medical practices understand that the cost of healthcare is a key concern for our patients. Although patient care is our main priority, we hope that you assist us by understanding your responsibility as it relates to our Financial Policy. If you have questions regarding our policy, a representative of our staff will be glad to assist you.

Thank you for choosing Eastern Washington Dermatology to provider dermatological services to you and your family. We are committed to giving you the best possible care. Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. The following is a statement of our Financial Policy:

Private Pay Patients
All private pay patients must pay a $70 deposit at time of check in and the balance must be paid at end of visit. If major service result in a large balance, a payment plan can be arranged.

Deductibles, Co-Payments and Co-insurance
Co-payments/Co-insurance is expected at the time of service unless prior arrangements are made with our office.

Referrals and Authorizations
All referrals and authorizations must be obtained PRIOR to your appointment with our office. The patient agrees to provide authorization numbers, and/or referral forms for each visit and/or procedure. The patient is responsible for all visits and procedures not properly authorized.

Medical Insurance
A copy of your insurance card is required at the time of the initial service. It is up to you to provide us with all necessary information to bill your insurance company. We will file claims with your medical insurance company for the services that are provided by our office. In order for the claims to process correctly, please ensure that the information provided to our office is accurate and current. If there is a change in insurance information please contact us immediately. We will submit claims to secondary insurance as long as we are given the correct information.

Submission of claim is not a guarantee of payment. You will be responsible for payment of all amounts deemed patient responsibility by your insurance company, along with any services not covered by your insurance company.

Medical insurance coverage is a contract between you and your insurance company. Eastern Washington Dermatology will not be involved in dispute between you and your insurance company regarding deductibles co-payments, covered charges, secondary insurance, etc., other than to supply factual information as necessary.

Provider Coverage
Eastern Washington Dermatology is not responsible for ensuring that our provider is covered under your particular plan provision. Please contact your insurance company to verify if our providers participate with your plan.

Payment methods and Other information
- There is a $30 NSF fee on all returned checks.
- An account management fee of 18% (1.5% per month) will be added to your balance if greater than 30 days old.
- Accounts left unpaid may be turned over to an outside collection agency and may result of dismissal from our practice.
- We accept Cash, Check, MasterCard and Visa.

Missed Appointment
We require 24 hour notice if you need to cancel or rescheduled your appointment. If appropriate notice is not provided it is considered a missed appointment. All late cancellations and missed visits may be subject to a $50.00 charge. Two or more missed appointments may result in discharge from the practice.

Minor Patients
The parent or legal guardian accompanying the minor at the first appointment must sign the patient registration form. That guarantor ultimately bears the legal responsibility for payment. We are unable to know the financial responsibilities of divorced parents. We will look to the adult accompanying the minor for payment.