

**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

Father Mother Brother Sister Son Daughter

- |               |                          |                          |                          |                          |                          |                          |                 |                          |                          |                          |                          |                          |                          |
|---------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|-----------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Allergies     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Lung Disease    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Melanoma        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Psoriasis       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Cancer        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Skin Cancer     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Eczema        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypertension  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                 |                          |                          |                          |                          |                          |                          |

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)

\_\_\_\_\_  
\_\_\_\_\_

**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: \_\_\_\_\_ Relationship (of other than patient) \_\_\_\_\_  
Patient or Representative

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 provide 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.