

Eastern Washington Dermatology

Surgery, Skin Cancer & Clinical Research
228 W. Birch St., Walla Walla, WA 99362

PH:(509)525-9404

FAX: (509)525-9433

MINOR PATIENT REGISTRATION

Date: _____

Minor's Name: _____ / _____
Last First MI Preferred Name

Mailing Address: _____
Street Address City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ - _____ - _____ Date of Birth: ____/____/____ Sex: M F

Referred by: _____ Primary Care Physician: _____

Legal Guardian or

Parent Name: _____ Parent's Date of Birth: _____

Mailing Address: _____
Street Address City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ - _____ - _____ Employer Name: _____ Employer Phone: _____

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 E-mail: _____

May we discuss your child's medical condition with any family member? Yes No

If yes, please provide: Name: _____ Relationship to child: _____

Name: _____ Relationship to child: _____

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 ____/____/____

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INFORMED CONSENT

Patient Name: _____ Date of Birth: _____

Preferred Language: _____ Race: _____

Ethnic Group: Hispanic or Latino Not Hispanic or Latino Decline to specify Unknown

To whom may we release medical information?

Name: _____ Relationship: _____

Name of Primary Care Physician: _____

Preferred Method of Communication

Select one or more of the following:

Phone E-mail Mail

Preferred Phone Number (day): _____ Alternate Phone Number (day): _____

May we leave a detailed message? YES NO

Email Address: _____

Preferred Pharmacy

May we contact your Pharmacy to ensure accuracy of your medications? YES NO

Local Pharmacy: _____ Mail Order: _____

City or Zip Code: _____ City or Zip Code: _____

Patient Portal

Do you want access to your medical information through the web on the Patient Portal? NO YES

**If YES, provide us your email address if not listed above. _____

The portal is only for Eastern Washington Dermatology visits. We are not tied to other medical clinics or hospitals.

By signing below, I authorize my consent to Preferred Method of Communication, Preferred Pharmacy and Patient Portal as selected above.

Patient Signature: _____ Date: _____

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Name: _____

Date of Birth: _____

INTAKE and HISTORY FORM

Past Medical History

Select any of the following medical conditions you currently have:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung Cancer |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> GERD | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> BPH | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hypercholesterolemia | <input type="checkbox"/> Other |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Hyperthyroidism | _____ |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypothyroidism | _____ |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Leukemia | _____ |

Past Surgical History

- | | |
|---|--|
| <input type="checkbox"/> Appendix (Appendectomy) | <input type="checkbox"/> Kidney: Kidney Biopsy |
| <input type="checkbox"/> Bladder (Cystectomy) | <input type="checkbox"/> Kidney: Kidney Stone Removal |
| <input type="checkbox"/> Breast: Breast Biopsy | <input type="checkbox"/> Kidney: Kidney Transplant |
| <input type="checkbox"/> Breast: Lumpectomy (Right, Left, Bilateral) | <input type="checkbox"/> Kidney: Nephrectomy |
| <input type="checkbox"/> Breast: Mastectomy (Right, Left, Bilateral) | <input type="checkbox"/> Liver: Hepatectomy |
| <input type="checkbox"/> Colon (Colectomy): Colon Cancer Resection | <input type="checkbox"/> Liver: Liver Transplant |
| <input type="checkbox"/> Colon (Colectomy): Diverticulitis | <input type="checkbox"/> Liver: Shunt |
| <input type="checkbox"/> Colon (Colectomy): Inflammatory Bowel Disease | <input type="checkbox"/> Ovaries (Oophorectomy): Endometriosis |
| <input type="checkbox"/> Colon: Colostomy | <input type="checkbox"/> Ovaries (Oophorectomy): Ovarian Cancer |
| <input type="checkbox"/> Gallbladder (Cholecystectomy) | <input type="checkbox"/> Ovaries (Oophorectomy): Ovarian Cyst |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Surgery | <input type="checkbox"/> Ovaries: Tubal Ligation |
| <input type="checkbox"/> Heart: Heart Transplant | <input type="checkbox"/> Pancreas: Pancreatectomy |
| <input type="checkbox"/> Heart: Mechanical Valve Replacement | <input type="checkbox"/> Prostate (Prostatectomy): Prostate Biopsy |
| <input type="checkbox"/> Heart: PTCA | <input type="checkbox"/> Prostate (Prostatectomy): Prostate Cancer |
| <input type="checkbox"/> Joint Replacement: Hip (Right, Left, Bilateral) | |
| <input type="checkbox"/> Joint Replacement: Knee (Right, Left, Bilateral) | |

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- Prostate (Prostatectomy): TURP
- Rectum: APR
- Rectum: Low Anterior Resection
- Skin: Basal Cell Carcinoma Skin: Melanoma
- Skin: Skin Biopsy
- Skin: Squamous Cell Carcinoma
- Spleen (Splenectomy)
- Testicles (Orchiectomy)

- Uterus (Hysterectomy): Fibroids
 - Uterus (Hysterectomy): Uterine Cancer
 - Uterus (Hysterectomy): Cervical Cancer
 - NONE
 - Other
- _____
- _____
- _____

Skin Disease History

Have you had any of the following?

- Acne
 - Actinic Keratoses
 - Asthma
 - Basal Cell Skin Cancer
 - Blistering Sunburns
 - Dry Skin
 - Eczema
 - Flaking or Itchy Scalp
 - Have Fever / Allergies
 - Melanoma
 - Poison Ivy
 - Precancerous Moles
 - Psoriasis
 - Squamous Cell Skin Cancer
 - NONE
 - Other
- _____

Do you wear Sunscreen?

Yes No

If yes, what SPF? _____

Do you tan in a tanning salon?

Yes No

Do you have a family history of Melanoma?

Yes No

If yes, which relative?

- Mother
- Father
- Sister
- Brother
- Daughter
- Son
- Aunt
- Uncle
- Niece
- Nephew
- Grandmother
- Grandfather
- Granddaughter
- Grandson

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Patient Name: _____

Date of Birth: _____

Medications to include prescription, over the counter medications, vitamins and herbal supplements

See attached list List all current medications below:

Allergies

List all allergies and reactions if known:

Social History

Smoking Status (please choose one):

- Current everyday smoker
- Current someday smoker
- Former smoker
- Never smoker
- Unknown if ever smoked

Start Smoking:

• mm/dd/yyyy _____

Quit Smoking:

• mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- None
- 1 or less per day
- 1-2 per day
- 3 or more per day

Driving Status:

- Drives in the Daytime
- Drives at Night

How often do you exercise?

- Unspecified
- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never
- Other _____

What is your caffeine use?

- Unspecified
- Several times a day
- Once a day
- A few times a week
- A few times a month
- Never
- Other _____

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Other social history:

- Not sexually active
- Sexually active with one partner
- Same sex partner
- Sexually active with more than one partner

- Drug Use
- IV Drug Use
- IV Drug Use Within Past 12 Months

- Patient feels unsafe at home
- Patient feels safe at home

Occupation and Workplace: _____

Place of Residence: _____

Family History

Legend: FA=Father, MO=Mother, BR=Brother, SI=Sister, SO=Son, DA=Daughter

	FA	MO	BR	SI	SO	DA		FA	MO	BR	SI	SO	DA
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"/>	STROKE	<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"/>	OTHER _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Eastern Washington Dermatology

AUTHORIZATION TO TREAT A MINOR

Many times parents find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child.

Minor's Name: _____ Date of Birth _____

Check **ALL** that apply:

- I hereby authorize Eileen Smith, MD / Marla Kae Stahlnecker, ARNP / Matthew Gambone, PA-C to evaluate and treat my child.
- I authorize evaluation and treatment to begin on: _____
Date
- I authorize evaluation and treatment to end on: _____
Date
- I DO NOT CONSENT** to evaluation and treatment of my child when I am not present.

Any child under the age of 13 **will not** be seen without a parent or guardian present. If someone else accompanies the child, **written consent must be presented** with this person's name at the time of visit authorizing consent to evaluate and treat.

PARENT or LEGAL GUARDIAN Signature: _____

Date: ____/____/____

Eastern Washington Dermatology
Health Insurance Portability And Accountability Act

Notice of Privacy Practices is made available on request

We provide 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 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

- | | |
|---|---|
| <ul style="list-style-type: none">✓ A basis for planning my care and treatment✓ A means of communication among the many health professionals who contribute to my care | <ul style="list-style-type: none">✓ 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:

- | | |
|--|--|
| <ul style="list-style-type: none">✓ The right to inspect and copy✓ The right to request restrictions✓ The right to amend | <ul style="list-style-type: none">✓ 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 re-disclosure 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.

Patient Signature: _____ Date: _____

Signed by: _____

Name and Representative Relationship (if other than patient)

EWD Witness: _____

UPON REQUEST, 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. 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 a major service results 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. **Keystone Medical Management** 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. **Keystone Medical Management** will submit claims to secondary insurance as long as they 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 or Keystone Medical Management 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 providers are 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.