Eastern Washington Dermatology

Surgery, Skin Cancer & Clinical Research

228 W. Birch St., Walla Walla, WA 99362

PH:(509)525-9404 FAX: (509)525-9433

PATIENT REGISTRATION

Date: _____

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 Marital Status _____

Employer Name _____ Employer Phone _____

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 E-mail: _____

Emergency Contacts:

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 ____/____/___

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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:

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

_____
_____
_____

Past Surgical History

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

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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

	FA	MO	BR	SI	SO	DA		FA	MO	BR	SI	SO	DA
ALLERGIES	☐	☐	☐	☐	☐	☐	LUNG DISEASE	☐	☐	☐	☐	☐	☐
ARTHRITIS	☐	☐	☐	☐	☐	☐	STROKE	☐	☐	☐	☐	☐	☐
ASTHMA	☐	☐	☐	☐	☐	☐	PSORIASIS	☐	☐	☐	☐	☐	☐
CANCER	☐	☐	☐	☐	☐	☐	SKIN CANCER	☐	☐	☐	☐	☐	☐
DIABETES	☐	☐	☐	☐	☐	☐	THYROID DISEASE	☐	☐	☐	☐	☐	☐
ECZEMA	☐	☐	☐	☐	☐	☐	TUBERCULOSIS	☐	☐	☐	☐	☐	☐
HEART DISEASE	☐	☐	☐	☐	☐	☐	HEPATITIS	☐	☐	☐	☐	☐	☐
HYPERTENSION	☐	☐	☐	☐	☐	☐	OTHER _____	☐	☐	☐	☐	☐	☐

Eastern Washington Dermatology

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 to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as your name appears on Medicare Card:

Name: _____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 your name appears on MEDIGAP Card:

Name: _____Date_____

EWD 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

- ✓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 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.