ISLAND DERMATOLOGY

on south Mercer Island

PATIENT REGISTRATION

How did you hear about us? Google ☐ Website ☐ Yelp ☐ Newsletter ☐ Print Ad ☐ Facebook ☐ Friend/Family (name):_____

Referring Doctor: _____ Primary Care Doctor: _____

Name: _____ MI: _____ Date of Birth: ___/___/_____

Address: _____ Unit: _____

City: _____ State: _____ Zip: _____ Sex: M ☐ F ☐

Preferred Phone: (___) _____ home-cell-work Alternative Phone: (___) _____ home-cell-work

Email: _____ Voicemail OK: Y ☐ N ☐

Social Security Number: _____ Marital Status: _____

Race (list if applicable): _____ Hispanic or Latino? Y ☐ N ☐ Newsletter: Y ☐ N ☐

Responsible Party (if other than Patient): _____ Date of Birth: ___/___/_____

Responsible Party Phone: (___) _____ home-cell-work Relationship: _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Policy Holder's Name: _____

Relationship to Patient: _____ Policy Holder's Date of Birth: ___/___/_____

Secondary Insurance Company: _____ Policy Holder's Name: _____

Relationship to Patient: _____ Policy Holder's Date of Birth: ___/___/_____

EMERGENCY CONTACT

Name: _____ Phone Number: (___) _____ home-cell-work

Relationship: _____

ASSIGNMENT AND RELEASE

Your insurance plan is a contract between you and your insurance provider. We cannot guarantee insurance coverage, it is patient responsibility to verify eligibility and know the limitations of their individual plan. All payments and co-payments are due at the time of service. If you have not yet met your deductible, you may receive a bill for services or treatments provided to you. With this consent, I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any non-covered services, co-pays, and deductibles. I authorize Island Dermatology to release any information required to process my claims.

With this consent, Island Dermatology may leave a voicemail on the numbers provided in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operation (TPO) including appointment reminders, insurance items, and clinical care including test results. Island Dermatology may mail to my listed address or email any items that assist the practice in carrying out TPO including patient statements. You have the right to request a preferred method of contact, or a preferred limitation on where we leave/send your personal health information, but the practice is not required to agree to these restrictions.

I understand the above information and guarantee this form was completed to the best of my knowledge. I understand it is my responsibility to inform the office of any changes to the information provided.

Patient/Guardian Signature: _____ **Date:** ___/___/_____

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Patient Name: _____ **DOB:** _____

As a patient and active participant in your health care, Island Dermatology wants you to know your rights. You have the right to health care that respects your culture, psychosocial, and personal values and beliefs. Your records and communications are confidential to the extent provided by law. By taking an active role in your healthcare, you can help your caregivers meet your needs. We ask that you provide, to the best of your ability, accurate and complete information about your present condition, past medical history, and medications/allergies. Please follow the treatment plan developed, or express any concerns about your ability to comply with your proposed course of treatment to your provider.

HIPAA/PRIVACY PRACTICES/PATIENT RIGHTS:
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 authorize payments of my medical benefits to the physician. I have the right to receive a copy of an itemized list of charges submitted by Island Dermatology to my insurer or another third party regarding my care. I acknowledge that I have had the opportunity to review the Notice of Privacy Practices for Island Dermatology available at the front desk. I authorize treatment of the person named above and agree to pay fees for such treatment. I authorize Island Dermatology to receive all benefits to which I or my dependents are entitled to under my health insurance plan. I agree that I am obligated to pay for the account, and I will not withhold or delay payment if my insurance company denies payment on any of my or my dependent's charges. Should the account exceed an amount that the undersigned is able to pay, agreed upon payments can be established with a 1% interest rate per month.

I understand that I have the right to inspect my medical record and receive a copy of anything within my medical record. Requesting a hard copy of my medical record will incur a fee, but I have access to my complete chart at no charge through my online Patient Portal. Medical records sent to a physician's office are free of charge, though authorizations of release must be filled out and signed by the patient for transfer of medical records to other physicians. Chart notes can be released to referring/primary physicians without this authorization if deemed medically necessary.

I authorize the clinic to use photographs, videotapes, or digital images as recorded documentation of my care. Island Dermatology will retain the ownership rights to these photographs, videotapes, or digital images, but I can view them or obtain copies. All images will be stored in a secure manner that will protect patient privacy, and will be kept for the time period required by law. Images that identify a patient will only be released and/or used outside of Island Dermatology upon written authorization from myself or a legal representative.

By signing below, I agree that I have reviewed and understand the following office policies:

- Verification of insurance benefits and coverage is patient responsibility. Please confirm your network benefits, deductibles, and coverage prior to your service.
- Please provide 24 hours notice if you are unable to keep an appointment. We would like to be able to offer your appointment to another patient. You will be charged $50 for each late cancellation (within 24 hours) or no-show.
- All cosmetic appointments over 30 minutes require a $200 deposit. Your deposit is applied to your service at the time of treatment. Failure to provide 24 hours notice of cancellation or a no show will result in a forfeit of your deposit. Another $200 deposit will be required to reschedule.
- Refunds on cosmetic procedures will be reviewed on a case by case basis, and depend on the treatments performed to date and late cancellation status. A $50 admin fee may be applicable to process a refund.
- Retail products may be returned within 30 days for credit or refund only if the product is expired or tampered with. All other refund requests will be handled on a case by case basis.

Patient/Guardian Signature: _____

Print Name: _____ **Date:** _____

Medicare Patients: Island Dermatology is a participating provider in the Medicare program. Patients are responsible for meeting their annual deductible. We do also file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed and responsible for the remaining balance. By signing this form, I authorize Island Dermatology to file claims to Medicare, as well as any secondary carrier, and to release information to that payer if they require it for the proper consideration of a claim. I permit a copy of this authorization to be used in place of the original. Regulations pertaining to Medicare assignment of benefits apply.

Patient/Guardian Signature: _____

Print Name: _____ **Date:** _____

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Patient Name: _____ **DOB:**_____

PAST MEDICAL HISTORY please check if you had/have any of the following, and please list year of diagnosis/treatment					
Anxiety		Defibrillator		Hyperthyroidism	
Arthritis		Depression		Hypothyroidism	
Artificial Heart Valve		Diabetes		Leukemia	
Asthma		End Stage Renal Disease		Lung Cancer	
Atrial Fibrillation		GERD (acid reflux)		Lymphoma	
Bone marrow transplantation		Hearing Loss		Pacemaker	
Breast Cancer		Hepatitis		Prostate Cancer	
Colon Cancer		Hypertension		Radiation Treatment	
COPD (emphysema)		HIV/AIDS		Seizures	
Coronary Artery Disease		Hypercholesterolemia		**None**	

Other: _____

SKIN DISEASE HISTORY please check if you had/have any of the following, and please list year of diagnosis/treatment					
Acne		Eczema		Precancerous Moles	
Actinic Keratosis		Flaking/Itchy Scalp		Psoriasis	
Basal Cell Skin Cancer		Hay Fever/Allergies		Squamous Cell Skin Cancer	
Blistering Sunburns		Melanoma		**None**	

Other: _____

SURGICAL HISTORY please check if you had any of the following, and please list year of surgery					
Appendectomy		Joint Replacement: Knee		Pancreatectomy	
Cystectomy (gall bladder)		Kidney Stone Removal		Prostate Biopsy	
Breast Biopsy		Kidney Transplant		Prostate Cancer	
Breast Lumpectomy		Kidney Nephrectomy		Prostate TURP	
Breast Mastectomy		Liver Hepatectomy		Rectum APR	
Colectomy		Liver Transplant		Rectum: Resection	
Heart: Valve Replacement		Liver Shunt		Splenectomy	
Heart: coronary artery bypass		Ovaries: Endometriosis		Testicles: Orchiectomy	
Heart: Transplant		Ovarian Cancer		Hysterectomy (fibroids)	
Heart: PTCA angioplasty		Ovarian Cyst		Hysterectomy (cancer)	
Joint Replacement: Hip		Ovaries: Tubal Ligation		**None**	

Other: _____

Medications (please enter all current medications and dosages):

_____

_____

Allergies: _____

Do you wear sunscreen? Y ☐ N ☐ **If so, what SPF?** _____ **Do you tan in a tanning salon?** Y ☐ N ☐

Do you have a family history of melanoma Y ☐ N ☐ **non-melanoma skin cancer?** Y ☐ N ☐ _____

Current every day smoker? Y ☐ N ☐ **Former smoker?** Y ☐ N ☐ **How many years?**_____

<u>Women only:</u> Are you pregnant or planning a pregnancy? Y ☐ N ☐ **Breastfeeding?** Y ☐ N ☐