Patient Registration

PACIFIC DERMATOLOGY & COSMETIC CENTER

Patient _____ Today's Date _____
Last Name First Name MI

Address _____
Street City State Zip

Date of Birth _____ Age_____ Social Security # _____ Home Phone (____)_____

Work Phone (____)_____

Employer/ occupation_____ Cell Phone (____)_____

E-Mail (appointment confirmations and medical communication only): _____

Marital Status: ☐ Single ☐ Married ☐ Legally Separated ☐ Widowed ☐ Divorced ☐ Life Partner
How did you hear about us? _____

In order to better assess medical risks and benefits, we need to ask how you identify your race and ethnicity.

Would you like to provide that information? ☐ African American ☐ Asian ☐ White ☐ Hawaiian ☐ Native American ☐ No Response

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ No Response

Patient Provider Information

Your primary care (family) physician (PCP) _____ Phone (____)_____

Provider who referred you (if any) _____ Phone (____)_____

Please have a copy of your insurance cards and driver's license or photo ID to verify your signature and date of birth

Patient Insurance Information

First Insurance _____ Relationship to primary holder ☐ Self ☐ Spouse ☐ Child ☐ Other

Second Insurance _____ Relationship to secondary holder ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of insured if not self _____ Social Security # _____ D.O.B _____
First Name Last Name

Address of insured if not self _____ (____)_____
Street City State Zip

****For Dependants/Students person responsible for bill**_____

Emergency Contact Information

In case of an emergency, friend or relative to be notified Name_____

Relationship _____ Home Phone (____)_____ Work Phone (____)_____

Would you be interested in receiving emails on any upcoming cosmetic promotions and specials? If yes, please provide us with your

Email address_____

Assignment of Benefits and Information Release Authorization

Assignment and Release: I authorize my insurance and government benefits to be paid directly to the physician. I authorize the release of medical information to my primary care physician, referring physician and medical consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

Patient Signature_____

11011 Meridian Ave N, Suite 102, Seattle, WA 98133 Phone: 206-859-5777 Fax: 206-859-5776
350 S 38th Court, Suite 115, Renton, WA 98055 Phone 206-859-5777 Fax 425-970-4565

Pacific Dermatology & Cosmetic Center

Notice of Privacy Practices - Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual	Date
Printed Name if signed on behalf of Patient	Relationship (parent, legal guardian, Personal representative)

Notations:

This form will be retained in your medical records.

PACIFIC DERMATOLOGY & COSMETIC CENTER
A division of
Reichel Dermatology Associates, PLLC
11011 Meridian Ave N, Ste 102
Seattle, WA 98133-8967

FINANCIAL POLICY

Thank you for choosing us for your skin care needs. We are committed to providing you with the best possible medical care. The following is a statement of our appointment and financial policies which we require you to read and sign prior to your treatment.

APPOINTMENT AND FINANCIAL POLICY – EFFECTIVE 08/01/2019

A scheduled appointment is a commitment of time between the doctor and patient. We have reserved time just for you. When appointments are missed or canceled with short notice, that time is lost. We ask that when you make an appointment for treatment, you make every effort to keep that appointment. We understand that emergencies do arise. However, if you find that you cannot keep your scheduled appointment, we require a minimum of one 24 hour business day notice of your cancellation to allow us time to schedule another patient in need of treatment. Please note that if you arrive late to your appointment, we will do our best to work you back into the schedule, however, you may be asked to reschedule.

	Please Initial
OUR RESPONSIBILITY: ❖ To bill all claims to your primary and secondary insurance carriers in a timely manner. ❖ To assist you in resolving any problems with claim payment.	
YOUR RESPONSIBILITY: ❖ To provide us with accurate information to submit your claims correctly and to include a copy of your insurance card. ❖ To make certain there is an authorization for our physicians to treat you if it is required by your insurance. ❖ To pay your copay at the time of service. We accept Cash, Check, Credit/Debit Card, and Care Credit at select locations. No Post-Dated or Third-Party Checks. All returned and NSF checks will result in a $25.00 fee. ❖ Complete a credit card authorization form and present a credit card, Health Savings or Flexible Spending card to be encrypted for automatic payment of remaining copay, coinsurance, deductible balances when they become due on your account as determined by your insurance plan.	_____
REFERRALS/AUTHORIZATIONS: ❖ Referrals and/or Authorizations are not a guarantee of payment. You are responsible for any balances classified as 'Patient Responsibility' by your insurance company. Any dispute with claim processing is between you and your insurance company.	_____
PAYMENT ARRANGEMENTS: ❖ If your authorized credit card expires or payment cannot be processed for any reason, you will be notified by mail of the failed attempt and receive a copy of your statement of the outstanding balance due. Please contact our billing office to update your credit card information or make necessary payment arrangements before the next 28 day billing cycle. ❖ Past Due Account balances must be settled prior to making or being seen for a subsequent appointment. ❖ A late fee of 3% will be assessed to your open account balance if the account becomes aged after 60 days without a payment arrangement established.	_____
GENERAL INFORMATION: ❖ Allied Dermatology does not bill absent parents for payments due at the time of service. The adult presenting the minor for care is the responsible party. ❖ Skin biopsies and pathology services performed in-house will be charged along with an office visit, which may be applied to your deductible along with your copay and coinsurance percentage. If further testing is required to obtain an accurate diagnosis, your specimen will be sent to an outside laboratory where separate charges may apply. ❖ **Missed appointments** or appointments canceled with less than one (24 hour) business day notice will require a credit card captured at the time of rescheduling to secure your next appointment. If you miss or cancel your rescheduled appointment without required notice, your card will be charged for a missed appointment fee of $50.00 for a standard appointment, or $100.00 for a missed surgery appointment. Insurance companies do not reimburse for missed appointment charges.	_____
❖ Ambulatory Surgery Center patients may be charged a facility fee. This covers our expenses for maintaining an accredited ambulatory surgery center. Insurers consider procedures in an ambulatory surgical center out-patient surgery. Some insurance plans require increased coinsurance payment for these procedures – Medicare does not.	_____
COLLECTION POLICY: ❖ Allied Dermatology has a collection policy in place for delinquent accounts. If we have been unable to obtain payment in full or maintain scheduled payment arrangements from you after 3 months of repeated attempts, the account will be turned over to our collection agency and you will be discharged from the practice. ❖ Patients who are discharged from Allied Dermatology due to non-payment may request a copy of their medical records be sent to the health care provider of their choice in order to continue care.	_____

I certify that I have read the financial and appointment policies of Allied Dermatology, and I agree to abide by these policies.

Signature _____ **Date** _____
(Parent or legal guardian must sign if patient is under 18)

Patient Name _____ **Date of Birth** _____ **Medical Record #** _____

PACIFIC DERMATOLOGY & COSMETIC CENTER

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY AND/OR CAREGIVERS

In the event Pacific Dermatology & Cosmetic Center may need to give your test results or medical information, may we … (Check all that apply)

_____ Leave a detailed voicemail on this phone, the number is _____

_____ Call you on your cellular phone, the number is _____

_____ Call you at work, the number is _____

_____ Email _____

_____ Speak to you directly, **ONLY**

I, _____(DOB) _____, give Pacific Dermatology & Cosmetic Center and staff, authoriztion to disclose my protected health information to the following family, friends and/or caregivers.

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Pacific Dermatology & Cosmetic Center.

I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as sighted in the Notice of Privacy Practices.

I understand that authorizing the disclosure of this health information is voluntary. Pacific Dermatology & Cosmetic Center and its entites will not condition treatment, payment, enrollment or eligibilty for benefits on providing, or refusing to provide this authorization. I understand that any disclosure of information carries with it the potential for an authorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy, which I obtained from my doctor's office.

Unless, otherwise revoked, this authorization will expire on the following datem event or condition: _____
If I fail to specify a date this authorization will expire one (1) year from the signature on this form.

_____ Date: _____
Signature of Patient

_____ Date: _____
Signature of Guardian or Personal Representative

Pacific Dermatology Surgery Center / Pacific Dermatology & Cosmetic Center
11011 Meridian Ave N, Seattle, WA 98133 Phone: 206-859-5777 Fax: 206-859-5776

Rev: 2017-05-19

PACIFIC DERMATOLOGY & COSMETIC CENTER

COSMETIC QUESTIONNAIRE

Your Name: _____ Date: _____

How did you hear about us? ❑ Friend ❑ Relative ❑ Doctor Referral (name)_____

❑ Internet: (❑Website ❑Google ❑Yahoo ❑Yelp ❑ CitySearch ❑ RealSelf ❑ Magazine ❑ Other _____

Do you have any upcoming events or vacations we should know about? _____

If you have any specific cosmetic interests, please check all that apply:

❑ Body Liposuction
❑ Neck Liposuction
❑ Eyelid Lift (Blepharoplasty)
❑ Fat Injection
❑ Laser Resurfacing / CO2
❑ Fraxel Dual
❑ Ultherapy
❑ IPL/BBL – Photo Rejuvenation
❑ VBeam Perfecta
❑ Clear & Brilliant
❑ Ear Surgery
❑ Leg Vein Treatment
❑ Spider Vein Treatments
❑ Leg Vein Treatment
❑ LightSheer Duet Laser Hair Removal
❑ Botox Cosmetic
❑ Sculptra
❑ Dysport
❑ Restylane
❑ Belotero
❑ Radiesse
❑ Juvederm
❑ Hand Aging
❑ Lip Augmentation
❑ Latisse
❑ Chemical Peels
❑ Skin Care Products:
❑Obagi, Skin Ceuticals, Skin Medica, Elta MD
❑ Botox for Excessive Sweating
❑ Facial / Body Aging
❑ Kybella
❑Voluma
❑Cellfina
❑SkinTyte

Have you had any previous cosmetic surgery? ❑ yes ❑ no
If yes, please list: _____

Please answer the following questions on a scale of 1 to 5 by circling the appropriate number.

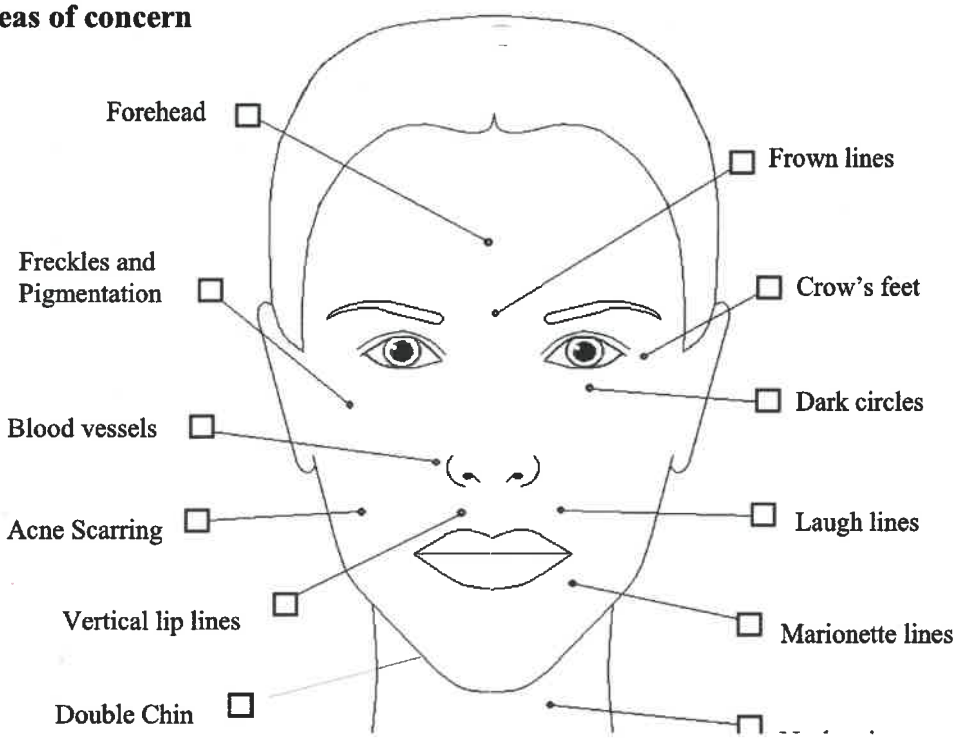
When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

Younger Than		*True Age*		*Older Than*
1❑	2❑	3❑	4❑	5❑

Each day, I look at myself in the mirror

Once or Twice per day		*Every now and then to freshen up*		*More than 10 times per day*
1❑	2❑	3❑	4❑	5❑

Check areas of concern



HISTORY AND INTAKE FORM (PAGE 1)

NAME: _____ **DATE OF BIRTH:** _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Chemotherapy
Depression
Diabetes
GERD (Acid reflux)
Hearing Loss
Heart Disease
Hepatitis
HIV/AIDS
Hypercholesterolemia
Hypertension
Kidney Disease
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizure
Stroke
Thyroid (hyper/ hypo)
None/Other
_____
_____
_____

Past Surgical History: (please check all that apply)

☐ Appendectomy
☐ Bladder
☐ Pancreas (Pancreatectmy)
Breast: ☐Biopsy ☐ Lumpectomy ☐Mastectomy
☐ Left ☐Right ☐Bilateral
Colon :☐Colectomy/CA resection ☐Diverticulitis
☐ Inflammatory Bowel Disease ☐Colostomy
☐ Gallbladder Removal
Heart Surgery: ☐valve/biological ☐Valve mechanical
☐Bypass☐Transplant ☐PTCA
Skin: ☐Basal cell carcinoma ☐Melanoma
☐Squamous cell carcinoma ☐Biopsy
Joint Replacement(s): ☐Hip ☐Knee
☐Left ☐Right ☐Both
Kidney: ☐Biopsy ☐transplant
☐Stone removal
☐nephrectomy
Liver: ☐Transplant☐shunt
☐Hepatectomy
Oophorectomy due to: ☐Cancer
☐Endometriosis ☐Cyst
Prostate/Prosetectomy:☐Cancer
☐Biopsy ☐TURP
☐Spleen (splenectomy)
☐Testicles (Orphiectomy)
Rectum: ☐APR
☐Low anterior resection
Hysterectomy due to: ☐Fibroids
☐uterine CA ☐Cervical CA
OTHER_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns:
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Precancerous Moles
Poison Ivy
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 immediate relative(s)? _____

Family history of skin disease? ☐NO ☐ YES WHAT DISEASE?_____ WHICH FAMILY MEMBER?_____

Medications: AND DOSE

_____
_____
_____
_____
_____

Medication Allergies: ☐**No Known Drug Allergies**

_____ Reaction:_____
_____ Reaction:_____
_____ Reaction:_____
_____ Reaction:_____
_____ Reaction:_____

Social History: (Please circle one)

Cigarette Smoking:
Never Smoked
Quit (former smoker)
Smokes less than daily
Smokes daily

Alcohol Use:
Yes If yes, how much per day?
No _____

Occupation and Workplace:_____ Pharmacy:_____

HISTORY AND INTAKE FORM (PAGE 2)

Patient Name_____ Birth Date____/____/_____ Today's Date____/____/_____

Are you presently or frequently bothered by any of the following symptoms? Please check any that apply. Feel free to add chronic symptoms that aren't listed that you feel are important and/or a concern to you.

GENERAL ☐ **None**

☐ fatigue
☐ Unexplained fever
☐ Unexplained weight loss or gain
☐ Night sweats
☐ Severe intolerance to hot or cold weather
☐ Excessive thirst

Integumentary ☐ **None**

☐ Problems with bleeding
☐ Problems with scarring (hypertrophic or keloid)
☐ Problems with healing
☐ Rash

EYES, EARS, NOSE, THROAT ☐ **None**

☐ Double or blurred vision
☐ Frequent nose trouble
☐ Sore mouth or throat
☐ Difficulty swallowing

HEART - CIRCULATION ☐ **None**

☐ Chest pain
☐ Leg vein trouble
☐ Ankle swelling

LUNGS - RESPIRATORY ☐ **None**

☐ Shortness of breath
☐ Daily cough
☐ Coughing blood

GASTROINTESTINAL ☐ **None**

☐ Diarrhea
☐ Blood in stool
☐ Frequent heartburn
☐ Bowel problems

BONES, JOINTS, MUSCLES ☐ **None**

☐ Joint pain or swelling
☐ Muscle pain or severe lack of strength

NEUROLOGIC ☐ **None**

☐ Dizziness
☐ Headache
☐ Memory problems

ALLERGY/IMMUNOLOGY ☐ **None**

☐ Sneezing
☐ Red/itchy eyes

HEMATOLOGIC/LYMPHATIC ☐ **None**

☐ Bleeding easily
☐ Bruising easily
☐ Lymph node swelling

OTHER SYMPTOMS NOT LISTED ABOVE:

_____

ALERTS: check all that apply

☐ adhesive allergy ☐ lidocaine allergy
☐ topical ointment allergy ☐ blood thinners
☐ defibrillator ☐ MRSA Hx
☐ Staph Hx ☐ previous chronic narcotic use
☐ Hepatitis B or C ☐ rapid heartbeat with epi
☐ pregnancy/breastfeeding ☐ Latex Allergy
☐ Hx of cold sores ☐ HIV/AIDS
☐ Pacemaker

May we leave you a detailed voice mail?

Yes **No**

If yes, what is your preferred phone number?

_____

PACIFIC DERMATOLOGY & COSMETIC CENTER

Preparing for your appointment

Please bring the following to your first appointment:

- The completed forms included with this letter
- Your insurance card and driver's license (unless this is a cosmetic appointment)

Medical Records
Bring relevant medical records with you or ask your referring physician to mail or fax them to us. Our address and fax number are noted at the bottom of this letter.

When to Arrive
Plan to arrive at our office 15 minutes before your appointment to complete registration and check-in. We understand the value of your time and work hard to keep to our scheduled times.

Cancellation Policy
We understand if you can not make your appointment and need to reschedule. However, please call 24 hours prior to your appointment for ANY cancellation. We charge $50.00 dollars for any no-show appointments, (or cancellations without 24 hour notice).

Important information about your bills

Insurance Based Patients
The **insurance billed** surgical outpatient services provided at Pacific Dermatology & Cosmetic Center and Pacific Dermatology Surgery Center are divided into two bills:

- One bill from Pacific Dermatology & Cosmetic Center. This bill covers the costs of the professional services of the physician.
- One bill from the Pacific Dermatology Surgery Center. This bill covers some of the facility costs (surgical suite, equipment, supplies and staff time).
- ***Each of these bills may incur a co-payment or co-insurance responsibility for the patient, depending on the insurance coverage.***
- The amount of the co-insurance or co-payments that you will be required to pay will depend upon the services provided during your visit and the coverage provided by your insurance.

Cosmetic Patients

- In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, payment is required for all services at the time they are rendered unless you are scheduled for a procedure that requires payment prior to the date of service. We accept cash, check, Visa, MasterCard, and American Express. We do have payment plans available through Care Credit.