

# Patient Registration

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 Dependents/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 \_\_\_\_\_

# 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.

## 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.

<p><b><u>OUR RESPONSIBILITY:</u></b></p> <ul style="list-style-type: none"> <li>❖ To bill all claims to your primary and secondary insurance carriers in a timely manner.</li> <li>❖ To assist you in resolving any problems with claim payment.</li> </ul>	
<p><b><u>YOUR RESPONSIBILITY:</u></b></p> <ul style="list-style-type: none"> <li>❖ To provide us with accurate information to submit your claims correctly and to include a copy of your insurance card.</li> <li>❖ To make certain there is an authorization for our physicians to treat you if it is required by your insurance.</li> <li>❖ 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.</li> <li>❖ 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.</li> </ul>	<p><b>Please Initial</b></p> <p>_____</p>
<p><b><u>REFERRALS/AUTHORIZATIONS:</u></b></p> <ul style="list-style-type: none"> <li>❖ 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.</li> </ul>	<p>_____</p>
<p><b><u>PAYMENT ARRANGEMENTS:</u></b></p> <ul style="list-style-type: none"> <li>❖ 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.</li> <li>❖ Past Due Account balances must be settled prior to making or being seen for a subsequent appointment.</li> <li>❖ 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.</li> </ul>	<p>_____</p>
<p><b><u>GENERAL INFORMATION:</u></b></p> <ul style="list-style-type: none"> <li>❖ 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.</li> <li>❖ 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.</li> <li>❖ <b>Missed appointments</b> 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.</li> </ul>	<p>_____</p>
<ul style="list-style-type: none"> <li>❖ 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.</li> </ul>	<p>_____</p>
<p><b><u>COLLECTION POLICY:</u></b></p> <ul style="list-style-type: none"> <li>❖ 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.</li> <li>❖ 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.</li> </ul>	<p>_____</p>

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, authorization 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.

\_\_\_\_\_  
Signature of Patient Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of Guardian or Personal Representative Date: \_\_\_\_\_

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

**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:

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

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.

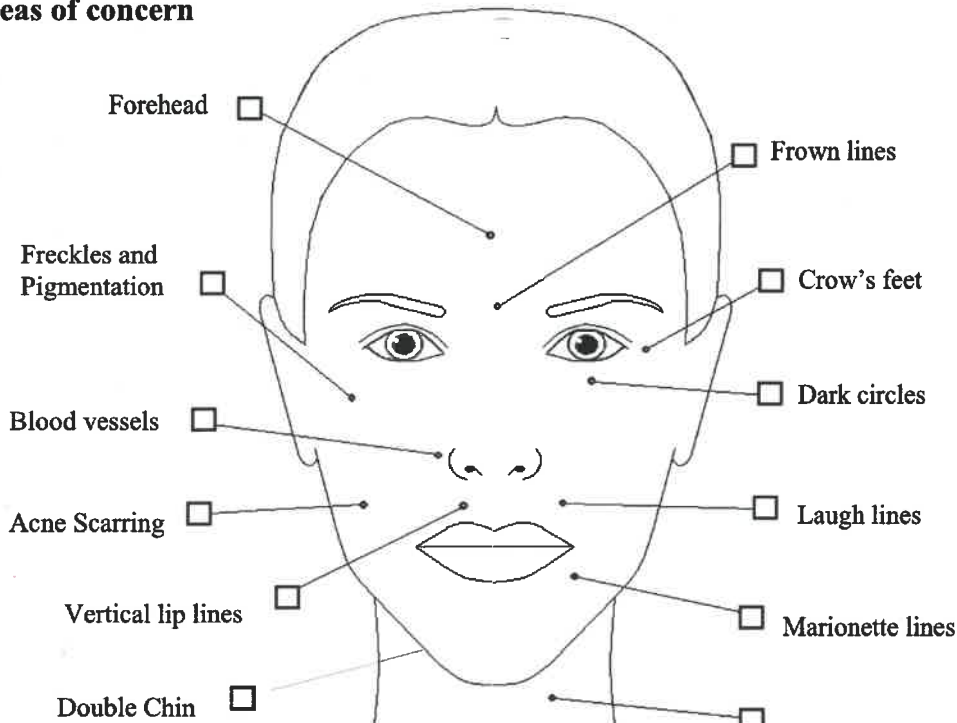
When looking at my face in the mirror, I believe I look younger, the same as, or older than my true age.

<i>Younger Than</i>		<i>True Age</i>		<i>Older Than</i>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

Each day, I look at myself in the mirror

<i>Once or Twice per day</i>		<i>Every now and then to freshen up</i>		<i>More than 10 times per day</i>
1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	5 <input type="checkbox"/>

**Check areas of concern**



HISTORY AND INTAKE FORM (PAGE 1)

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Past Medical History: (please circle all that apply)

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

Past Surgical History: (please check all that apply)

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

Skin Disease History: (please circle all that apply)

- |                        |                        |                           |                                |
|------------------------|------------------------|---------------------------|--------------------------------|
| Acne                   | Dry Skin               | Melanoma                  | None/ Other:<br>_____<br>_____ |
| Actinic Keratosis      | Eczema                 | Precancerous Moles        |                                |
| Asthma                 | Flaking or Itchy Scalp | Poison Ivy                |                                |
| Basal Cell Skin Cancer | Hay Fever/Allergies    | Psoriasis                 |                                |
| Blistering Sunburns:   |                        | Squamous Cell Skin Cancer |                                |

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: \_\_\_\_\_

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?**

\_\_\_\_\_

## 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.