

Name: \_\_\_\_\_  
(First) (Middle) (Last)

Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender: M  F  SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Home Work Cell

Phone: ( ) \_\_\_\_\_ Home Work Cell

Email Address: \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

Referring Physician (if different from PCP): \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone: ( ) \_\_\_\_\_

*Complete this section only if someone other than the patient is financially responsible.*

[ ] Same as Patient

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Birthdate: \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

**Primary Insurance:**

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_

**Secondary Insurance:**

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Group Number: \_\_\_\_\_ Policy ID Number: \_\_\_\_\_

If you wish to have medical information disclosed to a family member in your absence (i.e. Biopsy report or Lab reports) please list their name and relationship to you below:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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How did you learn about our Practice:

\_\_\_\_ Friend/Referral (Name: \_\_\_\_\_)      \_\_\_\_ Willamette Weekly

\_\_\_\_ Yellow Pages/Phone Directory      \_\_\_\_ Just Out Magazine

\_\_\_\_ Google/Bing/Yelp/Citysearch      \_\_\_\_ The Asian Reporter

\_\_\_\_ Facebook      \_\_\_\_ CDLS Mailer

\_\_\_\_ E-mail Blasts      \_\_\_\_ Prior Practice

\_\_\_\_ Other \_\_\_\_\_

Do you wish to receive e-mails regarding promotions & dermatology updates?       Yes       No

Do you wish to receive appointment reminders via e-mail (when available)?       Yes       No

Do you wish to receive medical information via e-mail (when available)?       Yes       No

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Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Patient Signature

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Responsible Party if patient is under 18 years of age



**PATIENT FINANCIAL POLICY and NOTICE OF PRIVACY PRACTICES (HIPAA)**

Patient Name: \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**RECEIPT OF PRIVACY PRACTICES:**

My signature below indicates that I have received (upon request) and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

**Patient or Responsible Party Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**FINANCIAL POLICY:**

**Self Pay:** All patients will be required to pay \$145.00 deposit at the time of service. All additional charges will be billed directly to you with payment due in full within 30 days from date of service.

**Insurances:** Patients are required to bring their current insurance identification card to *each* appointment. It is your responsibility to inform us of any changes in insurance, address, or telephone number. If no insurance card is present at the time of your visit you will be charged the \$145.00 deposit.

**HMO/PPO Plans:** HMO/PPO co-payments are due at the time of each visit. If a co-payment is not received at the time of your visit there will be a \$20.00 billing fee added to your account. You will be responsible for paying your annual deductible, co-insurance, co-payment and charges for all non-covered services. **If your insurance requires a referral, please call your primary care physician to obtain prior to your visit. Without a referral, you will be asked to reschedule your appointment.**

**Medicare:** We accept Medicare assignment and will bill your secondary insurance for you. You are responsible for paying your deductible, co-pay, co-insurance, and any amount not paid by Medicare or your secondary insurance.

**Commercial Plans:** Patients who are covered by a private plan in which our physicians are not providers will be required to pay a \$145.00 deposit at the time of service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

**Returned Check:** In the event we receive a returned check due to insufficient funds, a \$35.00 *check fee will be charged* to your account. Payment will be due in full immediately upon notification.

**Collection Agency Fee:** If your account balance is turned over to an outside collection agency *A \$25 processing fee will be charged* to your account.

**IMPORTANT NOTE ABOUT YOUR INSURANCE BENEFITS:**

Please be sure to check your insurance benefits. Treatments and procedures recommended for you are considered by your insurance company as a separate charge from the office visit with the physician, even if the appointment occurs on the same day as your appointment with the physician. Usually, co-pays and deductibles apply to these types of appointments. For specific questions regarding your insurance policy guidelines, please contact your carrier's customer service department.

**I have read and agree to abide by the policies set forth in this document.**

\_\_\_\_\_  
**Patient or Responsible Party Signature**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
**Date**