ROBERT B. HOPP, M.D.
& ASSOCIATES

CENTER FOR EXCELLENCE IN
DERMATOLOGY™
PLLC

FOR OFFICE USE ONLY

❑ New ❑ Follow-up
❑ Patient seen in last 4 weeks
PROVIDER: _____
APPT. TIME: _____
CHECK IN: _____
ROOMED: _____
CHECK OUT: _____

❑ Asuris Northwest Health
❑ Anthem Blue Cross Blue Shield
❑ Premera Blue Cross
❑ First Choice Health
❑ LifeWise of Washington
❑ LifeWise Health Plan of Oregon
❑ Regence
❑ Uniform Medical Plan
❑ Medicare
❑ Other: _____

Medical History

Patient Name: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Dr. Hopp works with six nurse practitioners and one physician assistant. All of our providers are trained in dermatology and consult with one another whenever problems arise that are outside their knowledge base.

Full body exams are very important in the diagnosis of skin cancers. A gown must be worn for this examination. Would you like a full body skin exam today? ❑ Yes ❑ No

Please tell us about the skin problems that bring you to the office today:

Chief Complaint #1

Description:

History:

Location on body:

Severity of problem:

Past treatment(s):

Effect of treatment(s):

Chief Complaint #2

Description:

History:

Location on body:

Severity of problem:

Past treatment(s):

Effect of treatment(s):

PROVIDER

INITIALS: _____
DATE: _____

INITIALS: _____
DATE: _____

INITIALS: _____
DATE: _____

INITIALS: _____
DATE: _____

Patient Name: _____ Date of Birth: _____

Medical History

Please indicate if you are currently having or have had trouble with any of the following conditions:

Melanoma	❑ No	❑ Yes	If yes, location on body: _____
Basal Cell	❑ No	❑ Yes	If yes, location on body: _____
Squamous Cell	❑ No	❑ Yes	If yes, location on body: _____
Cancer (not skin)	❑ No	❑ Yes	If yes, location on body: _____
Acne	❑ No	❑ Yes	If yes: _____
Eczema	❑ No	❑ Yes	If yes: _____
Psoriasis	❑ No	❑ Yes	If yes: _____
Asthma	❑ No	❑ Yes	If yes: _____
Allergies / Hay fever	❑ No	❑ Yes	If yes: _____
Heart Problems	❑ No	❑ Yes	If yes: _____
Kidney Problems	❑ No	❑ Yes	If yes: _____
Diabetes	❑ No	❑ Yes	If yes: _____
High Cholesterol	❑ No	❑ Yes	If yes: _____
Excessive Bleeding	❑ No	❑ Yes	If yes: _____
High Blood Pressure	❑ No	❑ Yes	If yes: _____
Peptic Ulcer Disease	❑ No	❑ Yes	If yes: _____
Hepatitis	❑ No	❑ Yes	If yes: _____
Autoimmune Disorder	❑ No	❑ Yes	If yes: _____
Allergy to sun	❑ No	❑ Yes	If yes: _____

Amount of sun exposure you've had in your life: ❑ Mild ❑ Moderate ❑ Severe

If female, are you pregnant or breastfeeding? ❑ No ❑ Yes: _____

Do you have artificial joints or heart valves? ❑ No ❑ Yes: _____

Do you have a pacemaker? ❑ No ❑ Yes: _____

What surgeries have you had in the past?

Any other medical problems not listed above?

List the names of current doctors:

_____

_____

_____

_____

PROVIDER

INITIALS: _____
DATE: _____

INITIALS: _____
DATE: _____

INITIALS: _____
DATE: _____

INITIALS: _____
DATE: _____

Patient Name: _____ Date of Birth: _____

Please list any prescription and over-the-counter medications you are currently taking:

Please list any prescription and over-the-counter medications you are ALLERGIC to, and the reaction you have had to them:

Please list the pharmacy that you use the most, including mail orders:

Review of Systems

Fever / chills? ❑ No ❑ Yes: _____

Feeling well otherwise? ❑ Yes ❑ No: _____

Circle any of the following skin symptoms you are experiencing:

Bruising	Color Change	Scar/keloids	Swelling	Itching
Lesions/sores/growths	Lumps	Rash	Hair problems	Nail problems

Family History

Has anyone in your family had the following problems?

Melanoma	❑ No	❑ Yes	If yes, who? _____
Basal Cell	❑ No	❑ Yes	If yes, who? _____
Squamous Cell	❑ No	❑ Yes	If yes, who? _____
Acne	❑ No	❑ Yes	If yes, who? _____
Eczema	❑ No	❑ Yes	If yes, who? _____
Psoriasis	❑ No	❑ Yes	If yes, who? _____
Other	❑ No	❑ Yes	If yes, who? _____

Has anyone in your family had skin problems similar to what you're here for today?

❑ No ❑ Yes If yes, who? _____

Social & Behavioral History

Do you use tobacco of any kind? ❑ No ❑ Yes If yes, what type: _____

Do you wear sunscreen regularly? ❑ No ❑ Yes If yes, SPF: _____

Do you use alcohol on a regular basis? ❑ No ❑ Yes If yes, amount: _____

Occupation: _____

Marital status: _____

FOR OFFICE USE ONLY

REVIEWED: ❑ PROVIDER SIGNATURE _____ DATE: _____

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NOTICE OF PRIVACY PRACTICES AND OFFICE POLICIES

This document is not open to revision & must be signed in its entirety

I AGREE AND UNDERSTAND:
Office visit charges are due at time-of service. There will be a $5.00 charge for office visit charges & previous balances not paid at the time-of-service. Co-pays, deductibles, and coinsurances are set by your insurance plan. If you are unsure about your insurance benefit coverage, please contact your insurance company. We are preferred providers for Blue Cross, Premera, Lifewise, Asuris NW Health, First Choice Health, United Health Care (until 4/30/2010), Uniform Medical, and Medicare. This office will courtesy bill** all other insurance companies. Your insurance may not cover every procedure done in this office. It is your responsibility to contact your insurance for questions on coverage and benefit information. This includes Medicare. For patients who have Medicare, please ask the receptionist for the additional form.

***Patients with Columbia Community Care will need to sign a waiver or our office will be unable to courtesy bill their insurance.*

PLEASE INITIAL _____

This office reserves the right to add additional charges for the following:

- Returned checks $29.00
- $40.00 charge for appointments missed or canceled without 24 hours notice.
- If you are more than 10 minutes late for your appointment, it may be necessary to reschedule it. If it's necessary to reschedule, this will be considered a missed appointment.
- Some cosmetic appointments require a deposit of $100.00. This is nonrefundable if you fail to cancel your appointment with at least 24 hours notice.

PLEASE INITIAL _____

Each patient has an individual account at this office. We require patients to present their insurance card at each visit. If you are unable to provide us with a copy of your insurance card at the time of service you will be responsible for payment in full. You will also be responsible for submitting any claim to your insurance company.

PLEASE INITIAL _____

I authorize treatments and agree to pay all fees and charges for such treatments. I agree to pay all charges as shown by statements promptly unless credit arrangements are agreed upon. If you are unable to pay your balance in full, please contact our billing department to set up a payment plan. Balances not paid in full within 30 days will be considered in default and we reserve the right to transfer the account to our in-house collection department or a third party collection agency. I agree to pay all collection costs and any third party costs attempting to collect the debt. I also understand that unpaid debts may be reported to credit report agencies and may affect my credit score.

PLEASE INITIAL _____

Please see the following page for additional information.

HOURS: 8 A.M.-5 P.M. MONDAY - THURSDAY AND 8 A.M.-4 P.M. FRIDAY
8901 W. GAGE BLVD., KENNEWICK, WA 99336, (509) 735-1100, DRHOPP.NET

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HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA):
We keep a record of the health care service we provide you. You may ask to see, copy, and/or correct that record. We will not disclose your protected health information (PHI) to others unless you direct us to do so or unless the law requires or compels us to do so. Patient's 18 years of age are legally responsible for their own healthcare and our office cannot discuss any PHI unless a written authorization is given. If you would like your PHI to be disclosed to any individuals (including immediate family) please ask the front office staff for a release form.

PLEASE INITIAL _____

Effective immediately our office will be charging $25.00 to complete any third party forms (i.e. Labor & Industries) and writing letters for compensation benefits. This fee is the responsibility of the patient.

PLEASE INITIAL _____

This office processes biopsy specimens in-house in a certified histology lab. The slides are then read and diagnosed by Dr. Robert Hopp who is board certified dermatopathologist. Occasionally a second opinion is necessary for diagnosis and these specimens are sent to a third party for review. There may be a separate charge accrued by the third party that will be billed to the patient or the patient's insurance. It is the responsibility of the patient to make sure the third party has their correct billing information.

PLEASE INITIAL _____

If you would like us to leave messages at your home regarding your office visits, health care, prescriptions, your account or anything else happening in the office.

PLEASE INITIAL _____

Minors are required to have a parent or legal guardian accompany them on all office visits.

PLEASE INITIAL _____

NOTICE: DO NOT SIGN THIS AGREEMENT BEFORE YOU READ AND AGREE TO THE CONDITIONS SET FORTH. WE RESERVE THE RIGHT TO CHANGE THESE POLICIES AT ANY TIME. YOU ARE ENTITLED TO A COPY OF THE AGREEMENT AND MAY REQUEST ONE FROM THE RECEPTIONIST. KEEP IT TO PROTECT YOUR LEGAL RIGHTS.

SIGNATURE: _____ DATE: _____
(PARENT OR GUARDIAN SIGNATURE IF PATIENT IS A MINOR)

PRINT PATIENT NAME: _____

RELATIONSHIP TO PATIENT (if signed on behalf of patient): _____

DCN41410

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REGISTRATION FORM

(Please Print) Today's date:

PATIENT INFORMATION

Patient's last name:	First:	M. I.:	Marital status (circle one): Minor / Single / Mar / Sep / Div / Wid / Partnered / for: yrs
Email address:	Birthdate: / /	Age:	Sex: ❑ M ❑ F
Address:	Social Security no.:	Home phone no.: ( )	
City:	State:	ZIP Code:	Cell phone no.: ( )
Occupation:	Employer/School:	Employer/School phone no.: ( )	
Employer's Address:	City:	State:	ZIP Code:
Spouse's name:	Spouse's work phone no.: ( )	Spouse's cell phone no.: ( )	Spouse's Social Security no.:

Selected our office because / Referred to office by (check all that apply): ❑ Another medical office or provider ❑ Insurance Plan
❑ Website ❑ Yellow Pages ❑ Newspaper ❑ Radio ❑ Postcard ❑ Been a patient here before ❑ Live or work nearby ❑ Word of mouth
❑ Golf Course Ad ❑ Saw your building or sign ❑ Another patient: ❑ Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Cell/home phone no.: ( )	Work phone no.: ( )

GUARANTOR INFORMATION (fill out if person responsible for bill is different than patient)

Guarantor's last name:	First:	Middle initial:	Birthdate: / /
Address (if different):	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.: ( )	Social Security no.:

PARENTS OF MINOR

Mother's last name: First: M. I.:	Father's last name: First: M. I.:

INSURANCE INFORMATION

Insurance Company:	Subscriber's **FULL** name:	Subscriber ID no.:	Group no. (if applicable):
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Subscriber's Employer:	Subscriber's S.S. no.:	Birthdate: / /

SECONDARY INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No If "**YES**," this section **MUST** be **COMPLETELY** filled out.

Insurance Company:	Subscriber's **FULL** name:	Subscriber ID no.:	Group no. (if applicable):
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Subscriber's Employer:	Subscriber's S.S. no.:	Birthdate: / /

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PATIENTS WITH MEDICARE: PLEASE READ AND SIGN

Medicare will only pay for services that it determines to be “reasonable and necessary” under section 1862(1)(1) of the Medicare Law. If Medicare determines that a particular service, although it would be otherwise covered, is not reasonable or necessary under Medicare program standards, Medicare will deny payment for that service which does not mean that you should not receive it. There may be a good reason why it is recommended.

Each calendar year Medicare sets a deductible that is the responsibility of the patient. After the year’s deductible has been met, Medicare will pay 80% of the allowable charges. If you have a secondary insurance through one of the following companies, you may not be responsible for your deductible or coinsurance: Premera, Blue Cross, Asuris NW Health, Lifewise, First Choice Health, United Health Care, Uniform Medical, Cigna. Medicare may send your claim on to your secondary insurance, but you must set up this service with Medicare.

Therefore, I agree to be personally and fully responsible for payment. I request that payment of authorized Medicare benefits be made for any services furnished. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents for any information needed to determine these benefits payable for related services. I understand that Medicare may pay only The Center for Excellence in Dermatology for reimbursement of charges incurred at this office.

SIGNATURE: _____DATE: _____

PRINT PATIENT’S NAME:_____

RELATIONSHIP TO PATIENT (IF SIGNED ON BEHALF OF PATIENT): _____