COSMETIC REGISTRATION FORM

TODAY'S DATE ____________________

PATIENT INFORMATION

Patient's Last Name:	First:	M.I.	Marital Status (Circle One): Minor / Single / Married / Separated / Divorced / Partnered / For: yrs

Email Address (Please provide only if it's OK to email you appointment reminders):	Birthdate:	Age:	Sex: ☐ Male ☐ Female

Address:	Home phone number: ( )	Cell phone number: ( ) ☐ OK to text

City:	State:	ZIP Code:	Social Security Number:

Occupation:	Employer / School:	Employer / School Phone Number:

Employer's Address:	City:	State:	ZIP Code:

Selected our office the first time because / Referred to office by (Check all that apply):

☐ Another Medical Office or Provider ☐ Insurance Plan ☐ Website ☐ Yellow Pages ☐ Newspaper

☐ Radio Station: ☐ TV Ad ☐ Live or work nearby ☐ Saw your building or sign

☐ Columbia Basin Racquet Club Ad ☐ Postcard ☐ Another Patient/Work of Mouth ☐ Chamber of Commerce

☐ Other:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address):	Relationship to patient:	Cell/Home phone number: ( )	Work phone number: ( )

PARENTS OF MINOR

MOTHER			FATHER		
Last Name:	First Name:	Middle Initial:	Last Name:	First Name:	Middle Initial:

WHAT ARE YOUR CONCERNS?

Please check any cosmetic concerns you'd like to address:

☐ Cellulite ☐ Fat Bulges ☐ Wrinkles ☐ Brown Spots, Freckles, Uneven Skin Tone ☐ Redness/Rosacea ☐ Acne

☐ Scars ☐ Dry Skin ☐ Broken Capillaries ☐ Unwanted Hair ☐ Skin Care Regimen ☐ Makeup

☐ Other:

OFFICE POLICIES

MINORS:

Patients under the age of eighteen (18) are required to have a legal guardian accompany them to **ALL** office visits. Each patient has an individual account at this office. In the case of divorce or separation, the party/parties responsible for the account prior to the separation will remain responsible for the account. After a divorce or separation, the parent authorizing treatment for a minor will be the responsible party for all charges incurred during that office visit. If the divorce decree requires the other parent to pay part/all of the costs, it is the authorizing parent's responsibility to collect monies from that parent.

INSURANCE/BILLING:

Co-pays, deductibles, co-insurance and previous balances are due at the time of your office visit. Private pay patients are expected to pay in full at the time of all office visits. If you have any questions regarding your bill, please ask our receptionists or billing department about our payment plans or financial assistance.

Balances not paid in full within thirty (30) days will be considered delinquent and we reserve the right to transfer the account to our in-house collection department or a third-party collection agency (this may affect your credit score). If your account is turned over to collections, you will need to contact Evergreen Financial Services at (509) 943-2224 to make payment arrangements before you are seen at our office again.

Our office will courtesy bill most insurance companies even if we are not a contracted provider. Insurances that will **not** be courtesy billed include: Any state insurance, DSHS (Washington State Department of Social & Health Services), Community Health Plan of Washington, Care of Oregon or Columbia Community Care.

If you are currently in a "home health episode" and have any lab work done at our office, you may be personally responsible for charges. This office processes all biopsy specimens in-house through a CLIA-certified histology lab. The slides are read and signed by Dr. Robert Hopp, who is a board certified dermatologist with over twenty-eight (28) years of dermatopathology experience. Occasionally, these specimens are sent to a third-party for a second opinion (usually the University of Washington). There is a separate charge generated for this review that is billed by the University of Washington.

***INITIALS:*____________**

CENTER FOR EXCELLENCE IN DERMATOLOGY PLLC | **(509) 735-1100** **Phone**

KENNEWICK	**HERMISTON**	(855) 525-4677 Toll-free
8901 W. Gage Blvd	1050 W. Elm St #220	(509) 735-1180 Fax
Kennewick, WA 99336	**Hermiston, OR 97838**	**www.drhopp.net**

OFFICE POLICIES (PG. 2)

POSSIBLE FEES:

This office reserves the right to add the following charges:

- Returned checks will be charged a $29.00 fee
- Stop payment requests for misplaced refund checks will be subject to a $35.00 fee (will be deducted from the total balance if a new refund check has to be issued).
- Failure to give 24 hours cancellation notice for your appointment will result in a $40.00 fee (Please note: If you are ten (10) or more minutes late to your appointment, this is considered a missed appointment and you may be charged a $40.00 fee. You may be asked to reschedule.)
- Co-pays not paid at the time of service will result in a $15.00 fee (in addition to your co-pay)
- Some cosmetic appointments require a $100.00 deposit. This deposit is non-refundable if you fail to give 24 hours notice to cancel your appointment or if you miss your appointment.

POTENTIAL COMPLICATIONS:

There are potential complications with any medical procedure. Common office procedures include: liquid nitrogen, triamcinolone injections, cantharone application, skin biopsy, skin excision and light therapy. Potential complications include:

- Bleeding
- Infection
- Scarring
- Allergic reaction
- Skin discoloration
- Pain

Please read this agreement in its entirety and notify our staff if you have any questions before signing. You may ask for a copy of these policies from the receptionist. We reserve the right to change our policies at any time.

I hereby give my express, written consent to Center for Excellence in Dermatology PLLC and any of its agents, successors or assignees acting on its behalf to communicate with me regarding my account(s) through various means of communication, including, but not limited to: 1) any cellular telephone number; 2) any landline telephone number; 3) any text or other similar electronic number that I provide. This express consent is given in order to permit Center for Excellence in Dermatology PLLC to more easily communicate with me regarding any issue, including for the purposes of billing, insurance and collection of any outstanding balances.

PRINT PATIENT NAME: ______________________________ DATE: _________________

SIGNATURE (if patient is a minor, parent or guardian's signature): ___________________________

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Notice of Privacy Practices

This notice describes how information about you as a patient of this practice may be used and disclosed and how to access your health information. This is required by the Privacy Regulation created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

The following circumstances may require us to use or disclose your health information:

1. **To provide treatment**: We will use your health information to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate your care between medical providers, technicians, nurses, business office staff, pathology laboratories, pharmacies or other health care personnel providing your treatment. It may be necessary to release your test results to a health care provider even when the provider requesting the results did not originally order the tests.
2. **To obtain payment:** We may include your health information with an invoice used to collect payment for treatment you received in our office. We may include your health information with insurance forms filed for you by mail or sent electronically. We will make every attempt to work only with companies with similar commitment to the security of your health information.
3. **To conduct health care operations:** Your health information may be used during performance evaluations of our staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities.
4. **Communications:** Because we believe regular follow up is very important to your health, we may remind you of a scheduled appointment or that it is time for you to contact us to make an appointment. These communications may include postcards, letters and telephone reminders. We may share your health information with those you tell us will be helping you with your home treatment, medications or payment. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home rather that at work. We will try to accommodate reasonable requests
5. **Required by law:** We may disclose your health information to public health authorities and health oversight agencies that are authorized by law to collect information when required to do so by a law enforcement official, lawsuits and similar proceedings in response to a court or administrative order when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public for Workers Compensation and similar programs.

Our patient medical records are kept confidential, secure, and out of reach by unauthorized persons. All reports, consultation and correspondence are reviewed by the physician prior to being filed in the medical records. A written release signed and dated by patient/guardian must be obtained prior to the release of medical record information.

You are entitled to receive a copy of this Notice of Privacy Practices.

I, ____, have had full opportunity to read and consider the contents your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, health care operations and laboratory testing.

Signature: ____ Date__________________________

8901 W. Gage Blvd
Kennewick, WA 99336
(509)735-1100

1050 W. Elm Ave, Suite 220
Hermiston, OR 97838
(541) 289-4601

www.drhopp.net
M-Th 8am- 5pm

Authorization to Disclose Protected Health Information (PHI)

____ ____
Patient Name Date of Birth

____
Phone Number

I request and authorize the Center for Excellence in Dermatology to disclose the protected health information (PHI) of the above named patient to the following individual(s):

Name:	Relationship:	Phone Number:
____	☐ Spouse ☐ Other:_________________	________________________
Name:	Relationship:	Phone Number:
____	☐ Spouse ☐ Other:_________________	________________________
Name:	Relationship:	Phone Number:
____	☐ Spouse ☐ Other:_________________	________________________

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 the Privacy Officer/Compliance department. 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 my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 3 years from the date signed below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for anun-authorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Policy Officer/Compliance Officer.

____ ____
Signature of Patient or legal representative Date

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