Today's date:

COSMETIC REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Patient's last name: First: M. I.:	Marital status (circle one): Minor / Single / Mar / Sep / Div / Wid / Partnered / for: yrs

Email address (please provide only if it's OK to email you appointment reminders):	Birthdate: / /	Age:	Sex: ❑ M ❑ F

Address:	Home phone no.: ( )	Cell phone no.: ( ) ❑ OK to text

City:	State:	ZIP Code:	Social Security no.:

Occupation:	Employer/School:	Employer/School phone no.: ( )

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

You first found out about our office from (check all that apply): ❑ Referred by another medical office or provider ❑ Insurance Plan
❑ Radio ❑ Website/Online ❑ Yellow Pages ❑ Saw our building or sign ❑ Postcard ❑ Newsletter ❑ Chamber of Commerce
❑ Another patient/word of mouth ❑ Other:

How did you get our phone number? ❑ Phone book ❑ Internet ❑ 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.: ( )

PARENTS OF MINOR

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

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:

BRILLIANT DISTINCTIONS

Are you enrolled in the Brilliant Distinctions Program? ❑ Yes ❑ No	If yes, what email address did you use:

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 charge for office visit charges and 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 UnitedHealthcare, Aetna, Blue Cross, Premera, Lifewise, Asuris NW Health, First Choice Health, Uniform Medical, Coventry/First Health 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.
- $40 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. 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.

Effective immediately our office will be charging $25 to complete any third party forms 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 ____________

I am aware of the following potential complications as outlined for any procedure performed here at The Center for Excellence in Dermatology:

- Bleeding
- Infection
- Scar
- Nerve damage
- Postoperative problems
- Pain

PLEASE INITIAL ____________

In the case of divorce or separation, the party/parties responsible for the account prior to divorce or separation remain responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

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**:_________________

(If patient is a minor, parent or guardian signature is required.)

PRINT PATIENT NAME: ____

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

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 ____________________________

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:
☐ Spouse
☐ Other:________________
Phone Number: ____________________________

Name: _______________________________________
Relationship:
☐ Spouse
☐ Other:________________
Phone Number: ____________________________

Name: _______________________________________
Relationship:
☐ Spouse
☐ Other:________________
Phone Number: ____________________________

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 an unauthorized 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

DCN.7.14.2010