Central Oregon Dermatology-Patient Registration

The Sections below <u>MUST</u> be completed for all patients:

New Patient _____ **Existing Patient _____** **Name Change _____**

Patient Name: _____
Last First Middle Initial

Date of Birth: _____/_____/_____ **Gender:** Male _____Female _____ **SSN:** _____/_____/_____

Mailing Address: _____
City State Zip Code

Home Phone :(____) _____ **Cell Phone** :(____) _____ Work Phone :(____) _____

Email: _____ Decline to provide email: _____

Occupation: _____ Place of Employment: _____

Marital Status: Single ____ Married ____Domestic Partner ____ Divorced ____Widowed ____ Separated ____

DO WE HAVE PERMISSION TO: ***Please Initial <u>Yes</u> or <u>NO</u>***

- **LEAVE A <u>MESSAGE ON YOUR CELL PHONE</u>?** YES_____ NO_____
- **LEAVE A <u>MESSAGE AT HOME</u>?** YES_____ NO_____
- **LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT?** YES_____ NO_____
- **SEND AN <u>EMAIL for visit confirmation</u>?** YES_____ NO_____
- **<u>DISCUSS</u> YOUR MEDICAL CONDITION <u>WITH ANOTHER PERSON</u>?** YES_____ (***List Name (s) below***) NO_____
  *If YES, With **<u>WHOM</u> can we speak?*** _____
  Relation to patient: _____

Responsible Party **<u>if Different</u>** from Patient: _____
Last First Middle Initial

Address: _____
City State Zip Code

Home Phone: (_____) _____ Cell Phone: (_____) _____

Name of Employer/Retired: _____

IN CASE OF EMERGENCY PLEASE CONTACT:

Name: _____**Relationship to Patient**: _____

Address: _____**Phone Number** (____) _____
City State Zip Code

Assignment of Benefits/Release:

*I authorize the release of Medical information to my primary care or Referring Physician. I also request that payment of authorized insurance benefits including Medicare (**if applicable**) be made on my behalf to **Central Oregon Dermatology, PC** for the services furnished to me. I further understand my signature authorizes the release of medical information necessary to pay my claim. If other Health insurance is indicated on the registration from, or elsewhere, on other approved claim forms or electronically submitted claims, my signature below authorizes the release of that medical information to the insurer or agency shown. In MEDICARE ASSIGNED Claims, Central Oregon Dermatology, PC agrees to accept the charge determination of the Medicare Carrier as the full charge and I understand that I will be billed only for the deductible, co-insurance and all other **NON-COVERED** services based on the determination of the Medicare Carrier.*

X_____ _____ _____

Signature of Patient or **Responsible Party** **Relationship** **Date**

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How did you hear about us?

Internet____ Doctor Referral____ Radio____ Newspaper____ Friend____ Phone Book____ Other_____

Insurance Information:

Primary Insurance: _____ Name of Insured: _____
Birthday for Primary Card Holder: _____ Relationship to insured: _____

Secondary Insurance: _____ Name of Insured: _____
Birthday for Primary Card Holder: _____ Relationship to insured: _____

_____ **Initial** My Insurance coverage is between me and my insurance carriers. I realize that **if I have not met my deductible, charges incurred today may be applied to my deductible, and I will be responsible for those charges**. I further understand it is **my responsibility to know what my individual insurance benefits are.**

_____ **Initial** I understand that if I do have insurance, and I **HAVE NOT presented the insurance card**, I will be **considered a PRIVATE PAY** patient and I will **be responsible for any charges**. Payment of those charges are due at the time of service.

Federal agencies require us to collect the following information regarding race and culture:

Race: American Indian ___Asian ___Black/African American ___Native Hawaiian/Pacific Islander___ White/Caucasian ___ Hispanic ___Unknown/other ___ **PATIENT REFUSED**____

Culture: Latino/Hispanic ___ Not Latino/Hispanic ___ Unknown/Other ___ **PATIENT REFUSED** ____

CENTRAL OREGON DERMATOLOGY FINANCIAL INFORMATION

Central Oregon Dermatology is contracted with several insurance groups and will be happy to bill your Insurance. **You may need to contact your insurance carrier to find out if we are contracted with your individual plan**. If Central Oregon Dermatology has a contract with your insurance carrier, we are required by that contact to bill for any covered non-cosmetic services. Please be aware your insurance coverage is a contract between you and your insurance carrier, so if you **have any questions regarding your specific insurance coverage you will need to contact your carrier**. The customer service telephone number can be found on the back of your insurance card. **Your co-pay and any deductible not met are expected at the time of service**. **Any prices quoted to you are ESTIMATES**. The completed billing may differ from your estimate as we review all documentation for completion before we submit a final bill to your insurance carrier. Any balance due will be billed to you at that time and **payment is expected within 30 days** unless other arrangements are made with the billing department. _____**Please Initial**

Any treatment that you have done is considered a surgical procedure *and your insurance carrier may process your claim according to your major medical benefit. (**If you have questions regarding your major medical benefits please contact your insurance carrier**). This means that charges may be applied to your deductible, your carrier may pay only a percentage of the total charges or you may be billed for surgical co-insurance. We have no way of knowing your specific insurance coverage, so we cannot provide individual reimbursement information.* ***You will need to contact your carrier for your specific coverage information****.*

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If we are <u>not billing insurance</u>, payment is <u>due at the time of service</u>. The cost of any service is not complete until the finished documentation of that visit is reviewed for accuracy and completion and <u>you may be sent a statement after the visit with additional charges</u>.

Dr. Hall and Physician Assistant will determine if your procedures are medically necessary or considered cosmetic. ***<u>Cosmetic procedures are to be paid in FULL at the time of service</u>*** *and* ***<u>WILL NOT be billed</u> to your insurance carrier****.*

Some methods of Treatment:
The treatment of skin conditions depends on the type and location of the growth and the symptoms you are having. Dr. Hall and Physician Assistant will discuss the treatment options that are the best for you. Some forms of treatment are:
Cryosurgery – *Scraping of the skin with a sharp surgical instrument to remove tissue.*
Laser surgery – *The Use of an intense beam of light to burn and destroy tissue.*
Shaving or Tangential Excision – *The horizontal removal of a lesion.*
Surgical Excision – *The site is injected with a local anesthetic followed by cutting into the skin with a surgical instrument, removing the growth and closing the wound.*

****Some treatments like Cryosurgery and Laser surgery may require <u>several visits</u> to treat and <u>each visit is a separate charge and will be billed separately</u>. *This is especially true for treatment of warts*. ****

<u>Central Oregon Dermatology reserves the right to charge a $25.00 NSF (non sufficient funds) fee on any check returned for non-payment</u>.
<u>Central Oregon Dermatology reserves the right to charge for any office visit not cancelled within 24 hours</u>.

When Dr. Hall or Physicians Assistant biopsies or removes a lesion there will be a billing charge for reading and processing the pathology. **<u>This charge will be in addition to any procedure and office visit charges</u>**. **OCCASIONALLY, your pathology slide may be sent out to ANOTHER pathology laboratory for a SECOND OPINION**; in this case, you will receive a bill from that outside pathology office as well as our office. **_____Please Initial**

I certify that I have read and fully understand the Central Oregon Dermatology, PC, financial policy and I have had my questions answered.

X_____ _____

Patient Signature **Date**