3rd and Sherman
MEDICAL PLAZA

PATIENT PROFILE

How did you hear about us? _____

Name: _____ Date of Birth: _____

Pronouns: _____ Preferred Name: _____ Birth Sex: [] Male [] Female

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ Social Security #: _____-_____-_____

Email Address: _____ Occupation: _____

Preferred Language: (Circle) English Spanish Other: _____

May we leave medical information/outcomes, lab/biopsy results, or other pertinent information on voicemail? YES [] NO []

Would you like access to your patient portal to view visit notes, lab results, and contact your provider? [] Yes [] No

Please provide your email address for registration:_____

Responsible Party [] same as patient

Name: Phone:

DOB: Soc. Sec#:

Address:

City, State, Zip:

Emergency Contact

Name:

Phone:

Relation:

Primary Insurance

Carrier:

Subscriber ID: Group:

Subscriber:

Date of Birth:

Relationship to Patient:

Secondary Insurance

Carrier:

Subscriber ID: Group:

Subscriber:

Date of Birth:

Relationship to Patient:

***Release of Benefits and Information*:** I consent for medical treatment and I have verified the insurance listed on this slip and authorize my insurance benefits be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or the insurance company to release any information required for this claim to my Primary Physician/Referring Physician/or consultants, if needed. I understand that I am responsible if my insurance plan requires a referral and to assure that I have a referral for medical treatment, if needed. **Initial:** _____

I have read and understand the office insurance/payment policy stated above.

Signature: _____ **Date:** _____

Patient guardian Signature: _____ **Date:** _____

Clinic Policies
Spokane Dermatology Clinic & Werschler Aesthetics

PAYMENT POLICY: Payment for services provided are due at the time of service, we accept all major credit cards as well as cash/checks. All Laser and cosmetic procedures require a 25% deposit to hold the time slot.

CANCELLATION POLICY: As a courtesy to our clinic, staff and other patients, we require 24-hour notice to change or cancel an appointment, in order to avoid a $50.00 cancellation fee. If the appointment was for a surgical or cosmetic procedure, the cancellation fee is 25% of the scheduled appointment. In the event ample notice is not given, the deposit will be applied to the cancellation fee.

LABORATORY / PATHOLOGY FEE AND RESULTS: As a part of your treatment, it may be necessary to have blood tests or a biopsy performed. All blood and biopsy specimens are sent to an outside laboratory for testing and analysis. You will be receiving a separate bill from the lab performing the tests, and their fees are in addition to those charged by Spokane Dermatology Clinic or Werschler Aesthetics.

INSURANCE POLICY: Your insurance policy is a contract between you and your insurance company. Insurance companies offer an array of choices for consumers & employees, and therefore it is your responsibility to understand the insurance package you have chosen, not all services are covered the same, even within an insurance company. You are responsible for all charges not paid by your selected carrier. As a courtesy to our patients, we will submit your claim for you. At time of service, co-pays are required, and you are responsible for all co-insurance and deductible amounts.

It is your responsibility to know if the provider you are seeing is contracted with your insurance, whether your insurance requires an authorization, as well as your plans specific coverage and benefits. Initial: _____Date: _____

Pre-Authorizations and Referrals: Many insurance companies require prior written authorization or referrals for treatment and follow-up visits. It is your responsibility as a patient to obtain all necessary authorizations or referrals from your insurance company, or primary care provider, BEFORE receiving medical services. If you have not received prior approval, the authorization has been denied, or you do not have a referral on file, you are fully responsible for all charges that your insurance company does not agree to pay. In addition, preauthorization of a procedure is not a guarantee for payment. Any procedure may be considered not covered under the terms of your agreement with your insurance company. Your insurance carrier will make a determination of payment once the claim is received and reviewed.

Collection costs: Accounts with balances greater than sixty (60) days may have interest accessed that will not be written off. Unpaid accounts past ninety days (90) may be sent to a third-party collection agency. Patients will be responsible for all collection charges and fees. In the event of legal action, the patient will pay reasonable attorney fees and the venue shall be in Spokane County.

FOR PATIENTS WITHOUT INSURANCE: Payment in full is expected at the time of service unless other arrangements have been made with billing prior to your visit. We accept the following methods of payment: Cash, Debit cards, Visa, Mastercard, American Express, Discover and Care Credit.

PREMIER CLINICAL RESEARCH: If you have been referred by Premier Clinical Research any and all medical treatment you receive from Spokane Dermatology will be your responsibility. There is no affiliation with Premier Clinical Research.

RECEIPT OF PRIVACY: I have read the Notice of Privacy Practices that is presented to me in a separate document. Only if I request a written copy, will I receive a hard copy to take with me.

For the treatment of minors, we hold parents or legal guardians responsible for any uncovered charges at time of service.

I have read and understand the above CLINIC POLICIES and all questions regarding this document have been answered.

Signature: _____ **Date:** _____

If Patient Is a Minor, Guarantor/Consent To Treat:

Patient Name: _____ Date of Birth: _____

Guardian Name: _____ Relationship to Patient: _____ Phone: _____

Guardian Signature: _____ Date: _____

Dermatology Medical History

Patient Name: _____ DOB: _____ Date: _____

Please list the phone number you prefer to be called with test results: _____

Primary Care Physician: _____ Preferred Pharmacy: _____

Past Medical History

Do you now have, or have you ever been diagnosed with any of the following conditions: (Check if Yes)

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial fibrillation
- □ Bone Marrow Transplant
- □ Breast Cancer
- □ Colon Cancer
- □ COPD
- □ Coronary artery disease
- □ Depression
- □ Diabetes
- □ End stage kidney disease
- □ GERD/Acid reflux
- □ Hearing loss
- □ Hepatitis B
- □ Hepatitis C
- □ High blood pressure
- □ HIV/AIDS
- □ High cholesterol
- □ Hyperthyroid (high)
- □ Hypothyroid (low)
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate cancer
- □ Radiation treatment
- □ Seizures
- □ Stroke
- □ **None of these**

Other medical problems not listed above**:** _____

_____

List any major surgeries: _____

Skin Disease History

Have you ever had skin cancer? □ Yes □ No □ Not Sure

If yes, check what type(s): □ Basal Cell □ Squamous Cell □ Melanoma □ Not sure

Do you use sunscreen? □ Yes □ No

Have you ever used a tanning bed? □ Yes □ No

Do any of your blood relatives have melanoma? □ Yes □ No Relationship: _____

Medications

Current medications (include prescriptions, over the counter, vitamins, and herbals): _____

_____

List any medication allergies: _____

Social History

Do you drink alcohol? □ Yes □ No If yes, _____ drinks per day

Do you smoke? □ Yes □ Quit □ No If yes, _____ packs per day,

Alerts

Do you have problems with healing? □ Yes □ No or excessive scarring (keloid)? □ Yes □ No

Do you have any problems with your immune system? □ Yes □ No

Have you ever had a bad reaction to local anesthesia? □ Yes □ No

Are you allergic to adhesive? □ Yes □ No

Are you allergic to topical antibiotic ointments? □ Yes □ No

Do you have an artificial heart valve? □ Yes □ No

Are you on blood thinners? □ Yes □ No

Do you have a defibrillator? □ Yes □ No

Do you have a pacemaker? □ Yes □No

Have you been told to take antibiotics prior to dental or surgical procedures? □ Yes □ No

Do you get a rapid heartbeat with epinephrine? □ Yes □ No

Are you pregnant or planning pregnancy? □ Yes □ No If pregnant, due date: _____

Patient Signature: _____**Date:** _____

Patient guardian signature: _____**Date:**_____

3rd and Sherman
MEDICAL PLAZA

CONSENT TO TELEMEDICINE

Patient Name: _____ Date of Birth: _____

Purpose

The purpose of this form is to obtain your consent for a telemedicine visit with a provider at Spokane Dermatology Clinic or Werschler Aesthetics. "Telemedicine" means that health care services are delivered through the use of interactive audio and/or video technology, allowing real-time communication between the patient and provider for the purpose of diagnosis, consultation, or treatment.

During your visit

During your telemedicine visit, details of your medical history and personal health information may be discussed with other health professionals through the use of interactive video, audio and telecommunications technology. Additionally, a physical examination of you may take place and video, audio, and/or photo recordings may be taken. You understand there are potential risks with technology, including interruptions, unauthorized access and technical difficulties. You understand that that you or your healthcare provider may discontinue the telemedicine visit if it is felt that the connection is not adequate for the situation.

Medical Information and Records

All federal and state laws covering access to your medical records (and copies of medical records) also apply to telemedicine. No one other than your health care team can view your photos or information unless you agree to give them access.

Privacy

All information given at your telemedicine visit will be maintained by the doctors, other health care providers, and health care facilities involved in your care and will be protected by federal and state privacy laws. You understand that your healthcare information may be shared with Clinic staff for scheduling and billing purposes.

Others may be present during the visit other than your healthcare provider and consulting healthcare providers in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. You further understand that you will be informed of their presence in the visit and will have the right to request the following: (1) omit specific details of your medical history/physical examination that are personally sensitive to you; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the visit at any time.

Your Rights

You may opt out of the telemedicine visit at any time. This will not change your right to future care or health benefits. You may schedule in-person visits at the office. You understand that billing will occur and you are responsible for payment of services.

Waiver/Release:

By signing below, you understand and agree that you solely assume the risk of any errors or deficiencies in the electronic transmission of information during your telemedicine visit or in the electronic submission of your images to your provider and further understand that no warranty or guarantee has been made to you concerning any particular result related to your condition or diagnosis. To the extent permitted by law, you also agree to waive and release your provider and their institution or practice from any claims you may have about this advice or the telemedicine visit generally.

By signing this form, you certify that you have read and understand this form and all questions have been answered.

Patient Signature: _____ **Date:** _____

Patient Guardian signature: _____ **Date:** _____