TRI-CITY DERMATOLOGY

112 Columbia Point Drive, Suite 105
Richland, WA 99352
Tel: (509) 873-7140
Fax: (509) 818-1303

PATIENT REGISTRATION

(PLEASE PRINT)

Date: _____

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____ Birth Sex: M_____ F_____

Address: _____

City: _____ State: _____ Zip: _____ Date of Birth: _____ Age: _____

Home Phone #: _____ Cell Phone #: _____ Preferred Phone #: home/cell

OK to leave message? ☐Yes ☐No Email: _____

Race/Ethnicity: ☐American Indian ☐Asian ☐Black ☐Hispanic/Latino ☐Pacific Islander ☐White ☐Other _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Care Provider: _____ Preferred Pharmacy: _____

For Minor Patients Only: *All minor visits require a legal guardian.

Parent/Guardian #1: _____ Relationship: _____ Phone (cell/home): _____

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Disclosure of Protected Health Information (PHI) and Billing or Payment Information (optional):

I authorize disclosure of my PHI and/or billing and payment information to the following individual(s):

Name: _____ Relationship: _____ Phone (cell/home): _____ ☐PHI ☐Billing

Name: _____ Relationship: _____ Phone (cell/home): _____ ☐PHI ☐Billing

INSURANCE INFORMATION

Primary Insurance Policy:

Primary Policy Holder: _____ Relationship to Patient: _____ Date of Birth: _____

Insurance Company: _____ Policy #: _____ Group # (if applicable): _____

Secondary Insurance Policy:

Primary Policy Holder: _____ Relationship to Patient: _____ Date of Birth: _____

Insurance Company: _____ Policy #: _____ Group # (if applicable): _____

Patient Signature (or legal guardian): _____ **Date:** _____

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PATIENT HISTORY

(PLEASE PRINT)

Please complete the following sections, to the best of your knowledge, concerning your current or past medical history.

CURRENT OR PAST MEDICAL CONDITIONS

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer (type): _____
- ☐ COPD
- ☐ Coronary Arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ End stage renal disease
- ☐ Epilepsy
- ☐ GERD
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Radiation treatment
- ☐ Stroke
- ☐ Other Medical Conditions: _____

PRIOR SURGERIES

- ☐ Appendix
- ☐ Bladder
- ☐ Brain
- ☐ Breast
- ☐ Colon
- ☐ Gallbladder
- ☐ Heart
- ☐ Joint Replacement: _____
- ☐ Kidney
- ☐ Ovaries
- ☐ Pancreas
- ☐ Prostate
- ☐ Testicles
- ☐ Uterus
- ☐ Other Surgeries: _____

SKIN CONDITIONS

- ☐ Acne
- ☐ Actinic Keratosis (pre-cancer)
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itching Scalp
- ☐ Psoriasis
- ☐ Warts or other growths
- ☐ Skin Cancer: Basal Cell
- ☐ Skin Cancer: Melanoma
- ☐ Skin Cancer: Squamous Cell
- ☐ Other: _____

Patient Height: _____ **Patient Weight:** _____

Do you wear sunscreen? ☐ Daily ☐ Sometimes ☐ No SPF? _____

Have you used a tanning bed? ☐ No ☐ Past ☐ Current (how often?): _____

Do you have a family history of melanoma? ☐ No ☐ Yes, please indicate whom: _____

CURRENT MEDICATIONS (PRESCRIPTION AND OVER-THE-COUNTER)

_____

_____

_____

_____

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PATIENT HISTORY cont.

KNOWN DRUG ALLERGIES

_____

_____

ADDITIONAL QUESTIONS

Do you use tobacco products? ☐ No ☐ Past ☐ Current (please circle type): Cigarettes Tobacco

Do you drink alcohol? ☐ No ☐ Yes (how many per week?): _____

Female patients only: are you pregnant or planning to become pregnant? ☐ No ☐ Yes

PATIENTS 65 AND OLDER

Have you received a pneumonia vaccination? ☐ No ☐ Yes, Date: _____

Do you have an advance directive or living will? ☐ No ☐ Yes: _____

Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No

PLEASE IDENTIFY A FAMILY HISTORY OF ANY OF THE FOLLOWING

☐ Skin Cancer_____	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Other Cancer_____	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Eczema	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Heart Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Lupus/Auto Immune Disease	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Psoriasis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
☐ Sarcoidosis	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son

PLEASE CHECK ALL THAT APPLY

☐ Allergy to adhesive
☐ Allergy to lidocaine
☐ Allergy to topical antibiotics
☐ Artificial heart valve
☐ Artificial joints within past two years
☐ Blood Thinners
☐ Defibrillator
☐ Hay fever
☐ Headaches
☐ Immunosuppressants
☐ Joint aches
☐ MRSA
☐ Muscle weakness
☐ Night sweats
☐ Pacemaker
☐ Pregnant or planning pregnancy
☐ Premedication prior to procedures
☐ Problems with bleeding
☐ Problems with healing
☐ Problems with scarring/keloids
☐ Rapid heartbeat with epinephrine
☐ Unintentional weight loss
☐ Other: _____

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OFFICE AND FINANCIAL POLICIES

OFFICE POLICIES

APPOINTMENT POLICY

Tri-City Dermatology understands that circumstances change. Please be respectful of our other patients and staff by adhering to your scheduled appointment. Appointments for patients arriving more than 15 minutes late are subject to cancellation. Please call if you will be late so we can try to accommodate you and our other patients. We request a minimum of 24-hour notice for cancelation of an appointment. In the event this is not possible, please call our office, as soon as possible, so your scheduled time may be offered to another patient. Patients who repeatedly disregard these requests are subject to termination with the practice at the discretion of the provider.

MINOR PATIENT POLICY

Any patient under 18 years of age is required to have a legal guardian accompany them to all appointments.

FINANCIAL POLICY

Tri-City Dermatology requires payment of co-pays and co-insurance at the time of service. Self-pay patients are expected to pay the agreed upon balance at the time of service. Balances from previous services must be paid before additional services will be rendered. Please contact us if you are unable to pay your balance to discuss payment plans.
I understand that I am financially responsible for, and hereby agree to pay, all deductibles, co-pays, and co-insurance that are not covered by my insurance policy(s).

INSURANCE POLICIES

I hereby direct and consent to Tri-City Dermatology (the "Practice") and/or my physician(s) submitting claim(s) for payment to my insurance carrier for services rendered to me. I understand that the Practice and/or my physician(s) is not obligated to do so unless under contract with the insurer or bound by State or Federal regulations to process such claim.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign benefits to be paid on my behalf to the Practice and/or the physician(s) who renders services to me. I guarantee prompt payment of all allowable charges (as determined by the Practice's and physician(s)'s contract with my insurance carrier) incurred by the Practice for services rendered after insurance payments are applied or such charges are not paid within a reasonable period of time by my insurance carrier or other third party payor. I agree to make payments on any remaining balance due in accordance with the Practice's policy for payment of such outstanding balance(s).

RELEASE OF RECORDS

I authorize the Practice and/or my physician(s) to release all or part of my medical record where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services.

CERTIFICATION OF PATIENT INFORMATION

I have reviewed my patient demographic and insurance information on this date and verify that all information reported to the Practice is correct and complete for purposes of permitting the Practice and/or my physician(s) to submit claims for reimbursement. I accept full financial responsibility for non-disclosure of any and all insurance information.

BILLING COMMUNICATION AUTHORIZATION

I authorize the Practice and/or my physician(s) to communicate information regarding my billing account and the payment for services rendered to me to the individuals as stated on my Patient Registration.

The above stated policies are available for review at any time on our website or upon request from the front desk.
I have read and agree to all terms specified in the above Office and Financial Policies.

_____ _____

Patient Name Parent/Guardian Name & Relationship (if other than patient)

_____ _____

Signature of Patient or Parent/Guardian Date

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ACKNOWLEDGMENT OF PRIVACY PRACTICES

Tri-City Dermatology, PLLC (the "Practice") is committed to using your health information responsibly. We have generated a *NOTICE OF PRIVACY PRACTICES* for your review detailing how your health information may be used and/or disclosed and how you can get access to it. A summary of our *NOTICE OF PRIVACY PRACTICES* is posted in our office and available on our website. The complete *NOTICE OF PRIVACY PRACTICES* is available upon request or on our website.

UNDERSTANDING YOUR PHI AND HOW WE MAY USE AND/OR DISCLOSE YOUR PHI

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") was established to maintain the security and confidentiality of Personal Health Information (PHI) obtained or created by us in any form. PHI is any information that relates to your past, present, or future physical or mental health, including treatment and payment. This record may contain information about your personal demographics, medical exam, diagnoses, test results, treatment, or other pertinent data. Your PHI may be disclosed to other health care professionals involved in your medical care, your insurance company, operations supporting the management of the practice, and for other relevant and necessary uses as described in our ***Notice of Privacy Practices***. Acknowledgment

If you wish for persons other than those released under normal operations as indicated in the ***NOTICE OF PRIVACY PRACTICES*** to receive confidential PHI that is protected by law, you must release them in writing. Please indicate on your patient registration form your spouse or other person(s) whom you wish to receive your PHI. You may choose not release information to anyone. You may also specify restrictions of what information is released to your listed individuals. Parents or guardians of minor children do not need to be released.

YOUR RIGHTS REGARDING YOUR PHI

Our ***Notice of Privacy Practices*** provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this acknowledgment. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. If you believe that your privacy rights have been violated, please contact the Practice's HIPAA Compliance Officer. You may also file a complaint with the U.S. Department of Health and Human Services - Office for Civil Rights. There will be no retaliation for filing a complaint with either the Practice's HIPAA Compliance Officer or with the Office for Civil Rights. By signing this form, I acknowledge that Tri-City Dermatology has made available for my review the Practice's Notice of Privacy Practices.

The above stated Notice of Privacy Practices is available for review on our website or upon request from the front desk.

I acknowledge the Notice of Privacy Practices has been made available to me. I have reviewed and agree to all terms described within the Notice of Privacy Practices.

_____ _____

Patient Name Parent/Guardian Name & Relationship (if other than patient)

_____ _____

Signature of Patient or Parent/Guardian Date