PATIENT INFORMATION

NAME (First, M.I., Last):	SEX:	BIRTHDATE:	AGE:	SSN:

MAILING ADDRESS:	CITY:	STATE:	ZIP:

PRIMARY PHONE:	SECONDARY PHONE:	EMAIL ADDRESS:
		BY PROVIDING MY EMAIL ADDRESS I CONSENT TO BE CONTACTED REGARDING CLINICAL TRIALS AND PRACTICE MESSAGES

MARITAL STATUS:	PRIMARY CARE PHYSICIAN (FIRST, LAST):	EMPLOYER'S NAME/ PHONE #:
☐ S ☐ M ☐ W		

EMERGENCY CONTACT:

_____/_____ PHONE: (_____) _____

Name (First, Last) Relationship to patient

PLEASE CHECK THE BOXES THAT APPLY

initial _____I prefer not to answer the questions below

☐ Black or African American
☐ Caucasian (white)
☐ Asian
☐ American Indian or Alaskan Native
☐ Other _____
☐ Latino
☐ Russian
☐ Hawaiian Native
☐ ASL

PREFERRED LANGUAGE:

☐ English
☐ Spanish
☐ Russian
☐ Other _____

GUARANTOR INFO: (IF THE PATIENT IS A MINOR)

RESPONSIBLE PARTY'S NAME (First, M.I. Last):	BIRTHDATE:	SSN:

MAILING ADDRESS:	CITY:	STATE:	ZIP:

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:_____ POLICY HOLDER'S NAME: _____

RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____/_____/_____

SECONDARY INSURANCE NAME: _____ POLICY HOLDER'S NAME:_____

RELATIONSHIP TO PATIENT: _____ DATE OF BIRTH: _____/_____/_____

FOR OFFICE USE ONLY: _____ **INITIAL**

DERMATOLOGY - REASON FOR VISIT

Patient Name: **Date of Birth:**

If you're here for a routine skin exam only, *please skip to medical checklist.*

Severity of problem: ☐ Mild ☐ Moderate ☐ Severe

Type of Problem: ☐ Rash ☐ Lesion ☐ Spot ☐ Mole ☐ Wart
☐ Acne ☐ Cyst ☐ Ulcer ☐ Scar ☐ Blister
☐ Skin Tag ☐ Discoloration ☐ Other _____

Symptom(s) associated with problem: ☐ Painful ☐ Itchy ☐ Burning
☐ Stinging ☐ Bleeding ☐ Unsightly ☐ Spreading
☐ Other _____

Area(s) of body affected: ☐ Scalp ☐ Face ☐ Neck ☐ Chest
☐ Back ☐ Abdomen ☐ Nails
☐ R. Upper Extremities ☐ R. Lower Extremities
☐ L. Upper Extremities ☐ L. Lower Extremities

How long has it been present? _____

Treatment used for condition: ☐ YES ☐ NO

MEDICAL CHECKLIST

Do you have any allergies? **Include allergies to medications** ☐ YES ☐ NO

Do you have a *family history* of: ☐ Skin Cancer ☐ Melanoma

Are you currently taking any medications? ☐ YES ☐ NO

If **yes**, please list **name** and **dosage**: _____
_____
_____

Pharmacy of choice: List name and location: _____

Patient History:

For patients who are 65 and older: Have you ever received a pneumococcal vaccine? ☐ YES ☐ NO

Have you had any form of skin cancer? ☐ YES ☐ NO

Do you have bleeding tendencies? ☐ YES ☐ NO

Do you have a pacemaker/defibrillator? ☐ YES ☐ NO

Frequent sun exposure? ☐ YES ☐ NO

Are you currently suffering from seasonal allergies? ☐ YES ☐ NO

Do you consume alcohol? ☐ YES ☐ NO

Do you smoke? ☐ YES ☐ NO

SILVER FALLS DERMATOLOGY & ALLERGY FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. Please understand that payment of your bill is considered part of your care plan. We ask that you read and sign this Financial Policy prior to any treatment. You may be asked to sign this page again as it is updated. Please let us know if you have any questions.

- We will verify your insurance coverage at every visit. It is the patient's responsibility to supply all current insurance cards.
- We may ask for a copy of your driver's license or picture identification issued from DMV for identity verification.
- If you do not have insurance, or cannot provide proof of insurance at the time of service, a pre-payment of $175.00 will be required before services are provided except in the case of emergency.
- A $15 fee may be assessed for any co-payment not made at the time of service.
- We accept cash, checks, Visa, and MasterCard. A $25 fee will be assessed for returned checks.
- Unless otherwise requested, Silver Falls Dermatology will not issue refund checks if the amount is under $40; instead, those amounts will be applied to future services.
- If your account is sent to collections for non-payment you will be assessed a fee of 30% of your total balance.
- No-show appointments/cancellations less than 24 hours in advance may be charged a $50 fee.
- If your insurance requires a referral from your Primary Care Provider (PCP) to see another physician, it is your responsibility to obtain a referral/authorization prior to your appointment. Any unauthorized charges will be your responsibility.
- The adult accompanying a minor to a visit and the legal parents/guardians are responsible for full payment. We will not be involved in negotiating between parents in custody disputes.
- When labs, x-rays, or other tests are ordered by Silver Falls Dermatology, PC, you are responsible to check with your insurance company as to where you are authorized to have these studies done. We will not be responsible for any bill if you have a test done at the wrong location.
- If you are here for multiple procedures, the provider will determine whether or not to perform all these procedures during the same office visit or to schedule them at a future date. We cannot guarantee multiple procedures on the same day of service. Your insurance company may have one co-payment for the office visit and a second co-payment for the actual procedure. In addition, if we provide a non-covered service during the same visit as a medical dermatology encounter, then you will have two separate charges.
- Initial_____ All procedures (such as biopsies, liquid nitrogen/freezing, benign removals, skin tags, etc.) are billed separately and are not included in the office visit.

As a courtesy to our patients, we will submit claims to your insurance carrier for you. For those plans that we participate in, we will also submit secondary and/or tertiary claims. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered by your particular plan. Patients are responsible for knowing the details/rules of their health plan(s), as we cannot change our coding in an attempt to obtain payment.

I hereby authorize Silver Falls Dermatology, PC to release any medical information required in the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to, co-payment, co-insurance, deductible, and non-covered services.

*****I have read, understood, and agree to the Financial Policy (above)*****

Name of Patient or Responsible Party (Please Print) Relationship to Patient

Signature of Patient or Responsible Party Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I acknowledge that I have been advised of SFD's Notice Of Privacy Policy (NOPP) by being offered to take a physical copy of the SFD Privacy Policy (on display at the lobby) OR view it online at http://www.silverfallsderm.net/Docs/nopp.pdf

Signature of Patient or Legal Guardian Date

MEDICARE AUTHORIZATIONS

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Silver Falls Dermatology, PC for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Patient or Responsible Party Date

PERMISSION FOR PATIENT HEALTH INFORMATION (PHI) COMMUNICATIONS

I permit Silver Falls Dermatology, their physicians, medical assistants, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care:

(List family members/friends and state the person's relationship to the patient below).

NAME	DATE OF BIRTH	PHONE NUMBER	RELATIONSHIP
1.			
2.			
3.			
4.			

This authorization is limited to the following time frame: ☐ One Year from Date Signed _____ Initial

☐ Does Not Expire _____ Initial

If, at any time, I do not want verbal discussion to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting Silver Falls Dermatology.

VOICEMAIL

☐ **I give permission** to Silver Falls Dermatology to leave financial information, lab results, test results and other medical information on my voicemail if I am not available at the time of their phone call.

☐ I do **not** give permission to Silver Falls Dermatology to leave financial information, lab results, test results and other medical information on my voicemail if I am not available at the time of their phone call.

Print Patient Name: _____ DOB: _____

Patient's signature: _____ Date: _____

INSTRUCTIONS

Bring this form to your appointment along with your New Patient paperwork. Or, print, sign and mail to:

Silver Falls Dermatology - Medical Records
1793 13th Street SE
Salem, Oregon 97302

Phone: 866-599-3376 (toll free)
Fax: 503-362-8435