Dermatology Professionals, LLC

Patient Information (please print)

Name: _____
Last First M.I.

Address:_____
Street Apt. # City State Zip

Telephone Home:_____ Cell:_____

DOB_____ Email Address:_____

Employer:_____ Telephone (Work):_____

Pharmacy Name: _____ Pharmacy Location: _____

Primary Care Provider Name: _____ Number: _____

Emergency Contact :_____Relationship:_____Number:_____

Care Facility Name:_____ Care Facility Contact:_____Number:_____

Caregiver Name:_____ Caregiver Phone: _____

Responsible Party (Person responsible for payment)
☐ **Same as above**
Name:_____Relationship: _____

Home Address:_____

Home Telephone:_____ Business Phone: _____

Primary Insurance
Insurance Name: _____ Co-Pay $:_____

Policy Holder/Subscriber Name: _____ Relationship: _____

Policy Holder DOB:_____ ID # _____Group or Plan# _____

Secondary Insurance (If applicable)
Insurance Name: _____ Co-Pay $:_____

Policy Holder/Subscriber Name (if different):_____ Relationship:_____

Policy Holder DOB:_____ ID # _____ Group or Plan# _____

Consent to Medical Care
In order to provide you with medical care, we need to have written consent from you.
Dr. Taylor will be happy to address any question or concerns you may have about your condition or treatment.

I give my permission to Claudia Taylor, M.D., and staff, to administer treatment and to perform such procedures as may be deemed necessary in the diagnosis and treatment of my condition.

_____
Signature of Patient (or guardian) Date

Dermatology Professionals, LLC

Financial Policy

Insured Patients: Dermatology Professionals is a contracted provider with many insurance companies. Patients are strongly urged to contact their insurance carrier directly with any questions regarding coverage, eligibility and benefits. It is the patient's responsibility to know their insurance benefits, however if there is a need for assistance in determining coverage of a proposed course of treatment our office is more than happy to help research a patient's insurance coverage and give an estimated out of pocket cost. Co-pays and deductibles are a contract between the patient and their insurance company and are due at the time of service or within 30 days of receipt of the statement. We understand that extenuating circumstances do arise and our office is more than willing to set up a payment plan.

Uninsured Patients: Patients without insurance will be given a quote prior to their appointment. Payment will be due at the time of service. In the event a patient's recommended course of treatment is different than the treatment quoted, patient will be advised and a new quote will be provided prior to rendering care. Please remember that any biopsies taken at the time of the appointment will be sent to an outside laboratory for preparation and evaluation. This service will incur additional charges. The preferred laboratory with which Dermatology Professionals contracts is CTA Lab; inquiries on diagnostic charges can be directed to this facility by calling (503) 906-7300.

Cosmetic Procedures / Non-Covered Services: Payment for cosmetic or non-covered services will be due at the time of service. Dermatology Professionals will not set payment arrangements for cosmetic or non-covered services.

Out of Network / Non-Contracted Insurance Carrier: In the event that a patient has an insurance with which we are not contracted the patient will be seen as an uninsured patient and will be quoted for services prior to the office visit and payment will be collected at the time of service.

Preferred Laboratory: Dermatology Professionals contracts with CTA Lab to process and evaluate patient tissue samples. If this particular lab is not contracted through a patient's insurance or is not a preferred facility it is up to the patient to indicate to the office that there is a need to send their samples to a facility which contracts with their insurance carrier.

Cancellation & No Show Policy: Please contact our office with at least 36 hours notice of cancellation. Cancellations of general appointments with less than 36 hours notice may be charged a $50 cancellation fee. Cancellations for surgical appointments with less than 36 hours notice may be charged a $100 cancellation fee. No-Shows may be charged $50 or $100 for general appointments or surgical appointments respectively.

Insurance Authorization

- ☐ **I am supplying Dr. Taylor's office with insurance information.** I authorize my insurance company to pay directly to Dr. Taylor all benefits due for my medical care, and hereby consider this an assignment of benefits. I authorize Dr. Taylor to provide all information my insurance company(s) requests concerning any treatment. I agree to pay for all services not covered or allowed by my insurance company (including deductibles and copays). Any money received in excess of charges will be refunded when my bill is paid in full.

- ☐ **I am not supplying Dr. Taylor's office with insurance information.** I understand that I am financially responsible for services performed. I understand and comply with the credit policies of the office of Dr. Taylor.

_____ Patient's Initials

Dermatology Professionals, LLC

Notice of Your Right to Decline Participation in Future Anonymous or Coded Genetic Research

The State of Oregon has laws to protect your genetic privacy. Laws that give you the right to decline to have your health information or biological samples used for research. A biological sample may include urine, blood, or other samples collected from your body. You can decide whether to allow your biological samples or health information to be made available for genetic research. This research can give us information on how to improve or prevent diabetes, cancer, and other diseases. Oregon law governs this research, so that a qualified team reviews all genetic research before it begins, making sure the benefits are greater than any risks to participants.

Your identity is protected in both types of research. In anonymous research, personal information that could be used to identify you, like your name or social security number, cannot be linked to your health information or biological sample. In coded research, personal information that could be used to identify you is kept separate from your health information to your health information or biological sample.

- If you want to allow your health information and biological sample to be available for anonymous or coded genetic research, check the allow box. If you make this choice, your health information or biological sample may be used for anonymous or coded genetic research without further notice to you.
- If you want to decline to have your health information and biological sample available for anonymous or coded genetic research, check the decline box.

Your decision is effective on the date your health care provider receives this form. Your decision will not affect the care you receive from your health care provider or your health insurance coverage.

Whatever you decide now can always be changed in the future. If you change your mind, the new decision will apply to health information or biological samples collected after your health care provider receives written notice of your decision.

If you have any questions or concerns, please contact:
Veronica Thompson, Clinic Practice Manager at 503-344-6643 extension: 105

☐ I allow my health information and biological samples to be available for anonymous or coded genetic research.
☐ I decline to have my health information and biological samples available for anonymous or coded genetic research.

_____ **Patient's Initials**

Dermatology Professionals, LLC

Notice of Patient Privacy Acknowledgment and Consent

We are required by law to protect the privacy of your medical information and to provide you with written notice describing: HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may use or disclose your medical information both created and received by this practice for purposes of providing or arranging for your health care. This may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information. This may also include information regarding payment for or reimbursement of the care that we provide to you, and any related administrative activities supporting your treatment.

We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise this notice from time to time. You have the right to receive a copy of our most current notice in effect. If you have not yet received a copy of out current NOTICE OF PRIVACY PRACTICES, please ask at the front desk and we will provide you with a copy.

If you have any questions about the NOTICE OF PRIVACY PRACTICES or your medical information, please contact our office at 503-344-6643.

_____ Patient's Initials

Authorization to Release Information Family and Friends

It is the office policy of Dermatology Professionals, LLC not to release confidential medical information regarding your treatment. If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretaker/babysitters, please indicate below.

1. _____ Relationship to Patient: _____

2. _____ Relationship to Patient: _____

_____ Initial to authorize the above named individual(s) to receive information regarding your treatment or care.

Authorization to Leave Messages

It maybe necessary that the staff at Dermatology Professionals leave you messages regarding scheduled appointments, as well as other information pertaining to your care (ie: pathology and lab results). At no time will a staff member at Dermatology Professionals discuss your medical condition without your consent. Please indicate below by checking the corresponding box of your preference.
You have a right to revoke this consent in writing.

- ☐ I allow Dermatology Professionals to leave voice messages reminding me of upcoming appointments at the following number:_____
- ☐ I allow Dermatology Professionals to leave detailed voice messages regarding personal information relating to my care (i.e.: pathology or lab results) at the following number: _____
- ☐ I decline to have Dermatology Professionals any voice messages

Patient Signature : _____ Date: _____

Dermatology Professionals, LLC

Name:_____

Primary Care Provider:_____

History and Intake Form

Past Medical History: ***(please circle all that apply)***

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: ***(please circle all that apply)***

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

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Skin Disease History: ***(please circle all that apply)***

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

Location of skin cancer, type of treatment and date:
_____
_____
Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Tanning salon use (past or present)? Yes No How often?_____

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications)
_____
_____
_____
Allergies to medications:
_____
_____

Social History: (Please circle all that apply)
Cigarette Smoking:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Alcohol usage:

- None
- Less than 1 drink per day
- 1-2 drinks per day
- 3 or more drinks per day

Occupation ***(former occupation if retired)***:_____

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Review of Systems: Are you currently experiencing any of the following?
(Please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring		
Immunosuppression		
Changing mole		
Rash		
Abdominal pain		
Anxiety		
Bloody stool		
Bloody urine		
Blurry vision		
Chest pain		
Cough		
Depression		
Fever or chills		
Headaches		
Hay fever		
Joint aches		
Muscle weakness		
Neck stiffness		
Seizures		
Shortness of breath		
Sore throat		
Thyroid problems		
Unintentional weight loss		
Wheezing		
Asthma		

Other Symptoms: _____

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Alerts:
(***Check any of the following that apply to you)***

Alert	Yes	No
Pacemaker		
Defibrillator		
Artificial joints within past two years		
Artificial heart valve		
Premedication prior to procedure		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
Pregnancy or planning a pregnancy		
Allergy to lidocaine		
Rapid heart beat with epinephrine		
Yeast infection with antibiotics		
GI upset with antibiotics		

Other Symptoms: _____