

Patient Name

Appointment Date/Time

Advanced Skin Center

<input type="checkbox"/> Paul D. Reicherter, M.D.	<input type="checkbox"/> Winthrop Head, PA-C
<input type="checkbox"/> Tony N. Nakhla, D.O.	<input type="checkbox"/> Sarah Vouch, PA-C
<input type="checkbox"/> Catherine Barry, D.O.	<input type="checkbox"/> Ashley Heuer, PA-C
<input type="checkbox"/> Jody Zurita, FNP-C	<input type="checkbox"/> Jacob Thompson, PA-C
<input type="checkbox"/> Jaclyn Loner, FNP-C	<input type="checkbox"/> Jaddon Rogers, PA-C
<input type="checkbox"/> Griffin Mansell, PA-C	

<input type="checkbox"/> Roseburg Main Office 1813 W. HARVARD, STE. 310 ROSEBURG, OR 97471 541-672-7546	<input type="checkbox"/> Grants Pass Clinic 1021 NE 6 th ST. GRANTS PASS, OR 97526 541-507-1881	<input type="checkbox"/> Coquille Clinic 940 EAST 5 th ST. COQUILLE, OR 97423 541-672-7546	<input type="checkbox"/> Reedsport Clinic 385 RANCH RD. REEDSPORT, OR 97467 541-672-7546
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To Our Valued Patient:

Thank you for scheduling an appointment with Advanced Skin Center. For your convenience, we are enclosing your new patient paperwork.

Please do the following:

- Complete and sign the forms. Bring the forms with you to your scheduled appointment.
- Bring all insurance cards and or proof of insurance.
- If you take medications, please bring list of those medications to your appointment.

To help us serve you better, please be on time for your scheduled appointment. If you should have any questions regarding your paperwork, please come a few minutes early to speak with our receptionist.

Please be mindful of people with allergies and keep the use of perfume, cologne, body spray, scented lotions and hair products to a minimum when visiting our offices. In addition, you may find it helpful to remove any makeup, especially concealer and or foundation, prior to your appointment.

Thank you for your cooperation. We look forward to seeing you!



ADVANCED SKIN CENTER
Dermatology & Skin Cancer Specialists

(ALL PATIENTS)

CONSENT FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION / HIPAA CONSENT

With this consent, Advanced Skin Center may call my home or other alternate numbers provided by me and leave a message on my answering machine or voicemail in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations (TPO). This includes appointment reminders and any calls pertaining to my clinical care.

With this consent, Advanced Skin Center may mail to my home or alternate addresses provided by me any items that assist the practice in carrying out treatment. This includes correspondence regarding appointments and patient statements.

I have the right to review the Notice of Privacy Practices which provides information about how the Advanced Skin Center may use and disclose my personal health information (PHI). I have the right to request that Advanced Skin Center restrict how it uses or discloses my PHI to carry out healthcare operations (TPO). I may revoke my consent in writing at any time.

Initial

PAYMENT POLICY

I acknowledge that co-payments, deductibles, and any non-covered charges are due at the time of service unless special arrangements have been made. Cosmetic services need to be paid in full at the time of service and any outstanding balances must be paid prior to receiving cosmetic services. For those patients who are without health insurance or those who elect to have services rendered which are not covered by their insurance, a 15% discount will be afforded for payment in full on the day of their appointment. Payment in the form of *cash, money order or credit / debit* card will be accepted. **If payment in full cannot be rendered at the time of service, a \$100 deposit for all office visits (an additional deposit for procedures) will be required.** In addition, a payment plan must be arranged for billing and payment of the remaining balance.

There will be an 18% finance charge added to my account after 60 days of nonpayment, as well as a \$25 charge for all checks returned for non-sufficient funds (NSF).

Initial

NO SHOW / LATE NOTICE FEE

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving proper care. Due to high patient demand and limited availability of appointments, there will be a **\$25 no-show fee**. As of March 1, 2012, 24-hour advanced notice is required to cancel appointments. Failure to do so will result in a \$25 administrative fee or **\$100 for any scheduled surgery**.

Cosmetic Procedures require a \$100 non-refundable deposit- to be applied to the total cost of the procedure. This deposit will be forfeited in the event that the appointment is cancelled or rescheduled without at least 24 hours notice, during business hours.

Initial

By signing below I acknowledge that I have read and agree to the above listed policies. I understand that if at any time I am not able to abide by this statement, I will make arrangements with the Advanced Skin Center billing department.

Signature

_____/_____/_____
PATIENT NAME

Date of Birth

Relationship (if other than patient) & Printed Name

Date

YOU HAVE A CHOICE ABOUT WHERE TO RECEIVE DIAGNOSTIC TESTING, HEALTH CARE TREATMENT, AND SERVICES

- ✓ You have a right to receive referred care with a provider of your choice, either local or non-local.
- ✓ Although we may make recommendations, we encourage you to talk to us about your options when a test or referral to another facility is needed.
- ✓ For additional information on medical services and facilities in the area, please contact Douglas County Health & Social Services at 1-800-234-0985.

Health & Social Services at 1-800-234-0985.

MEDICARE PATIENT REGISTRATION

Please answer the following questions by placing a check in the appropriate column:

- | Yes | No | |
|-----|-----|--|
| [] | [] | Do you have an insurance policy that replaces your Medicare? (i.e., Atrio, Regence MedAdvantage) |
| [] | [] | Are you or your spouse still working? |
| [] | [] | Are you being treated for this condition at the VA (Veteran’s Administration)? |
| [] | [] | Is this condition covered by the Federal Black Lung or End Stage Renal Disease Program? |
| [] | [] | Are you receiving Medicaid? |

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____	____/____/____
Signature as it appears on Medicare card	Date

If you have a supplemental policy and it is a supplemental policy to which your Medicare Carrier automatically “crosses over”, we are required to keep a separate signature on file:

I request authorized supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

_____	____/____/____
Signature as it appears on supplemental card	Date

Automatic Credit Card Billing Authorization Form

This is a free service from Advanced Skin Center. If you would like to enjoy the convenience of having your card information on file with us, or utilize our automatic billing simply complete the Credit Card Information section below and sign the form. All requested information is required. Upon approval, we will automatically bill your credit card for the amount indicated and your total charges will appear on your monthly credit card statement. You may cancel this automatic billing authorization at any time by contacting us.

Payment Information (Please check the appropriate boxes)

I authorize Advanced Skin Center to: automatically bill as specified keep this information of file

I acknowledge that my card will be billed \$_____ OR the balance Due after Insurance

I authorize the payments to be processed according to the following frequency: (select one option)

Weekly every Friday Bi-Weekly on 1st & 15th Monthly 1st OR 15th

Advanced Skin Center will:

Start billing on: _____ / _____ / _____ And End billing when: D.O.S. is paid in full _____ / _____ / _____
 Balance is paid in full.

Credit Card Information (To be completed by customer)

Advanced Skin Center accepts the following cards: **Visa, MasterCard, Discover, American Express**

Credit card type: _____ Sec. Code: _____ Credit card number: _____ Expires: _____ / _____

Cardholder's name: _____ Cardholder's Address & Zip code (required): _____

(as shown on credit card) (from credit card billing address)

Customer's signature: _____ Date: _____
Email Address: _____

Customer Information (To be completed by A.S.C.)

Customer name: _____ Customer account number: _____ Phone: _____ - _____ - _____

Other Patients accounts to be included: _____