Patient Name Appointment Date/Time

Advanced Skin Center

□ **Paul D. Reicherter, M.D.**	□ **Winthrop Head, PA-C**
□ **Tony N. Nakhla, D.O.**	□ **Sarah Vouch, PA-C**
□ **Catherine Barry, D.O.**	□ **Ashley Heuer, PA-C**
□ **Jody Zurita, FNP-C**	□**Jacob Thompson, PA-C**
□ **Jaclyn Loner, FNP-C**	□ **Griffin Mansell, PA-C**

□ **Roseburg Main Office** 1813 W. HARVARD, STE. 310 ROSEBURG, OR 97471 541-672-7546	□ **Grants Pass Clinic** 1021 NE 6th ST. GRANTS PASS, OR 97526 541-507-1881	□ **Coquille Clinic** 855 W. CENTRAL BLVD, STE. B COQUILLE, OR 97423 541-672-7546 **NEW ADDRESS AS OF 01/01/2021**	□ **Reedsport Clinic** 385 RANCH RD. REEDSPORT, OR 97467 541-672-7546

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

1813 W. Harvard Avenue, Suite 310 Roseburg, OR 97471

Today's Date _____/_____/_____

PATIENT INFORMATION [ ] New Patient [ ] Name Change [ ] Address Change [ ] Insurance Change [ ] Other

Name: _____ [ ] Jr. [ ] Sr.
Last First Middle

Name you preferred to be called: _____ Social Security #: _____

Date of Birth: ____/____/____ Age: _____ Sex: [ ] Male [ ] Female [ ] Identifying Sex Marital Status: _____

Mailing Address: _____
City State Zip

Home Phone: ( ) _____ Work Phone: ( ) _____

Cell Phone: ( ) _____ Alternate: ( ) _____

Email: _____

RESPONSIBLE PARTY (i.e. Parent or Guardian, if different from patient)

Name: _____ Date of Birth: _____/_____/_____
Last First Middle

Address: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ SS# _____

EMERGENCY CONTACT INFORMATION:

In case of emergency, who should be notified? _____
Relationship to patient: _____ Phone Number ( ) _____

Do you give our office permission to discuss your medical information with family members?
[ ] Yes [ ] No If yes, please provide their names and phone numbers below.

Name: _____ Relationship: _____
Daytime Phone Number: ( ) _____ Evening Phone Number: ( ) _____

May we leave personal medical information on your answering machine or cell phone? [ ] Yes [ ] No

How did you hear about our clinic?
____ Family/Friend ____ Insurance Company ____ Internet ____ Referring Doctor
____ Phone Book [ ] Dex [ ] Local Pages [ ] Phone Source [ ] Supermedia [ ] Yellowbook

Referred by**:** _____ Phone Number**:** ( ) _____

Primary Care Physician**:** _____ Phone Number**:** ( ) _____

Are you being seen due to an automobile accident? Yes [ ] No [ ]
Are you being seen due to an injury at work? Yes [ ] No [ ]

INSURANCE COVERAGE – PRIMARY

Insurance Company Name: _____

Name of Subscriber (Insured): _____ Social Security No.:_____ Date of Birth: _____/_____/_____

INSURANCE COVERAGE – SECONDARY

Insurance Company Name: _____

Name of Subscriber (Insured): _____ Social Security No.:_____ Date of Birth: _____/_____/_____

(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.

Pathology or laboratory results are highly recommended to be discussed in person with a provider at a follow up appointment. In certain cases, a phone call from provider may be made and insurance will be billed to discuss these results by phone.

A $25 charge for all checks returned for non-sufficient funds (NSF) will be added to your account.

_____
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

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