Patient Name

Appointment Date/Time

ADVANCED SKIN CENTER

Dermatology & Skin Cancer Specialists

☐ **Catherine Barry, D.O.**	☐ **Jody Zurita, FNP-C**
☐ **Winthrop Head, PA-C**	☐ **Samantha Magana, PA-C**
☐ **Sarah Vouch, PA-C**	☐ **Lauren Anderson, DNPFNP**
☐ **Ashley Heuer, PA-C**	☐ **Shannon Rasmussen, PA-C**
☐ **David Collins, PA-C**	☐ **Megan Smith, PA-C**
☐ **Amber Willis, 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	☐ **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!

Paul Reicherter, MD

Tony Nakhla, DO

ADVANCED SKIN CENTER

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

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

IF YOU ANSWERED YES TO EITHER OF THE ABOVE QUESTIONS, PLEASE SEE THE FRONT DESK.

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 your emergency contact?
[ ] Yes [ ] No

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

Referred by: _____ Phone Number: ( ) _____

Primary Care Physician: _____ Phone Number: ( ) _____

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: ____/____/____

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.

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 PATIENTS)

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.

_____ _____/_____/_____

Patient Signature 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.

_____ _____/_____/_____

Patient Signature Date

Yearly Intake and History Form

Name: _____ Date of birth: _____ Date of visit: _____

Street Address: _____ City / State: _____

Zip Code: _____ Phone Number: _____ Weight _____ Height _____

FOR EXISTING PATIENTS ONLY

If there have been no changes since your last visit please sign and date here.

SIGNATURE _____ **DATE** _____

Preferred Pharmacy: _____ City or Zip Code: _____

Please list who we have permission to share medical information with:

_____

Allergies

List all allergies and reactions if known:

_____

_____

Medical History/Medications

Select any of the following medical conditions and medications you take for the diagnosis you currently have:

CONDITION:	MEDICATION:	CONDITION:	MEDICATION:
◯ Anxiety	_____	◯ Hearing Loss	_____
◯ Arthritis	_____	◯ Hepatitis	_____
◯ Asthma	_____	◯ High Blood Pressure	_____
◯ Atrial Fibrillation	_____	◯ HIV / AIDS	_____
◯ Bone Marrow Transplant	_____	◯ High Cholesterol	_____
◯ Enlarged Prostate (BPH)	_____	◯ Hyperthyroidism	_____
◯ Breast Cancer	_____	◯ Hypothyroidism	_____
◯ Colon Cancer	_____	◯ Leukemia	_____
◯ COPD	_____	◯ Lung Cancer	_____
◯ Heart Bypass (CAD)	_____	◯ Lymphoma	_____
◯ Stent Placement (CAD)	_____	◯ Prostate Cancer	_____
◯ Depression	_____	◯ Radiation Treatment	_____
◯ Diabetes	_____	◯ Seizures	_____
◯ End Stage Renal Disease	_____	◯ Stroke	_____
◯ GERD	_____	◯ NONE	

Other medical history and medications:

_____

_____

_____

Required Insurance Questionnaire

YES	NO	
◯	◯	Would you like to have life saving measures performed in an emergency?
◯	◯	Do you have a surrogate decision maker for your medical decisions?

If yes; please list name of decision maker and contact number;
NAME: _____ CONTACT NUMBER: _____

◯ ◯ Have you had your pneumonia vaccination?
◯ ◯ Do you smoke cigarettes?
◯0 ◯1 ◯2+ MEN: How many times in the past year have you had 5 or more drinks in a day?
◯0 ◯1 ◯2+ WOMEN & ADULTS 65+: How many times in the past year have you had 4 or more drinks in a day?

Past Surgical History

Have you had any surgeries on the following organs?

◯ Joint Replacement What year? _____
◯ Heart Valve Replacement What year? _____
◯ Mastectomy (Right or Left)

◯ Pacemaker
◯ Heart stent placement
◯ Heart Bypass

Other pertinent surgeries:
_____

Skin Disease History

Have you had any of the following?

◯ Acne
◯ Actinic Keratoses
◯ Asthma
◯ **Basal Cell Skin Cancer**
◯ Blistering Sunburns
◯ Dry Skin
◯ Eczema
◯ Flaking or Itchy Scalp

◯ Have Fever / Allergies
◯ **Melanoma**
◯ Poison Ivy
◯ Precancerous Moles
◯ Psoriasis
◯ **Squamous Cell Skin Cancer**
◯ NONE

Do you wear Sunscreen? **YES** **NO**
If yes, what SPF? _____
Do you tan in a tanning salon? **YES** **NO**

Do you have a family history of Melanoma? **YES** **NO**
If yes, which relative? _____

Social History

Smoking Status:
◯ Never smoker
◯ Former smoker
◯ Current every day smoker
◯ Current some day smoker

Review of Systems

Do you have any of the following?

◯ New onset of shortness of breath
◯ Recent illness

◯ Problems with scarring
◯ Rash

Yearly Intake and History Form

Alerts

Do you have any of the following?

- ◯ Problems with healing
- ◯ Problems with bleeding
- ◯ Allergy to latex
- ◯ Allergy to adhesive
- ◯ Allergy to lidocaine
- ◯ Allergy to topical antibiotic ointments
- ◯ Artificial heart valve
- ◯ Artificial joints within past two years
- ◯ Blood thinners
- ◯ Defibrillator
- ◯ MRSA
- ◯ Pacemaker
- ◯ Premedication prior to procedures
- ◯ Rapid heartbeat with epinephrine
- ◯ HIV
- ◯ Hepatitis B or C
- ◯ Planning a pregnancy
- ◯ Currently pregnancy

ADVANCED SKIN CENTER

Dermatology & Skin Cancer Specialists

Patient Rights and Responsibilities

Advanced Skin Center Role in Your Healthcare

- Providers are responsible for assessment and treatment of our patients. Providers will refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment.
- Medical assistants are responsible to support providers and the medical needs of our patients.
- Support staff are responsible to provide administrative support such as referrals, eligibility, prior authorizations, medical records, billing, financial and resource assistance for patients.

You have the right to:

- Be treated with consideration, respect and dignity
- Receive care that is delivered in a way that is free from abuse, harassment or discrimination
- Receive assistance with communication through free language services
- Privacy and confidentiality of your personal health information
- Know the names and qualifications of the people caring for you within the facility
- Know your diagnosis, test results, and the advantages and risks of treatment
- Be involved in developing and implementing your care plan
- Utilize informed consent and informed refusal in regard to your care
- Refuse to participate in research or experimentation
- Have an individual present with you during your visit if desired

You have the responsibility to:

- Treat staff with consideration, respect, and dignity
- Observe facility rules and regulations that are for the safety and consideration of all patients and staff
- Take an active role in your health care
- Follow the agreed upon treatment plan or inform provider if you feel a change needs to be made

- Provide accurate and complete information about present medical concerns, past illnesses, medications, allergies, and other matters relating to your healthcare
- Accept the outcome if you do not follow the recommended care plan or treatment
- Meet your financial obligations
- Make or cancel appointments and ensure current insurance information, mailing address and phone numbers are provided to the facility

Financial Assistance

- Please contact our office if you are in need of financial assistance with your bill

Grievances, Suggestions or Compliments

- Complaints, suggestions, or compliments can be filed in person, by phone, or by mail.
- Patients should request to speak with office manager or supervisor
- There will be no retaliation for filing a complaint
- We are committed to prompt resolution to grievances

Records and Policies

- I have the right to receive a copy of all medical records and test results
- I have a right to receive a written copy of the Notice of Privacy Practices

Authorization is granted to Advanced Skin Center

- To render treatment as needed
- To release information regarding my treatment to my insurance company for billing purposes
- For payment of medical benefits of services rendered

By signing this form, I accept my rights and responsibilities as a patient and consent to the treatment and services provided by Advanced Skin Center. I certify that I have not withheld insurance coverage information for the time of service. I accept full responsibility for all charges whether they are covered by insurance or not. I have read and understand the above information and agree to adhere to office policies while in the care of Advanced Skin Center.

_____ _____

Printed Name **Relationship**

_____ _____

Signature **Date**

Roseburg Office
1813 W. Harvard Ave., Ste 310
Roseburg, OR97471

Directions from the south:

1. Head northwest on I-5 N
2. Take exit 124 City Center exit
3. Turn left at the light onto W Harvard Ave.
4. Continue to follow Harvard Ave. going through several lights until you see Hometown Drug sign on left.
5. Turn left on to Stanton St.
6. Take a left at the third driveway entrance. We are located next door to Hometown Drug. We are street level even though unit says 310.

Directions from the north:

1. Head South on I-5
2. Take exit 124 for OR-138 E toward City Center /Diamond Lake
3. Turn left at W. Harvard Ave. Continue to follow W. Harvard Ave. through several lights until you see Hometown Drug sign on the left.
4. Turn left on to Stanton St.
5. Take a left at the third driveway entrance. We are located next door to Hometown Drug. We are street level even though unit says 310.

Grants Pass Office
1021 NE 6th street
Grants Pass, OR 97526

Directions from the south:

1. Head north on I-5 towards Grants Pass
2. Take exit 58 toward US-99/OR-99/ Redwood Hwy/Grants Pass/City Center
3. Merge onto NE Scoville Rd
4. Turn left to stay on Scoville Rd
5. Continue straight merging onto 6th St (Pass by McDonalds-on the left)
6. Destination will be on the left in 1.0 mi (Pass by Dollar Tree-on the right)

Directions from north:

1. Head south on I-5 to Medford
2. Take exit 58 for State Route 99/ Redwood Hwy toward US-100/Grants Pass/ City Center
3. Merge onto N 6th St/Redwood Hwy/ NE Scoville Rd. Continue to follow N 6th St/Redwood Hwy
4. Continue on 6th St (Pass by McDonalds-on the left)
5. Destination will be on the left in 0.9 mi (Pass by Dollar Tree-on the right)

Coquille Office

855 W. Central Blvd, STE. B
Coquille, OR 97423

Directions from the east:

1. Head west on OR-42W
2. In Coquille, turn right at N Central Blvd 1.2 mi
3. Destination will be on the left

Directions from Bandon:

1. Head North on Hwy 101
2. Turn right on E Beaver Hill Rd
3. Destination will be on the left

Directions from Coos Bay:

1. Head south on US-101 and OR-42
2. In Coquille, turn left on N Central Blvd 0.6 mi
3. Destination will be on the left

Reedsport Office

385 Ranch Rd.
Reedsport, OR97467

From the south:

1. Turn left at the first traffic signal in Reedsport onto 22nd street.
2. Immediately turn left again onto Frontage road.
3. Continue west on Frontage Rd for 0.5 mi
4. Turn right into Ranch Rd
5. Destination will be on the right in 449ft. (Pass by church-on the right)

From the north:

1. Proceed south on Highway 101/ Oregon Coast Hwy through Reedsport
2. Turn right at traffic signal onto 22nd St
3. Immediately turn left onto Frontage Road.
4. Turn right onto Ranch Rd
5. Destination will be on the right in 449ft. (Pass by church-on the right)