PATIENT REGISTRATION

PATIENT INFORMATION Date Completed _____/_____/_____

Full name _____ SS# _____
Last First MI

Address _____ Apt # _____ Gender ☐ M ☐ F

City/State _____Zip_____ Birth date _____Age_____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Daytime Phone _____ Work Phone _____ Cell Phone _____

Pharmacy _____ Primary Care Physician _____

Employer _____ Occupation _____

E-mail _____ Are you a student? ☐ Yes ☐ No Student Status ☐ Full-time ☐ Part-time

SPOUSE or **PARENT** (if patient is a minor)

Full Name _____ Birth date _____
Last First MI

SS# _____ Employer _____ Work Phone _____

Address ☐ Same as above _____City/State_____ Zip _____

I give permission to discuss my medical condition with this person ☐ Yes ☐ No

INSURANCE INFORMATION

Please present your insurance card to the receptionist when you arrive at the clinic. Insurance will only be billed if a card is presented. IN ADDITION TO PROVIDING YOUR INSURANCE CARD, COMPLETE INFORMATION BELOW.

INSURED/SUBSCRIBER _____
Last First MI

SUBSCRIBER BIRTH DATE _____

SUBSCRIBER EMPLOYER _____

WHO MAY WE CONTACT IF WE CAN'T REACH YOU:

Full Name _____ Daytime Phone _____
Last First MI

Relationship to patient _____

Address _____ City/State _____ Zip _____

☐ Same as above

I give permission to discuss my medical condition with this person ☐ Yes ☐ No

- I have read and understand the Financial Policy. I have been provided a copy for my personal records.
- I authorize the taking of photographs to document my medical condition.
- I authorize the doctor and/or staff to leave messages on my home or cell phone voice mail.
- I authorize the doctor and/or staff to send me e-mail messages at the e-mail address above.
- I authorize Deschutes Dermatology to obtain information on my prescription(s) from SureScripts to conduct electronic prescribing.

SIGNATURE _____ DATE_____

Leslie A. Carter, MD, MPH, FAAD
325 sw upper terrace drive, ste 100
Ph. 541.330.0900 Fax 541.312.5739

Carrie Baxter, PA-C
bend, oregon

DESCHUTES dermatology center

FINANCIAL POLICY

INSURANCE BILLING

- ***Because your health insurance policy is a contract between you and your carrier, it is imperative that you research your coverage benefits before your visit.*** *Due to the number of plans and coverage options, we cannot provide individual policy benefits information. We are contracted with many insurance carriers but may not be contracted with your individual plan or group. Ultimately, all charges are the responsibility of the patient or his/her guardian.* ***_____ initial***
- *We will submit claims to your insurance carrier (primary and secondary) as a courtesy. In order to do so, we require you to present your insurance card at the time of service.* ***Your co-pay and any applicable deductible are due at the time of service unless special arrangements have been made prior to your visit.*** *If we do not receive a copy of your insurance card, we will request payment in full at the time of service.* ***If, for any reason, your insurance carrier has not paid their portion of the charges within 60 days of the date of service, you will be responsible for payment in full.*** *Outstanding balances unpaid beyond this period will be subject to collection services.* ***_____ initial***
- ***If you do not have any health insurance, we will request payment in full at the time of service.*** *We do extend a 10% discount to uninsured patients who pay in full on the day medically necessary services are provided. (This discount is not applicable to patients who have high deductible policies as they will automatically receive a discount based on our contracted rate with their insurance company.)* ***_____ initial***

OUTSIDE SERVICES

It is customary for Deschutes Dermatology Center to send specimens to outside sources for processing. Common examples of these services are pathology and laboratory testing. Should such services be needed in the course of your care, you will receive separate billing statements from these outside sources. ***These charges will be in addition to those for services rendered directly by Deschutes Dermatology Center. _____ initial***

ELECTIVE SERVICES

Only medically necessary procedures will be billed to the insurance carrier. ***You are financially responsible for all charges associated with elective, cosmetic and non-covered services or treatments. Payment in full is expected and the time of service. _____ initial***

APPOINTMENT CANCELLATIONS

We ask that you provide twenty-four hour notice for cancellation or rescheduling. If a least 24 hour notice is not provided, you will be charged a flat fee of $25 for a missed office visit. Missed cosmetic visits will be subject to forfeiture of the deposit. ***_____ initial***

LATE CHARGES AND OTHER FEES

- *Accounts with balances over 60 days old are subject to late fees.*
- *Accounts referred to a collection agency will be subject to a $50.00 collection fee, attorney fees and/or the percentage allowed under Oregon state law.*
- *There is a $35.00 fee for all checks returned for NSF (non-sufficient funds)* ***_____ initial***

Patient Signature: _____ ***Date:*** _____

Parent/Guardian (please specify) signature required for minors

Printed Patient Name: _____ ***Date of Birth:*** _____

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