GOODSKIN DERMATOLOGY

Clackamas, Hillsboro, Troutdale & Portland
P: 503-654-7546 | F: 503-786-3542
www.GoodskinMD.com

PATIENT INFORMATION

(Please print and complete all sections)

Legal Name of Patient _____ **Age** _____ **Date** _____
(Last) (First) (Middle)

Date of Birth _____ **SSN** _____ **Gender** _____ **Marital Status** _____

Mailing Address _____
(Street/PO Box) (Apt#) (City) (State) (Zip)

Primary Phone Number	**Secondary Phone Number**	**Ok To Leave Detailed Message**
_____	_____	_____
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Yes ☐ No

Email Address _____
We want to make sure you know that email communications between Goodskin Dermatology and our patients will not be encrypted and therefore are not considered secure communications. Email communication is not appropriate for emergencies or time sensitive appointment requests.

Emergency Contact _____
(Name) (Relationship) (Phone Number)

Primary Care Physician _____
(Name) (City/State)

Referring Physician _____
(Name) (City/State)

Occupation/Previous Occupation _____ **Retired:** ☐ Yes ☐ No

Patient's Employer _____
(If minor, give guardian's information) (Name) (City/State)

The Federal Government requests that we collect the following information:

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Multiracial ☐ Native Hawaiian ☐ White

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Preferred Language:** _____

RESPONSIBLE PARTY INFORMATION

PLEASE COMPLETE THE SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE BILL

Name _____ **Date of Birth** _____ **SS#** _____
(Last) (First) (Middle)

Mailing Address _____
(Street/PO Box) (Apt#) (City) (State) (Zip)

Best Daytime Phone Number	**Secondary Phone Number**	**Ok To Leave Detailed Message**
_____	_____	_____
☐ Cell ☐ Home ☐ Work	☐ Cell ☐ Home ☐ Work	☐ Yes ☐ No

MEDICAL INSURANCE INFORMATION

Primary Insurance Company_____
ID Number _____
Group Number _____
Name of Insured _____
Relationship to Patient _____
Insured Date of Birth _____ **SS#** _____

Secondary Insurance Company _____
ID Number _____
Group Number _____
Name of Insured _____
Relationship to Patient _____
Insured Date of Birth _____ **SS#** _____

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MEDICAL HISTORY AND INTAKE FORM

Name of Patient _____ **Date of Birth**_____
(Last) (First) (Middle)

Preferred Pharmacy _____ **Phone** _____ **City/Zip Code** _____

MEDICAL HISTORY - PLEASE CHECK ALL THAT APPLY

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ Bone Marrow Transplantation
□ BPH (benign prostatic hyperplasia)
□ Breast Cancer
□ Colon Cancer
□ COPD
□ Coronary Artery Disease
□ Depression
□ Diabetes
□ End Stage Renal Disease
□ GERD
□ Hearing Loss
□ Heart Attack: Year _____
□ Hepatitis: Type _____
□ High Blood Pressure
□ HIV/AIDS
□ Hyperthyroidism
□ Hypothyroidism
□ Leukemia
□ Lung Cancer
□ Lymphoma
□ Phlebitis/Blood Clots
□ Prostate Cancer
□ Radiation Treatment
□ Seizures
□ Stroke
□ Other _____

List all surgical procedures in the last year _____

SKIN CONIDITON HISTORY – PLEASE CHECK ALL THAT APPLY

□ Acne
□ Actinic Keratosis
□ Basal Cell Carcinoma –Year_____
□ Blistering Sunburns
□ Dry Skin
□ Eczema
□ Flaking or Itchy Scalp
□ Hay Fever/Allergies
□ Melanoma – Year _____
□ Poison Ivy
□ Precancerous moles
□ Psoriasis
□ Squamous Cell Carcinoma –Year __
□ Lupus – Skin or Systemic
□ Other _____

Do you wear Sunscreen? □ Yes □ No **If yes, what SPF?** _____ **Do you tan in a tanning salon?** □ Yes □ No

Has anyone in your family had Melanoma? □ Yes □ No **If yes, which relative(s)** _____

Does anyone in your family have: □ Asthma □ Hay Fever □ Dry Skin **If yes, which relative(s)** _____

MEDICATIONS

Please list all prescriptions, vitamins, supplements, and over-the-counter medications **or** provide these on a separate page

Medication	Dosage
1.	
2.	
3.	
4.	

DRUG ALLERGIES

Please list all allergies and reactions **or** circle:
No Known Drug Allergies

Drug Allergy	Reaction
1.	
2.	
3.	
4.	

TOBACCO USE

Current Smoking Status: □ Smoke every day □ Smoke sometimes □ Former smoker □ Never smoked
Alcohol Use: □ None □ Less than 1 drink per day □ 1-2 drinks per day □ 3+ drinks per day

ALERTS

□ Allergy to Adhesive
□ Allergy to Lidocaine
□ Artificial heart valve
□ Artificial joint replacement - where _____
□ Blood Disorders - _____
□ Currently Pregnant or Breastfeeding? _____
□ Defibrillator
□ History of MRSA
□ Pacemaker
□ Previous reaction to local anesthetic - _____
□ Problems with scarring or healing - _____
□ Require antibiotics prior to a surgical procedure
□ Rapid heartbeat with epinephrine

Do you give Goodskin Dermatology permission to discuss your medical information with your family/friend/advocate? □ Yes □ No

Name _____ **Relationship** _____ **Phone Number** _____

I consent to having photographs taken which will only be used to document my care/condition and for teaching

********************I verify that the information on this form is correct to the best of my knowledge********************

Patient Signature _____ **Date** _____

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FINANCIAL POLICY

Thank you for trusting your medical care to Goodskin Dermatology. We strive to deliver excellent medical care to you, your family, and all of our patients. We ask that you review our Financial Policy below. It reviews your financial obligations when services are rendered to you. We look forward to seeing you!

- Goodskin Dermatology accepts and is contracted with many insurance carriers, PPOs, and HMO's. Charges for services will be billed to our contracted insurance carriers and will be discounted to their allowed amount. You are responsible for any copays, deductibles, any non-covered services, and usual and customary amounts for non-contracted insurance.
- Please bring your current medical insurance card to every visit and notify us if there is a change in your insurance coverage.
- Co-payments are due at the time of check-in along with any amount due on your account. If you are unsure of your copay, deductible, or coinsurance amount, please contact your insurance company prior to your appointment.
- **All procedures (such as biopsies, liquid nitrogen/freezing, benign removals, skin tags, etc.) are billed separately and are not included in the office visit. These procedures generally fall under deductible.**
- If your insurance requires a referral, we must receive it prior to your visit.
- We will submit claims to your insurance carrier for you. For those plans that we participate in, we will also submit secondary and/or tertiary claims.
- If you have questions or concerns about what will be covered by your insurance company, please contact them prior to your visit. All uncovered services are your responsibility.
- Cosmetic Services are not covered by insurance. Payment for these services are due, in full, at time of service and are non-refundable. Any prepaid cosmetic packages are to be used within one (1) year of the purchase date.
- If you do not have insurance, payment is due in full at the time of service. If a specimen is sent to an outside laboratory, they will send you a separate statement for that service.
- You will receive an itemized statement monthly, and payment is due within 30 days of the statement date. If you are unable to pay the balance in full, please contact our business office immediately to develop a payment plan.
- We accept cash, checks, Visa, Discover, American Express and MasterCard. ***A $35 fee will be assessed for returned checks***.
- If you have a tissue biopsy done, you will receive a separate bill from CTA Lab or OHSU, in addition to your bills from Goodskin Dermatology, as their pathologists perform the analysis of the tissue.
- Responsibility for minor/dependent accounts rests with the legal guardian that accompanies the minor to the visit and we may ask for proof of guardianship.
- Any balances that have been unpaid for a period of 60 days or longer will be sent a notice letter. This is your final opportunity to resolve your account. If no contact is made with our patient accounts/billing department, your account may be sent to our legal collection agency. All contact regarding your account must then be made with the collection agency's account representative.
- If your account is sent to collections for non-payment, future services will be provided on a cash only basis.
- If at any time you have questions regarding your bill, please call our patient accounts/billing department at 503.654.7546 and we will be happy to assist you.

I hereby authorize Goodskin Dermatology, to release any medical information required regarding my medical conditions to my insurance carrier, or the Health Care Administration and it's intermediaries. I agree that I am responsible for payment of any amount not paid by my insurance, per plan provisions of my insurance policy. I have read and understand this financial policy, and agree to abide by these terms for services provided at Goodskin Dermatology.

_____	_____	_____
Signature of Patient or Responsible Party	Date	Relationship to Patient

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HIPPA ACKNOWLEDGEMENT AND CONSENT

I understand that Goodskin Dermatology will use and disclose health information about me.

I understand that health information may include information both created and received by Goodskin Dermatology, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions and similar types of health-related information.

I understand and agree that Goodskin Dermatology may **use and disclose** my health information in order to:

- Make decisions about and plan for my care and treatment.
- Refer to, consult with, coordinate among and manage along with other healthcare providers for my care and treatment.
- Determine eligibility and my insurance coverage, submit bills/claims and other insurance-related information to my insurance companies or others who may be responsible to pay for some or all of my healthcare.
- Perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effect health care.

I understand that I have the right to receive and review a written description of how Goodskin Dermatology will handle health information about me. This written description is known as **Notice of Privacy Practices** and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Goodskin Dermatology, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of This Practice's Notice of Privacy Practices in effect will be posted in the waiting/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Goodskin Dermatology is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above.

Print Patient Name _____ Signature _____ Date _____

- OR -

Patient Representative _____ Signature _____ Date _____

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PATIENT PORTAL

What is The Patient Portal?

The Patient Portal is a web-based system that allows for secure communication and transfer of information between Goodskin Dermatology and our patients. When a patient logs into The Portal, current medical information is pulled directly from the patient's electronic medical record database and displayed on the web page viewed by the patient. No patient information is stored on The Patient Portal server.

You will be asked to sign the 'Patient Portal Terms of Service' so that we can activate your use of the system. Once this form is signed, The Portal will send a message to your email address with your login and password.

After logging into The Portal, you can:

- Use the messaging function to
  - Communicate with clinic staff.
  - Request a medication refill.
- View results of lab and other diagnostic tests.
- View Patient information and send update requests if you see missing information.
- Print or save an electronic copy of your Visit Information.

The clinic staff can use The Patient Portal to:

- Communicate with patients via an online messaging system.
- Send results of lab and other diagnostic test to patients via the Portal and include messages related to the results.
- Receive medication refill requests.

To access The Patient Portal, after you establish your initial password, go to: goodskinderm.ema.md

We hope that the Portal will facilitate ease of communication between you and your medical provider. The service is optional and can be revoked at any time by either you or your provider.

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PATIENT PORTAL TERMS OF SERVICE

Patient Name: _____ Date of Birth: _____/_____/_____

Email Address: _____

Online communication with your doctors at Goodskin Dermatology is provided to you for your convenience. Please read and keep the accompanying 'Goodskin Patient Portal' before signing this document.

By using The Patient Portal, the patient agrees to the following:

- ✓ The Portal should not be used to communicate with your doctor in the event of an emergency. In these circumstances, you should call 911, if it is a life-threatening emergency.
- ✓ The Portal should not be used to communicate highly sensitive medical conditions such as those regarding substance abuse, HIV, or mental disorders, to name a few.
- ✓ Response times to your online message can take 24 to 48 hours, so please take this into consideration when communicating with us in this fashion.
- ✓ Clinically relevant messages and responses will be documented in the medical record. Portal messages that are received by Goodskin Dermatology cannot be printed and forwarded by staff members.
- ✓ Goodskin Dermatology will not be liable for information lost or misdirected due to technical errors or failures. The Portal can only be used by patients who are established patients with Goodskin Dermatology.
- ✓ The Portal is not a vehicle for online clinical consultations.
- ✓ Your doctor cannot make a diagnosis or prescribe treatment for a condition that has not been addressed in person.
- ✓ You will be able to see your Visit Information and print a copy of this to take to other physicians of your choice. You will be able to submit a request to us that certain information is included in this record.
- ✓ Your Patient Information is distinct from medical records maintained by your doctor. The accuracy of your Patient Information is the responsibility of the patient or their caregiver, as the owner of the record. Entering information into this record does not guarantee that they will see it.
- ✓ You must contact your clinician if you have questions about your medical condition or if you need medical help.
- ✓ Your user ID and password are your responsibility, protect from unauthorized access and use by third parties.

By signing this form, I authorize Goodskin Dermatology to communicate via a secured access Patient Portal with me. I authorize that the following types of protected health information may be used, disclosed, and retained by healthcare providers of Goodskin Dermatology as a result of these communications:

1) My personal health information
2) Laboratory test results
3) Pathology reports
4) Other diagnostic test results

I understand that I have the right to revoke this authorization at any time. If I want to revoke this authorization, I must do so in writing, and address it to Goodskin Dermatology. I understand that if I revoke this authorization, it will not apply to any information already released as a result of this authorization.
I understand that I may refuse to sign this authorization. I also understand that Goodskin Dermatology cannot deny or refuse to provide treatment, payment, or medical records if I refuse to sign this document.

I have read and understand the information in this authorization form

_____ _____/_____/_____

Signature Date