

Dear Patient,

We are delighted to welcome you to Deschutes Dermatology Center. This letter contains answers to some of the most commonly asked questions by patients entering our practice.

Deschutes Dermatology is located in the Old Mill District. We are a full service dermatology practice providing medical, cosmetic, and surgical services to patients of all ages. Our hours are Monday through Friday from 8:00am to 5:00pm. Our providers include Leslie A. Carter MD, Carrie A. Baxter PA-C, and Kelly McKenna, Medical Aesthetician.

All new patients are asked to complete the Patient Registration, Financial Policy, Notice of Privacy Practices and Health History in full and provide them to the receptionist when checking in for their initial appointment. If you find that you're unable to keep this appointment, please contact our office 24 hours prior to your scheduled time.

For the benefit of our patients, we are contracted with several insurance carriers as a preferred provider. You will want to check with your Insurance Company to find out if we are listed as providers within your particular network. As part of our contract with your insurance carrier, we are required to collect any co-pay(s) from you at the time of service. Please come prepared with your copay, driver's license, and insurance card.

If you have any questions or concerns, please call our office at 541-330-0900. We look forward to meeting you soon!

Sincerely,

Dr. Carter & Staff of Deschutes Dermatology Center

# FINANCIAL POLICY

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## INSURANCE BILLING

Deschutes Dermatology Center will submit claims to your insurance carrier (primary and secondary) either as a courtesy to the patient/subscriber or as mandated by law. In order to do so we will request you provide us with the following information:

- Your written authorization to submit claims and release any medical information deemed necessary by your insurance carrier to process claims (authorization is included on our Patient Registration Form).
- Verification of insurance coverage. If Deschutes Dermatology Center will be billing insurance, we require you to submit your insurance card at the time of service.
  - *If we do not receive a copy of your insurance card your account will be established as self-pay.*
- Assignment of benefits (authorization is included on our Patient Registration Form).
- Timely notification and verification of any change in coverage or carriers.

Unless mandated by law or other contractual agreements, we bill insurance as a courtesy. Due to the number of plans and coverage options; we cannot provide individual policy benefits information. We are contracted with several insurance carriers but may not be contracted with your individual plan or group. You will need to contact your carrier directly to determine if we are contracted with them and on your network. Only medically necessary procedures will be billed to the insurance carrier. Your co-pay and any applicable deductible are due at the time of service.

Your insurance carrier will not be billed for elective, cosmetic and other non-covered services. Payment for these services will be collected at the time of service.

We accept cash, local checks, debit cards, credit cards, and CareCredit.

## OUTSIDE SERVICES

To provide the best care possible, Deschutes Dermatology Center may, on occasion, send specimens to an outside source for processing. Examples of these services are pathology and laboratory testing. Should we send specimens to other providers you will receive a separate billing statement from the outside pathologist and/or laboratory; these charges will be in addition to those for services rendered by Deschutes Dermatology Center.

## COSMETIC PROCEDURES

Elective cosmetic procedures are not covered by insurance companies. You are financially responsible for all charges associated with elective, cosmetic and non-covered services. These services and/or procedures are payable in full at the time of service. Prior to cosmetic treatment(s) we request that you make an appointment with our office for a cosmetic consultation. Because of the increasing number of missed appointments, cosmetic services require a deposit at the time of scheduling. We charge \$50 to reserve a Botox appointment and \$200 to reserve an injectable filler appointment (\$500 for a Sculptra appointment). This will be applied to the charge for your procedure. The balance is due on the date of service.

## APPOINTMENT CANCELLATIONS

The providers make every effort to see you at your appointed time; we ask that you make every effort to arrive on schedule. We understand that occasionally it will be necessary to cancel an appointment. We ask that you provide twenty-four hour notice. If a twenty-four 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 forfeit of the deposit.

## CARECREDIT PAYMENT PLANS

CareCredit offers comprehensive payment plans: including interest-free plans for treatments of \$300 or more. Extended plans of 3/6/12 month payments are the only payment options Deschutes Dermatology Center accepts for treatments over \$300. This is a revolving line of credit that can be used for ongoing treatments without having to reapply. For additional information, or to apply, please visit the CareCredit website at "<http://www.carecredit.com/>".

## GIFT CERTIFICATES

Deschutes Dermatology Center offers Gift Certificates for services and products. They are available in amounts from \$100-1000, in \$100 increments, and are not redeemable for cash. Gift Certificates are issued to a specific person. For tracking purposes, a patient/client account will be established for the gift card recipient (if not already set-up) at the time a Gift Certificate is purchased.

## LATE CHARGES AND OTHER FEES

- Accounts with balances over 90 days old are subject to late fees.
- Accounts referred to a collection agency may 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).

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian signature required for minor (less than 18 years of age)

Relation to patient other than self (circle):      Parent      Guardian

Printed Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

# DERMATOLOGY HEALTH HISTORY

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Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for visit today: \_\_\_\_\_

Medications (including prescription, over the counter, vitamins, herbals, etc.) \_\_\_\_\_

Medication allergies: \_\_\_\_\_

Non-medication allergies: Latex ? Lidocaine? Other? \_\_\_\_\_

History of Skin Cancer:  basal cell carcinoma  squamous cell carcinoma  melanoma  none

Have you had suspicious looking moles removed in the past? Yes No

Have you had precancers (actinic keratoses) frozen with liquid nitrogen previously? Yes No

Have you done home treatment with Efudex or Carac? Yes No

Have you had photodynamic therapy for precancers? Yes No

Medical History: (please circle all that apply)

Anemia	Glaucoma	High cholesterol	Pacemaker
Arthritis	Hay fever / allergies	HIV	Rheumatologic disease
Artificial joint	Healing difficulties	Keloids / thick scars	Thyroid disease
Asthma	Heart failure	Kidney disease	
Bleeding or clotting issues	Heart murmur	Lung infections	Other cancer:
Depression/ anxiety	Hepatitis	Lupus	_____
Diabetes	Herpes (cold sores)	Neurologic disease	_____
Eczema	High blood pressure	Psoriasis	_____

Do you have a family history of melanoma? Yes No

Do you wear sunscreen daily? Yes No

Do you wear a hat and /or protective clothing? Yes No

Do you work outdoors? Yes No

Would you like to discuss your skin care regimen or cosmetic treatments? Yes No

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Leslie A. Carter, MD, MPH, FAAD Carrie Baxter, PA-C  
325 sw upper terrace drive, suite 100 bend, oregon 97702  
541-330-0900 fax 541-312-5739



# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

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I understand that, under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information.

I understand that my health information may include information both created and received by Deschutes Dermatology Center, may be in the form of written, 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 that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in my treatment, both directly and indirectly.
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for partial and/or entire healthcare.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that Deschutes Dermatology Center has the right to change its Notice of Privacy practices from time to time and that I may contact Deschutes Dermatology Center at any time to obtain a current copy of the Notice.

I understand that I may request in writing that Deschutes Dermatology Center restrict how my private information is disclosed to carry out treatment, payment or health care operations. I also understand Deschutes Dermatology Center is not required to agree to my requested restrictions.

**Note:** *I authorize Deschutes Dermatology Center to leave messages regarding pathology and lab results, schedule changes and medication information on a voicemail and/or answering machine.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian signature required for minor (less than 18 years of age)

Relation to patient other than self (circle):      Parent      Guardian

**Printed** Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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# MEDICAL RECORDS RELEASE FORM

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## Authorization to Use and Disclose Protected Health Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

### I REQUEST AND AUTHORIZE:

Organization/Person \_\_\_\_\_ Phone: \_\_\_\_\_

Organization Address \_\_\_\_\_ Fax: \_\_\_\_\_

### TO RELEASE RECORDS TO:

Organization/Person \_\_\_\_\_ Phone: \_\_\_\_\_

Organization Address \_\_\_\_\_ Fax: \_\_\_\_\_

The information to be disclosed (if such records exist):

Billing Statement(s)  Diagnostic Imaging Report(s)

Clinical Record(s)  Laboratory Report(s)

Cosmetic Record(s)  Pathology Report(s)

Other: \_\_\_\_\_

This authorization DOES NOT apply to records related to HIV/AIDS, mental health, genetic testing, or drug/alcohol diagnosis. A separate, signed authorization form is required for those records.

I understand that I may revoke my authorization at any time by making such a request in writing to Deschutes Dermatology Center. This authorization shall expire automatically one year from the date of my signature, unless requested to end at an earlier date: \_\_\_\_\_. I also understand that once released, my protected health information may be subject to redisclosure.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian signature required for minor (less than 18 years of age)

Relationship to patient (if other than self): \_\_\_\_\_

Adapted from ORS 192.518 to 192.526

**Printed Patient Name:** \_\_\_\_\_

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# PATIENT REGISTRATION

## PATIENT INFORMATION

Date Completed \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Full name \_\_\_\_\_ SS# \_\_\_\_\_  
Last First MIAddress \_\_\_\_\_ 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 Provider \_\_\_\_\_

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

## PERSON RESPONSIBLE FOR PAYMENT

 Check **SELF** if you are 18 years of age or older **AND SKIP THIS SECTION.**  SELFFull Name \_\_\_\_\_ SS # \_\_\_\_\_  
Last First MIBirth date \_\_\_\_\_ Relationship to patient  Spouse  Parent  Legal Guardian  Other

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Address  Same as above \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

## 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

**ALTERNATE CONTACT**

(Please list a person who is not living with you)

Full name \_\_\_\_\_ Home Phone \_\_\_\_\_  
Last First MI

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

**SIGNATURES ARE REQUIRED TO ESTABLISH THE PATIENT ACCOUNT**

**Please sign both boxes below**

**ALL PATIENTS (OR GUARANTORS) PLEASE COMPLETE THIS SECTION**

**RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS (Parent or guardian must sign if patient is a minor)**

- I authorize the release of any information to my insurance company that they may require for the processing of my claim(s).
- I authorize the release of any medical information for myself or my dependents to consulting or referring physicians.
- I authorize the direct payment of insurance benefits to Deschutes Dermatology Center for services rendered to me or my dependents.
- I authorize treatment by Leslie A. Carter, M.D., Carrie A. Baxter PA-C and staff.
- I authorize Deschutes Dermatology Center to obtain information on the patient's prescription(s) from SureScripts to conduct electronic prescribing.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**ALL PATIENTS (OR GUARANTORS) PLEASE COMPLETE THIS SECTION**

**OTHER AUTHORIZATIONS**

- 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 would like to receive information, announcements or newsletters from the clinic periodically.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**FOR OFFICE USE ONLY:**  INSURANCE CARD(S) COPIED  FINANCIAL POLICY SIGNED  SIGNATURES VERIFIED  CONTACTS  NOTICE OF PRIVACY PRACTICES

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