



**MID-COLUMBIA
DERMATOLOGY**

Patient Demographic Form

Patient Name _____
Last Name First Name Middle Name

Patients Date of Birth _____ Age _____ Gender M F _____
Social Security Number _____

Primary Language _____ Marital Status Single Married Widowed Divorced

Mailing Address _____
Apt/Unit # City State Zip Code

Telephone _____
Home(xxx)xxx-xxxx Mobile(xxx)xxx-xxxx Work(xxx)xxx-xxxx

Email Address _____ Employer _____
Check to Opt Out of Email List ☐

Emergency Contact _____
Full Name Relationship To Patient Phone Number

Referring Physician _____
If A Physician did not refer you, please tell us how you heard about of office
Website Social Media Insurance Carrier Word of Mouth

Parent/Guardian _____
Name Date of Birth Relationship to Patient Phone Number

Primary Insurance	Secondary Insurance
PRIMARY INSURANCE COMPANY NAME	SECONDARY INSURANCE COMPANY NAME
SUBSCRIBER'S NAME IF DIFFERENT FROM PATIENT	SUBSCRIBER'S NAME IF DIFFERENT FROM PATIENT
SUBSCRIBER ID NUMBER	SUBSCRIBER ID NUMBER
GROUP NUMBER SUBSCRIBERS BIRTHDATE Self Spouse Father Mother Partner PLEASE INDICATE RELATIONSHIP TO PATIENT	GROUP NUMBER SUBSCRIBER BIRTHDATE Self Spouse Father Mother Partner PLEASE INDICATE RELATIONSHIP TO PATIENT

Patient or Guardian Signature _____ Date _____



Patient Policy

Patient Responsibility: Patients are responsible for all charges resulting from treatment provided by this clinic. As a service to you, we bill most insurance carriers directly. However, primary responsibility for the account is yours. Payment is due at the time of service, unless other financial arrangements are made. This includes deductibles, co-pays, and/or co-insurance. Established patients with a balance will be asked for payment at time of service.

I assign Mid-Columbia Dermatology all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days may be subject to fees and be turned over to a collection agency.

For cosmetic procedures and skin care products, payment in full is expected at the time of each visit.

Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

Referrals: If your insurance requires a referral from your primary care provider (PCP) to see a specialist, it is your responsibility to obtain a referral/authorization before your appointment.

Insurance Billing: We will, as a courtesy, bill your primary insurance carrier. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your new insurance information at your next visit. Charges owed due to claim rejection and/or non-response by the insurance company is the responsibility of the patient.

Medicare: Our providers are participating providers. I understand that I will be responsible for any portion determined by Medicare as "patient responsibility" and any charges not covered by Medicare will be my responsibility. Please provide staff with secondary insurance information if you have it.

Check Returns: It is our policy to charge all patients a \$30.00 fee for returned checks.

Cancellations & No Shows: A \$50.00 fee will be charged for any appointment cancelled without 24 hours' notice.

Laboratory: We send all biopsies and lab work to an outside lab. You will receive a separate bill from this company.

I am aware of the following potential complications as outlined for any procedure performed at Mid-Columbia Dermatology: Bleeding, Nerve damage, Infection, Postoperative problems, Scarring, Pain

I am aware that if I become pregnant, I am responsible for reporting to my OB/GYN any and all prescriptions that I am using, including Isotretinoin and/or topical retinoids.

Authorization to Release Information: I have read, and I accept this policy for my testing and/or treatment with Mid-Columbia Dermatology. The Notice of Privacy Practices for Mid-Columbia Dermatology is available at the clinic reception desk, and I acknowledge I have seen a copy of the Notice of Privacy Practices.

I, or my appointed agent, have read, fully understand, and agree to the above statements.

Patient Name (print) Patient Signature Date

If the patient is under the age of 18, or otherwise unable to sign, complete the following:

Patient is _____ year(s) of age or is unable to sign because: _____

Signature Relationship to Patient Date