CENTER FOR EXCELLENCE IN DERMATOLOGY PLLC

NEW PATIENT MEDICAL HISTORY FORM

Date: _____/_____/_____

Name (please print): _____ ***Date of Birth:*** _____

Best contact phone number: _____ ***Ok to leave a message? YES NO***

Referring provider (name/phone): _____

Preferred pharmacy (name/phone): _____

Weight: _____ ***Height:*** _____

Sex/Gender assigned at birth (circle one): Male Female

Sex/Gender to be identified as (circle one): Male Female

Reason for today's visit: _____

Symptoms of your current skin condition (circle all that apply): Bleeding Itching Painful Growing Changing

Duration of skin condition(s): _____

Have you tried any medication(s) for this condition? YES NO

If yes, please list medication(s): _____

Personal past medical history of current diseases:

Skin Cancer	Y / N	HIV/Aids	Y / N
Actinic Keratosis	Y / N	Hepatitis C/Liver Disease	Y / N
Melanoma	Y / N	Thyroid Disorders	Y / N
Cancers	Y / N	Diabetes	Y / N
Psoriasis	Y / N	Eczema	Y / N
Seasonal Allergies/Hay Fever	Y / N	High Blood Pressure	Y / N
Keloids	Y / N	Pacemaker/Defibrillator	Y / N
Autoimmune Disease	Y / N	Arthritis/Artificial Joints	Y / N

If you answered **YES** to any of the above, please explain: _____

Other major medical illness/surgeries: _____

Family History: If any blood relative has any condition listed below, check and specify which blood relative.

Allergies/Hay Fever (_) _____
Eczema (_) _____
Asthma (_) _____
Hives (_) _____
Severe Acne (_) _____
Psoriasis (_) _____
Diabetes (_) _____
Skin Cancer (_) _____
Other Cancer (_) _____
Heart Disease (_) _____
High Blood Pressure (_) _____
Autoimmune Disease (_) _____

Allergies (Medication, Latex, Food): _____

Review of Systems: Are you having any of these symptoms today (*please circle all that apply*): Fever, Chills, Nausea, Vomiting, Diarrhea, Constipation, Chest Pain, Shortness of Breath, Cough, Headaches, Numbness, Joint Pain, Vision Changes, Unintended Weight Loss, Anxiety, Depression, Easy Bruising/Bleeding

***Alcohol Use**: (18 Yrs. And older)* How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women? #_____

Tobacco Use: Do you smoke, Vape or Use Tabacco products? **Yes** Or **No**

Current Medication:	***Dose:***	***Frequency:***

ROBERT B. HOPP, M.D. & ASSOCIATES
CENTER FOR EXCELLENCE IN DERMATOLOGY™ PLLC

REGISTRATION FORM

(Please Print)

Today's date: _____

PATIENT INFORMATION

Patient's last name: First: M. I.:			Marital status (circle one): Minor / Single / Mar / Sep / Div / Wid / Partnered / for: yrs
Email address:	Birthdate: / /	Age:	Sex (Assigned at Birth): ❑ F ❑ M ❑ N/A
Mailing Address:	Home phone no. ( )		Cell phone no.: ( )
City:	State:	ZIP Code:	Social Security no.:
Occupation:	Employer/School:		Employer/School phone no.: ( )
Employer's Address:	City:	State:	ZIP Code:
Spouse's name:	Spouse's work phone no.: ( )	Spouse's cell phone ( )	Spouse's Social Security no.:

Preferred Pharmacy:

Primary Care Provider:

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Cell/home phone no.: ( )	Work phone no.: ( )

Guarantor Information (fill out if person responsible for bill is different than patient)

Guarantor's last name:	First:	Middle initial:	Birthdate: / /
Address (if different):	City:	State:	ZIP Code:
Occupation:	Employer:	Employer phone no.: ( )	Social Security no.:

Parents of Minor

Mother's last name: First: M. I.:	Father's last name: First: M. I.:

INSURANCE INFORMATION

Insurance Company:	Subscriber's **FULL** name:	Subscriber ID no.:	Group no. (if applicable):
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Subscriber's Employer:	Subscriber's S.S. no.:	Birthdate: / /

SECONDARY INSURANCE

Is patient covered by additional insurance? ❑ Yes ❑ No If "**YES**," this section **MUST** be **COMPLETELY** filled out.

Insurance Company:	Subscriber's **FULL** name:	Subscriber ID no.:	Group no. (if applicable):
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other	Subscriber's Employer:	Subscriber's S.S. no.:	Birthdate: / /

MEDICARE ONLY

Does patient live in a skilled nursing facility? ❑ Yes ❑ No	Is patient currently under hospice care? ❑ Yes ❑ No

Novel
SKIN SOLUTIONS

Cosmetic Services

We offer a variety of products and services at our cosmetic office, Novel Skin Solutions. These include:

- ❒ SkinPen microneedling for acne scarring and collagen production
- ❒ Botox for fine lines and creases
- ❒ Restylane/Juvederm/RHA Collection for use as dermal fillers
- ❒ Fraxel resurfacing for sun damaged skin
- ❒ Ultherapy for skin tightening on face, head, and neck
- ❒ Advice on cosmetics and makeup
- ❒ Coolsculpting for fat on abdomen, hips, thighs, underarms, and/or double chin
- ❒ IPL treatment for sun spots and freckles
- ❒ Diode laser for dilated blood vessels
- ❒ Chemical peels and/or extractions
- ❒ Skincare products to use at home
- ❒ Monthly specials and promotions

If you'd like to contact our cosmetic office to set up a complimentary consultation, call us at

(509) 735-1186

You can also learn more about the products and services we offer at our website:

novelskinsolutions.com

Follow us on Instagram and Facebook:

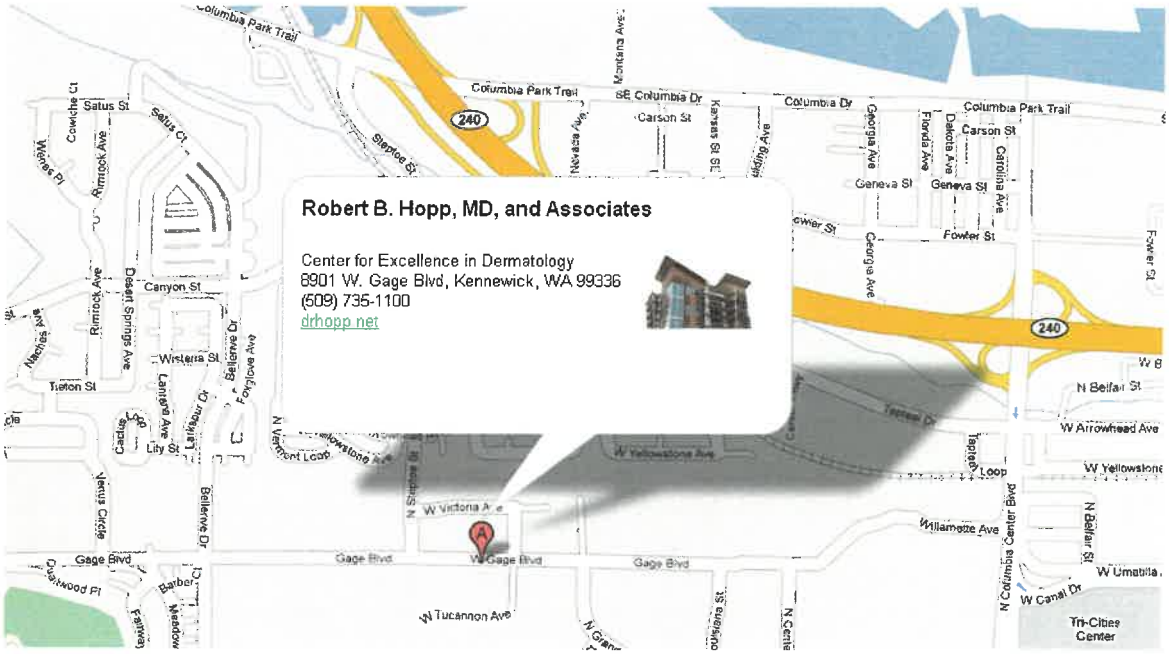
@novel_skin_solutions

To subscribe to our mailing list and be the first to hear about limited specials and promotions, sign up for the Novel Newsletter at novelskinsolutions.com!

ROBERT B. HOPP, M.D.
& ASSOCIATES

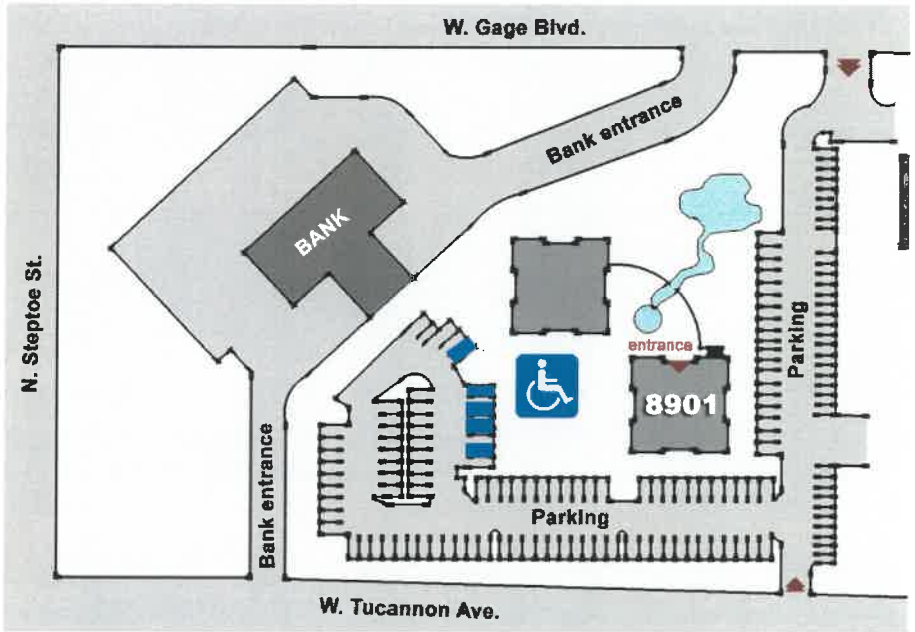
CENTER FOR EXCELLENCE IN DERMATOLOGY™ PLLC

Map & Directions



HANDICAPPED PARKING

Our handicapped parking is located around and behind our building. See the diagram below. The parking spots in blue are handicapped parking. From these parking spots there are no stairs to go up to get to our main entrance.



ROBERT B. HOPP, M.D. & ASSOCIATES

CENTER FOR EXCELLENCE IN DERMATOLOGY™ PLLC

DIRECTIONS FROM RICHLAND:

- Take WA-240 E towards Kennewick
- Take the Columbia Park Trail exit
- At the traffic circle, take the 2nd exit onto N. Steptoe St.
- Turn left onto W. Gage Blvd.
- The Center for Excellence in Dermatology building will be on the right (South) side of Gage

DIRECTIONS FROM SPOKANE / DOWNTOWN PASCO:

- Take Highway 395 south through Pasco, crossing the blue bridge.
- After crossing into Kennewick, keep right at the fork and merge onto WA-240 W
- Take the Columbia Park Trail exit
- Turn left onto Columbia Park Trail
- At the traffic circle, take the 2nd exit onto N. Steptoe St.
- Turn left onto W. Gage Blvd.
- The Center for Excellence in Dermatology building will be on the right (South) side of Gage

DIRECTIONS FROM HERMISTON:

- Take I-82 W/US-395 N toward Kennewick Yakima
- Continue to follow I-82 W
- Take exit 109 for Badger Rd.
- Turn right onto E. Badger Rd.
- At the traffic circle, take the 3rd exit onto Leslie Rd.
- Turn right onto W. Gage Blvd.
- The Center for Excellence in Dermatology building will be on the right (South) side of Gage

DIRECTIONS FROM DOWNTOWN KENNEWICK:

- Head west on W. Clearwater Ave.
- Turn right onto N. Columbia Center Blvd.
- Turn left onto W. Quinault Ave.
- Take slight right toward N. Center Pkwy.
- At the traffic circle, take the 3rd exit onto W. Gage Blvd.
- The Center for Excellence in Dermatology building will be on the left (South) side of Gage

8901 W. Gage Blvd
Kennewick, WA 99336
(509)735-1100

1050 W. Elm Ave, Suite 220
Hermiston, OR 97838
(541) 289-4601

www.drhopp.net
M-Th 8am- 5pm

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& ASSOCIATES

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OFFICE POLICIES

MINORS:

Patients under the age of eighteen (18) are required to have a legal guardian accompany them to **ALL** office visits. Each patient has an individual account at this office. In the case of divorce or separation, the party/parties responsible for the account prior to the separation will remain responsible for the account. After a divorce or separation, the parent authorizing treatment for a minor will be the responsible party for all charges incurred during that office visit. If the divorce decree requires the other parent to pay part/all of the costs, it is the authorizing parent's responsibility to collect monies from that parent.

INSURANCE/BILLING:

Co-pays, deductibles, co-insurance and previous balances are due at the time of your office visit. Private pay patients are expected to pay in full at the time of all office visits. If you have any questions regarding your bill, please ask our receptionists or billing department about our payment plans or financial assistance.

Balances not paid in full within thirty (30) days will be considered delinquent and we reserve the right to transfer the account to our in-house collection department or a third-party collection agency (this may affect your credit score). If your account is turned over to collections, you will need to contact Evergreen Financial Services at (509) 943-2224 to make payment arrangements before you are seen at our office again.

Our office will courtesy bill most insurance companies even if we are not a contracted provider. Insurances that will **not** be courtesy billed include: Any state insurance, DSHS (Washington State Department of Social & Health Services), Community Health Plan of Washington, Care of Oregon or Columbia Community Care.

If you are currently in a "home health episode" and have any lab work done at our office, you may be personally responsible for charges. This office processes all biopsy specimens in-house through a CLIA-certified histology lab. The slides are read and signed by Dr. Robert Hopp, who is a board certified dermatologist with over thirty (30) years of dermatopathology experience. Occasionally, these specimens are sent to a third-party for a second opinion (usually the University of Washington). There is a separate charge generated for this review that is billed by the University of Washington.

INITIALS: _____

CENTER FOR EXCELLENCE IN DERMATOLOGY PLLC

KENNEWICK
8901 W. Gage Blvd
Kennewick, WA 99336

HERMISTON
1050 W. Elm St #220
Hermiston, OR 97838

(509) 735-1100 **Phone**
(855) 525-4677 Toll-free
(509) 735-1180 Fax
www.drhopp.net

ROBERT B. HOPP, M.D.
& ASSOCIATES

CENTER FOR EXCELLENCE IN DERMATOLOGY PLLC

OFFICE POLICIES (PG. 2)

POSSIBLE FEES:

This office reserves the right to add the following charges:

- Returned checks will be charged a $35.00 fee
- Failure to give 24 hours cancellation notice for your appointment will result in a $40.00 fee (Please note: If you are ten (10) or more minutes late to your appointment, this is considered a missed appointment and you may be charged a $40.00 fee. You may be asked to reschedule.)
- Co-pays not paid at the time of service will result in a $15.00 fee (in addition to your co-pay)
- Some cosmetic appointments require a $100.00 deposit. This deposit is non-refundable if you fail to give 24 hours notice to cancel your appointment or if you miss your appointment.

POTENTIAL COMPLICATIONS:

There are potential complications with any medical procedure. Common office procedures include: liquid nitrogen, triamcinolone injections, cantharone application, skin biopsy, skin excision and light therapy. Potential complications include:

- Bleeding
- Infection
- Scarring
- Allergic reaction
- Skin discoloration
- Pain

Please read this agreement in its entirety and notify our staff if you have any questions before signing. You may ask for a copy of these policies from the receptionist. We reserve the right to change our policies at any time.

I hereby give my express, written consent to Center for Excellence in Dermatology PLLC and any of its agents, successors or assignees acting on its behalf to communicate with me regarding my account(s) through various means of communication, including, but not limited to: 1) any cellular telephone number; 2) any landline telephone number; 3) any text or other similar electronic number that I provide. This express consent is given in order to permit Center for Excellence in Dermatology PLLC to more easily communicate with me regarding any issue, including for the purposes of billing, insurance and collection of any outstanding balances.

PRINT PATIENT NAME: _____ ***DATE:*** _____

PATIENT'S SIGNATURE (*NOTE* if patient is under the age of eighteen (18), parent or guardian's signature): _____

CENTER FOR EXCELLENCE IN DERMATOLOGY PLLC

KENNEWICK
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(509) 735-1100 Phone
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(509) 735-1180 Fax
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Notice of Privacy Practices

This notice describes how information about you as a patient of this practice may be used and disclosed and how to access your health information. This is required by the Privacy Regulation created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

The following circumstances may require us to use or disclose your health information:

1. **To provide treatment:** We will use your health information to provide you with the best health care possible. This may include administrative and clinical office procedures to schedule and coordinate your care between medical providers, technicians, nurses, business office staff, pathology laboratories, pharmacies or other health care personnel providing your treatment. It may be necessary to release your test results to a health care provider even when the provider requesting the results did not originally order the tests.
2. **To obtain payment:** We may include your health information with an invoice used to collect payment for treatment you received in our office. We may include your health information with insurance forms filed for you by mail or sent electronically. We will make every attempt to work only with companies with similar commitment to the security of your health information.
3. **To conduct health care operations:** Your health information may be used during performance evaluations of our staff, during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process od certification, licensing or credentialing activities.
4. **Communications:** Because we believe regular follow up is very important to your health, we may remind you of a scheduled appointment or that it is time for you to contact us to make an appointment. These communications may include poscards, letters and telephone reminders. We may share your health information with those you tell us will be helping you with your home treatment, medications or payment. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may request that we contact you at home rather than at work. We will try to accommodate reasonable requests.
5. **Required by law:** We may disclose your health information to public health authorities and health oversight agencies that are authorized by the law to collect information when required to do so by a law enforcement official, lawsuits and similar proceedings in response to a court or administrative order when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public for Workers Compensation and similar programs.

Our patient medical records are kept confidential, secure, and out of reach by unauthorized persons. All reports, consultation and correspondence are reviewed by the physician prior to being filed in the medical records. A written release signed and dated by patient/guardian must be obtained prior to the release of medical record information.

You are entitled to receive a copy of this Notice of Privacy Practices.

I, _____, have had full opportunity to read and consider the contents of your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities, health care operations and laboratory testing.

Signature: _____ **Date:** _____

ROBERT B. HOPP, M.D. & ASSOCIATES

CENTER FOR EXCELLENCE IN DERMATOLOGY™ PLLC

Authorization to Disclose Protected Health Information (PHI)

Patient Name _____ Date of Birth _____

Phone Number _____

I request and authorize the Center for Excellence in Dermatology to disclose the protected health information (PHI) of the above-named patient to the following individual(s):

Name:	Relationship:	Phone Number:
_____	☐ Spouse ☐ Other:_____	_____
Name:	Relationship:	Phone Number:
_____	☐ Spouse ☐ Other:_____	_____
Name:	Relationship:	Phone Number:
_____	☐ Spouse ☐ Other:_____	_____

I understand that I have the right to revoke this authorization at any time. I understand this authorization will remain in effect until a written request to revoke this authorization is received and recorded by the Center for Excellence in Dermatology PLLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for authorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Policy Officer/Compliance Officer.

_____ _____

Signature of Patient or legal representative Date

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PATIENTS WITH MEDICARE: PLEASE READ AND SIGN

Medicare will only pay for services that it determines to be "reasonable and necessary" under section 1862(1)(1) of the Medicare Law. If Medicare determines that a particular service, although it would be otherwise covered, is not reasonable or necessary under Medicare program standards, Medicare will deny payment for that service which does not mean that you should not receive it. There may be a good reason why it is recommended.

Each calendar year Medicare sets a deductible that is the responsibility of the patient. After the year's deductible has been met, Medicare will pay 80% of the allowable charges. If you have a secondary insurance through one of the following companies, you may not be responsible for your deductoble or coinsurance: Premera, Blue Cross, Asuris NW Health, Lifewise, First Choice Health, United Health Care, Uniform Medical, Cigna. Medicare may send your claim on to your secondary insurance, but you must set up this service with Medicare.

Therefore, I agree to be personally and fully responsible for payment. I request that payment of authorized Medicare benefits be made for any services furnished. I authorize any holder of medical information about me to be released to Health Care Financing Administration and its agents for any information needed to determine these benefits payable for related services. I understand that Medicare may pay only the Center for Excellence in Dermatology for reimbursement of charges incurred at this office.

SIGNATURE: _____ **DATE:** _____

PRINT PATIENT'S NAME: _____

RELATIONSHIP TO PATIENT (if signed on behalf of patient): _____