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PORTLAND DERMATOLOGY CLINIC LLP

1414 NW Northrup, Ste 600
Portland, Oregon 97209
**ph**: 503 223-3104
www.portlanddermclinic.com

# Medical Dermatology Welcome Kit

PORTLAND DERMATOLOGY CLINIC LLP

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**Portland Dermatology Clinic, LLP is located in the Machine Works Building, look for the building with the big red stripe! Parking is available on the 5th floor in the parking garage. Enter building's parking garage on 15th and Northrup (between Northrup and Marshall).**

## DRIVING DIRECTIONS

From the North via I-5:

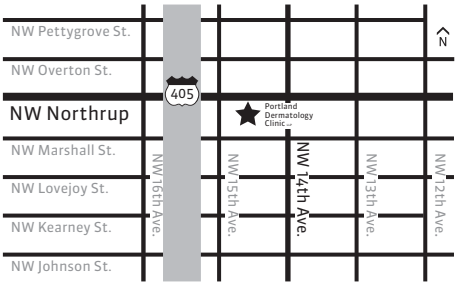
Take Exit 302A toward city center.
Turn slight right onto Broadway.
N. Broadway becomes Broadway Bridge.
Turn right onto NW Lovejoy St.
Take 2nd right onto NW 10th Ave.
Take 2nd left onto NW Northrup St.
1414 NW Northrup St. is on the left.
Turn left on 15th, then left into parking garage.
Park on the **5th** floor and take the elevator
up to the clinic on the **6th** floor.

From the East via I-84

Merge onto I-5 N/US-30W toward Seattle.
Take Exit 302A toward
Rose Quarter/Broadway-Weidler St.
Off ramp becomes NE Victoria Ave.,continue straight
Turn left onto NE Broadway
NE Broadway becomes Broadway Bridge.
Turn right onto NW Lovejoy St.
Take 2nd right onto NW 10th Ave.
Take 2nd left onto NW Northrup St.
1414 NW Northrup St. is on the left.
Turn left on 15th, then left into parking garage.
Park on the **5th** floor and take the elevator
up to the clinic on the **6th** floor.

From the West via Hwy 26

Merge onto I-405 via exit on the left towards
St. Helens/Seattle
Take Exit 2B - Everett St.
Follow the rest of the directions from the
South via I-5

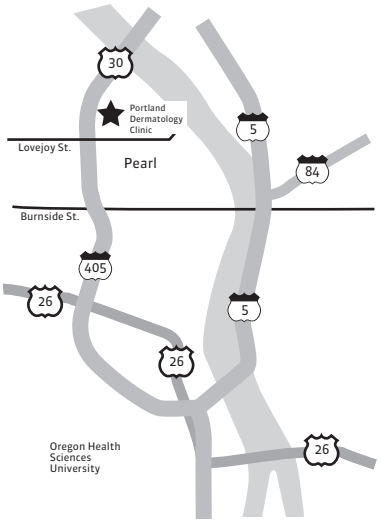



From the South via I-5:

Merge onto I-405 N via Exit 299B on the left,
toward US-26 W/City Center/Beaverton.
Take Exit 2B toward Everett St.
This exit turns into NW 14th Ave.
Take left onto NW Northrup St.
1414 NW Northrup St. is on the left
Turn left on 15th, turn left into parking garage.
Park on the **5th** floor and take the elevator
up to the clinic on the **6th** floor.

From the West via Hwy 30 (St. Helens):

Take Hwy 30 towards SE Santosh St.
Keep right at the fork, follow signs for
I-405 S/ US 26/ Salem and merge onto I-405 S
Take Exit 2B towards Everett St.
Merge onto NW 16th Ave.
Turn left onto NW Everett St.
Take the 2nd left onto NW 14th.
Take left onto NW Northrup St.
1414 NW Northrup St. is on the left
Turn left on 15th, turn left into parking garage
Park on the **5th** floor and take the elevator
up to the clinic on the **6th** floor.



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# MEDICAL DERMATOLOGY HEALTH QUESTIONNAIRE

Name_____ Birthdate _____Preferred nickname, if any _____

How did you hear about us? _____

Referring Physician _____Other referral _____

Primary Care Provider _____ Phone _____

Preferred Pharmacy _____ Phone _____

YOU AUTHORIZE US TO LEAVE VOICEMAIL? Yes ☐ No ☐ PREFERRED MESSAGE PHONE#_____

Your authorized contact(s) name _____ Phone _____

Your authorized contact(s) name _____ Phone _____

All current Medications and Dosage, including Supplements: (please use separate page if needed)_____

_____

**Drug Allergies**: Yes ☐ No ☐ if yes, please list:_____

*Circle any other allergies:* local anesthetics ☐ rubber/latex ☐ tape/bandages ☐ topical antibiotics ☐

Do you take a blood thinner, (aspirin, ibuprofen, Coumadin, Vit E)? Yes ☐ No ☐

If yes, list _____

Do you take antibiotics before dental procedures? Yes ☐ No ☐ If yes, what antibiotic: _____

**SKIN HISTORY:**

Where did you live from ages 0-18? _____

Blistering sunburns? Yes ☐ No ☐ How many? _____

Tanning bed use? Yes ☐ No ☐ How often? _____

History of skin cancer? Yes ☐ No ☐ Type: _____

Family history of skin cancer? Yes ☐ No ☐ Type: _____

History of allergies/asthma/eczema/other skin disease? _____

In family? _____

**SOCIAL HISTORY:**

Do you drink alcohol? _____ drinks/day _____ Do you smoke? _____ packs/day _____

Marital Status: S☐ M☐W☐ D☐ DP☐ Pregnant? Yes ☐ No ☐ If so, what is your due date? _____

Are you breast feeding? Yes ☐ No ☐

Children and ages: _____

Occupation: _____

Hobbies: _____

*For office use only*

Reviewed by/date _____ _____ _____ _____ _____ _____

**-PLEASE COMPLETE BOTH SIDES-**

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| Do you have NOW or in the PAST any of the following? | YES | NO | EXPLAIN |
|---|---|---|---|
| General symptoms (fever, chills, weight change)? | ☐ | ☐ | |
| Diabetes | ☐ | ☐ | |
| Pacemaker or Defibrillator | ☐ | ☐ | |
| High blood pressure | ☐ | ☐ | |
| Heart disease | ☐ | ☐ | |
| Bleeding tendency | ☐ | ☐ | |
| Joint problems or Artificial joint | ☐ | ☐ | |
| Hepatitis or liver disease | ☐ | ☐ | |
| Gastrointestinal disease | ☐ | ☐ | |
| Kidney disease | ☐ | ☐ | |
| Eye or vision problems | ☐ | ☐ | |
| Keloids or abnormal healing | ☐ | ☐ | |
| HIV or other immunodeficiency | ☐ | ☐ | |
| Nerve damage or stroke | ☐ | ☐ | |
| Breathing problems (asthma/emphysema) | ☐ | ☐ | |
| Mental Health disorders | ☐ | ☐ | |
| Leg swelling or varicose veins | ☐ | ☐ | |
| Cold Sores | ☐ | ☐ | |
| Cancer other than skin | ☐ | ☐ | |

Other diseases/conditions/surgeries: _____

_____

_____

_____

Additional Comments: _____

_____

_____

_____

Patient signature _____ Date _____

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PORTLAND DERMATOLOGY CLINIC LLP

# PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

**Patient Name:** _____ DOB: ___/___/___ Date ____/_____/_____

**Receipt of Privacy Practices:**
My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). I have been given the option of signing a separate Patient Consent Form.
May we e-mail you announcements and our newsletter? ☐ Yes ☐ No email: _____

**Patient or Responsible Party Signature** _____ **Date** _____/_____/_____

## FINANCIAL POLICY:

Portland Dermatology Clinic (PDC) is pleased to participate in a large number of different insurance plans. While we are pleased to participate in these plans patient's individual coverage is not verified by our office staff prior to appointments. Patients should contact their insurance companies directly for any coverage questions they may have. Co-pays and deductibles usually apply to office visits and treatments performed at PDC. If the insurance company denies payment or only pays a portion of the medical bill, the patient will be responsible for payment of the remaining balance.

### ____Patients with insurance (not including Medicare):

Patients are asked to bring their current insurance identification card to each appointment. If your insurance information is not received within 1 business day of your appointment, the balance incurred from your visit will be your responsibility and your insurance will not be billed. Co-payments are due at time of service. Patients are responsible for paying insurance deductibles, co-insurance, and any services not covered by insurance.
For patients on insurance plans in which our doctors are not contracted, as a courtesy, we will submit a claim to your insurance company. A down payment of $217 is due at the time of service. **PATIENTS SCHEDULED FOR MOHS SURGERY, please contact our billing department for payment arrangements**. Any additional services will require a payment of 35% of the total bill at the time of service.

### ____Patients without insurance (Private Pay):

Payment is due in full at the time of service. Please note, if you have a procedure your specimen may be sent out for tissue processing which could prompt an additional bill from our preferred laboratory.

### ____Cosmetic Procedures:

Payment for any cosmetic procedure is due at time of service. Certain procedures require a prepayment to hold the appointment. This payment is kept as a deposit and will be applied to the consultation with the doctor.

## Agreement:

I attest that the information I have provided to Portland Dermatology Clinic is correct and true to the best of my knowledge. I hereby assign benefits to Portland Dermatology Clinic, LLP, and authorize them to furnish information regarding my medical condition to my insurance carrier. **I understand that I am responsible for any amount not paid by my insurance per the provisions of my policy. Furthermore, I understand that if payment is returned due to insufficient funds or my account is turned to a collection agency for non-payment, a $25 fee will be assessed. I have read and understand the financial policy and my signature below indicates I accept this policy and agree to abide by the terms for my treatment at the Portland Dermatology Clinic.**

Patient or Responsible Party Signature _____ Date _____/_____/_____

***MEDICARE PATIENTS SEE REVERSE SIDE***

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# Medicare Subscribers

Medicare Payment Policy:

_____We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $147.00 deductible and paying for the 20% copayment. We do file with secondary / supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balanced billed.

**Please sign so we may have your Medicare Authorization on file:**

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare Claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits applies.

Signature: _____ Date: _____/_____/_____

Please sign so we may have your Supplemental Authorization on file:
I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature: _____ Date: _____/_____/_____

Note: If you have recently joined (or changed) to a Medicare Advantage plan, please let our staff know so we can update your records and advise you if we are participating providers.

**Please present Medicare and secondary insurance card(s) and a photo ID to the receptionist so copies may be made.**

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# Notice of Your Right to Decide Participation in Future Anonymous or Coded Genetic Research

The State of Oregon has laws to protect the genetic privacy of individuals. These laws give you the right to decline to have your health information or biological samples used for research. A biological sample may include a blood sample, urine sample, or other materials collected from your body. You can decide whether to allow your health information or biological samples to be available for genetic research. Your decision will not affect the care you receive from your health care provider or your health insurance coverage.

Research is important because it gives us valuable information on how to improve health, such as ways to prevent or improve treatment for heart disease, diabetes, and cancer. Under Oregon law, a special team reviews all genetic research before it begins. This team makes sure that the benefits of the research are greater than any risks to participants.

In anonymous research, personal information that could be used to identify you, like your name or medical record number, cannot be linked to your health information or biological sample. In coded research, personal information that could be used to identify you is kept separate from your health information or biological sample so it would be very difficult for someone to link your personal information to your health information or biological sample. Your identity is protected in both types of research.

**If you want to allow** your health information and biological sample to be available for anonymous or coded genetic research, please check the box below. If you make this choice, your health information or biological sample may be used for anonymous or coded genetic research without further notice to you.

**If you want to decline** to have your health information and biological sample available for anonymous or coded genetic research, **you must complete this form and submit it to your health care provider.**

**Your decision is effective on the date your health care provider receives this form.**

If you have any questions or concerns about this notice, please contact Cathy Palin at: (503) 223-3104.

No matter what you decide now, you can always change your mind later. If you change your mind, tell your health care provider your decision in writing by sending a letter to:

**Portland Dermatology Clinic, LLP**
**1414 NW Northrup Ste 600**
**Portland, OR 97209**

If you change your mind, the new decision will apply only to health information or biological samples collected **after your health care provider receives written notice of your new decision.**

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☐ I decline to have my health information and biological samples available for anonymous or coded genetic research.

☐ I understand that my health information and biological samples are available for anonymous or coded genetic research.

_____ **Printed Name**

_____/_____/_____ **Date of Birth**

**Signature**

_____/_____/_____ **Today's Date**

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