Dermatology & Allergy Specialists of Olympia, PLLC

Main Office: 304 West Bay Dr NW, Suite 301, Olympia, WA 98502
Voice: (360) 413-8760 Fax: (360) 413-8839

3rd Floor Suite 301: Jennifer Winter, PAC Dre Cigliola, PAC
Sarra Vashchenko PAC

2nd Floor Suite 204: Dr. Kaley Myer

Appointment Date: _____ Time: _____ Check-in: 3rd Floor/2nd Floor

Thank you for choosing our Dermatology office! We look forward to making your visit as comfortable and productive as possible. The following steps will help us provide the best use of your time with the provider:

- ***Minor Patients: All minors must be accompanied by a parent/legal guardian at each visit. If not accompanied the appointment may be rescheduled.***
- **Please arrive 15 minutes early so we can register/update your information.**
- **Please provide ALL insurance cards, Picture ID, POA and/or current Provider One card if applicable:**
  - ***Current insurance card/s are required by your insurance company to be presented at every visit to our office. Your appointment will be rescheduled to the next available appointment if you do not present all insurance cards at registration.***
  - *Your insurance company obligates us to maintain a copy of your insurance card in your medical record for the purpose of billing your visit.*
- Please refrain from wearing perfume or colognes to our office. Many of our patients have severe allergies, and as a courtesy to them our office is a "scent free" zone.
- Bring your referral, if required. Your insurance company can tell you if you need a referral; we are unable to contact them for you. If your insurance company requires a referral and one is not provided to us, your appointment will be rescheduled.
- Please be prepared to pay your co-pay at the time of check-in if one is required. We charge a $10.00 fee to bill you later for co-pays.
- Please bring in the containers of any medications or over-the-counter products that you are using to treat the current problem.
- Please read entire packet and completely fill out any forms sent to you before arrival.
- *Individuals seeking treatment are not considered to have been accepted into the practice and formed a provider-patient relationship until they have completed a face-to-face visit with a provider who has completed an evaluation and assessment.*

We recommend you allow plenty of time for your first appointment. This initial visit takes time to register, and we do not want to shorten your time with the provider or have to reschedule your appointment if you are late. Due to the shortage of dermatology providers, your appointment may have been scheduled some time ago, and it may not work with your current schedule. Please call us as soon as you are aware that you need to reschedule. With 48 hours notice, we are happy to reschedule; however the new time might be several weeks later. ***If you fail to keep your appointment without notifying us in advance, you will not be rescheduled again.***

Directions: Please see reverse side →

Office Hours: Monday, Tuesday, Wednesday 7:00 am - 4:30 pm / Thursday 9 am – 4:30 pm / Friday 7:00 am - 4:00 pm
Appt Phones Open: Monday through Thursday 7:30 am – 4:30 pm / Friday 7:30 am – 4:00 pm

Directions to Dermatology & Allergy Specialists of Olympia

TRAVELING SOUTH on I-5, EXIT 105B:
Head west off Exit 105B, down ramp and travel 0.3 mi. Merge onto Plum St SE. Follow Plum St. to State Avenue, approximately 0.6 mi. Turn left onto State Ave NE and go 0.6 mi. Stay to the right and merge onto 4th Ave W and cross the bridge. At the first traffic circle, stay to the right and follow Olympic Way to the second traffic circle. Stay to the right and take the 1st exit on the right: West Bay Drive NW. The office will be one block down on the right.

TRAVELING NORTH on I-5, EXIT 103:
Head down the ramp to Deschutes Way SE and remain on this road as it becomes Deschutes Parkway SW. Continue on Deschutes Pkwy SW along the west side of Capital Lake for 1.8mi. Deschutes Pkwy turns into 5th Ave at the junction with the bridge. Travel for 0.1mi. Turn left on Simmons Street NW. Turn left onto 4th Ave W and cross the bridge. Merge into right lane and at the first traffic circle, stay to the right and follow Olympic Way to the second traffic circle. In the right lane take the 1st exit on the right: West Bay Drive NW. The office will be one block down on the right.

TRAVELING EAST on Highway 101:
Take the Black Lake Blvd exit toward W Olympia. At bottom of ramp turn left onto Black Lake Blvd SW, Travel 1.2mi. Turn right onto Harrison Ave NW and go approximately 0.6mi. As you head downhill, stay in left lane as you enter the traffic circle. Proceed around to the left, merge to the right and take the 2nd exit (right) onto W Bay Drive NW. The office will be one block down on the right.

Parking: During peak time, parking in Dermatology and Allergy's parking lot may be difficult. If space is available there is additional parking along the street on West Bay Drive.
***If you need help with parking or need assistance please call our appointment line at 360-413-8760**

8.11.2023

Dermatology & Allergy Specialists of Olympia

Financial Policy and Assignment of Benefits

We would like to share our financial policies with you. The following outlines our mutual business responsibilities and allows us to provide quality, timely and complete health care.

PLEASE READ ALL INFORMATION CAREFULLY AND ACKNOWLEDGE BY INITIALING IN THE DESIGNATED AREAS. WHEN COMPLETED SIGNATURE IS NEEDED ON BACK PAGE.

Patient: _____

Date of Birth: _____ **MRN #:** _____

Patient Responsibility, you agree to:

- Bring all your current insurance card(s) and picture ID to each visit. You are responsible to provide us with all current insurance information. Failure to provide us with the most current insurance information will result in all charges incurred being patient/legal guardian responsibility.
- I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.
- I understand that any biopsy or specimen collected may be sent to an outside lab. These labs have been chosen for superior quality of slide preparation and the expertise and trusted opinions of the dermatopathologists. I understand that I am responsible for these charges and can contact my insurance company or the billing department at the dermatopathology lab regarding coverage.
- Payment for any co-pays as well as any charges for non-covered services or any outstanding balances are expected to be paid at the time of your visit. Your co-payment will be collected at the time of service. If three consecutive co-pay payments are not made at the time of service, it may lead to a dismissal from our practice. We accept cash, checks, Visa, and Master Card.
- **Contact the Business Office prior to your visit if you have no insurance to make payment arrangements, we will ask that you pay a small deposit prior to being seen of $100 for new patients and $75 for established patients.**

I have read and understand the billing policy _____ (please initial)

- To cancel your appointment please call at least 2 business days in advance. Our business days are Monday through Friday. **We may charge a "missed appointment" fee for the following:**
  - **$50 for Office Visits**
  - **$100 for Procedures**

***Cancellations made after normal business hours may also be subject to cancellation fee**

I have read and understand the cancellation policy _____ (please initial)

- Notify us of a change of address, telephone numbers, employer or insurance.
- Obtain any necessary referrals or authorizations prior to your visit, if your plan requires this to see a specialist.
- Angry or foul language directed at our staff is not tolerated and will be grounds for immediate dismissal from our practice.

SEE BACK PAGE →

Dermatology & Allergy Specialists Responsibility

- Commercial/Government Insurance Patients: If we participate with your plan, we will bill your insurance for you. If we do not participate with your insurance, as a courtesy we will file your claims. Understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. If we do not receive payment from your primary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement, unless other arrangements have been made.

- Medicare Insurance patients: We are participating providers with Medicare and will bill Medicare for all your covered charges. If you have supplemental insurance, we will also bill that for you. If payment is not received from your supplemental insurance within 45 days of being submitted, we may bill you for the balance due. If you do not have a supplemental insurance, your portion (20% of amount allowed by Medicare) may be collected at the time of service, along with charges for non-covered or cosmetic services (you will be asked to sign an Advance Beneficiary Notice form in the event that a service is provided for which we expect Medicare will not pay).

- Collections: We may assess a 1% monthly interest charge on unpaid balance over 30 days old. If we have not received payment in full after 90 days from the date of service, we may refer your account to an outside collection agency where you will be responsible to pay the costs of collection (including court costs and reasonable attorney fees). Any legal action shall be brought and maintained exclusively in a state court of Thurston County, State of Washington and the parties hereby submit themselves to the personal jurisdiction and venue of those courts for the purpose of any such action and hereby waive any defense related to personal jurisdiction, process or venue brought in those courts. If your account is turned over to collections or you have an unpaid balance that is 90 days or older, you may no longer be able to be seen at Dermatology and Allergy Specialists of Olympia, PLLC. A fee of $50 will be charged to any account with a check returned unpaid by the bank.

Remember whether you do or do not have insurance you are financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at (360) 413-8408.

I authorize payment to be made directly to Dermatology and Allergy Specialists of Olympia. I understand any monies paid over and above my indebtedness will be refunded. I understand that whether I sign as patient or responsible party (e.g. parent, legal representative, guarantor), I am directly responsible and will pay for services rendered and not paid by my insurer, and that assignment of benefits under any insurance policy or medical reimbursement plan shall not be deemed a waiver of Dermatology and Allergy Specialists of Olympia's right to require payment directly from me. I understand and agree to adhere to Dermatology and Allergy Specialists of Olympia's financial/credit policy.

I have read and have a full understanding of the financial policy of Dermatology and Allergy Specialists of Olympia, PLLC and agree to these terms therein.

Signature: _____ Date: _____

_____ Relationship to Patient: _____

Print clearly signer's name

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PATIENT INFORMATION AND DEMOGRAPHICS FORM

MRN: _____

1) Patient's Last Name:_________**First Name:**_____ **MI:** _____

Maiden or Alternate Name: _____ Gender: M / F / U

Marital Status: Single / Married / Divorced / Widowed / Legally Separated

Email: _____

Social Security #:___ ___ _ - _____ -_____Date of Birth: _____ /_____ /_____

2) Mailing Address:_____ City:_____

(If mailing address is a **PO Box** please provide physical address for emergencies)

State: _____ Zip Code: _____

****Physical Address**: _____ City: _____

(If same as mailing – write **SAA** (Same As Above))

State: _____Zip code: _____

Home Phone #:_____ Cell Phone #: _____

3) Patient's Employer: _____ **Student:** Yes / No

Work Phone: _____ May we call you at work? Yes / No

4) Guarantor Information: Self / Parent / Spouse / Other: _____
(Please circle the one that applies)

Last Name: _____ First Name: _____ MI: _____

Date of Birth:_____ /_____ /_____ Gender: M / F / U

Mailing Address: _____City: _____

State: _____ Zip: _____ Contact Phone #: _____

Employer: _____ Work Phone #: _____

Social Security #: ___ ___ _ - _____ -_____

5) Who may we contact in case of emergency? Name: _____

Phone #: _____ Relation: _____

6) Primary Care or Referring Physician: _____Phone #: _____

7) Do you have a Power of Attorney? Yes / No If **YES**, please provide a copy to our office.

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

MRN: _____

Due to the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, we must have your written acknowledgement of having had an opportunity to receive and review a copy of our Notice of Privacy Practices.

I, _____, or my Parent/Guarantor/Guardian_____,
(PRINT **PATIENT** NAME HERE) (circle one) (PRINT NAME HERE IF APPLIES)

acknowledge the opportunity to review and receive Dermatology and Allergy Specialists of Olympia, PLLC Notice of Privacy Practices.

OFFICE USE ONLY:

☐ Patient refuses, or is unable to acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Employee Signature Date

Disclosures to Family, Friends, and Clinical Information Calls

We may need to disclose some of your **Private Health Information (PHI) / Billing / Scheduling** with some of your family members or friends. Please read and complete sections 1-3:

1. I agree that this office may disclose my private health information to only the following individuals that are my **family members or friends**
2. For Minors, please include ALL parental or family names to be included in release of information (We are sorry, but due to HIPAA laws if name is not listed, no information can be released) **(PLEASE PRINT).**

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

NAME: _____ RELATIONSHIP: _____

OR:

☐ I do not want my private health information disclosed to any individual asking about me, regardless of whether or not they may be a family member or friend.

2. How would you like us to **communicate with you** regarding clinical information (such as test results and treatment plans or appointments)? Following your visit, we will call and leave a message on the following:

☐ Home Phone (____)_____ ☐ Cell Phone (____)_____

☐ Work Phone (____)_____ ☐ Other (____)_____

3. Appointment Reminders: Please check the preferences for receiving future appointment reminders and combine 2 options (if applicable):

☐ Voice Message (Home/Cell) ☐ Text Message ☐ Email: _____

_____ _____
Signature **Date**

_____
Signers Relationship to Patient (if signed on behalf of the patient)

8.11.2023

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MEDICARE AUTHORIZATION FORM

MRN:_____

This office is required to keep your signature on file authorizing us to file claims to Medicare on your behalf and to release information to that carrier if they require it for the proper consideration of a claim. Please read and sign the following:

_____
Print Patient Name

_____
Medicare Number

I request that payment under the medical insurance program be made either to me or to Dermatology and Allergy Specialists of Olympia, PLLC and its providers on any bills for services furnished to me during the effective period of this authorization. Furthermore, I authorize Dermatology and Allergy Specialists of Olympia, PLLC and its providers to release to the Social Security Administration and the Health Care Financing Administration, their intermediaries, and their carriers, any information needed for this claim, any related Medicare claim, or determination of benefits. Regulations pertaining to Medicare assignment of benefits apply. I further permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

SECONDARY/SUPPLEMENTAL COVERAGE WITH MEDICARE

If you have a supplemental policy to your Medicare Carrier, we are legally required to keep a separate signature on file:

SUPPLEMENTAL AUTHORIZATION

I request that payment under the medical insurance program be made to Dermatology and Allergy Specialists of Olympia, PLLC and its providers on any bills for services furnished to me. Furthermore, I authorize Dermatology and Allergy Specialists of Olympia, PLLC and any holder of medical information to release to my supplemental insurance plan any information needed for this claim, any related claim, or determination of benefits. I further permit a copy of this authorization to be used in place of the original.

Printed Name: _____ Date: _____

Signature: _____

Dermatology & Allergy Specialists of Olympia, PLLC

HEALTH HISTORY FORM

MRN: _____

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

Primary Doctor: _____ Pharmacy/City: _____

Welcome to our Practice!

Please help us get to know you better by filling out the Health History form listed below. (2 sided)

Past Medical History: (circle and date)	Past Surgical History: (circle and date)
• Anxiety • Arthritis: Osteo or Rheumatoid • Asthma • Atrial Fibrillation/Irregular Heartbeat • Bone Marrow Transplant • BPH (prostate) • Breast Cancer: R / L / B • Colon Cancer • COPD • Coronary Artery Disease • Depression • Diabetes • End Stage Renal Disease • GERD (gastroesophageal reflux disease) • Hearing Loss • Hepatitis: A / B / C • Hypertension • HIV/AIDS • Hypercholesterolemia • Lung Cancer • Lymphoma • Prostate Cancer • Radiation Treatment (site): • Seizures • Stroke • Thyroid disease: Hypo or Hyper • Other: (Women) are you pregnant? **NO / YES** Due Date_____	• Appendix • Bladder: (Cystectomy) • Breast Biopsy: R / L / B • Breast Lumpectomy: R / L / B • Breast Mastectomy: R / L / B • Colon: (Cancer, Diverticulitis, IBS, Colostomy) • Gallbladder (Cholecystectomy) • Heart: Mechanical Valve Replacement • Heart: Coronary Artery Bypass • Heart: Transplant • Heart: Biological Valve Replacement • Heart: PTCA • Joint replacement: Hip R / L / B • Joint Replacement: Knee R / L / B • Kidney Biopsy • Kidney Stone Removal • Kidney Transplant • Liver (Hepatectomy) • Liver: Transplant or Shunt • Ovaries: (Cancer or Cyst) • Ovaries: Tubal Ligation • Pancreas: Pancreatectomy • Prostate Biopsy • Prostate Removal (Cancer) • Prostate: (TURP Procedure) • Rectum: ARP • Rectum: Anterior Resection • Spleen (Splenectomy) • Testicles (Orchiectomy) • Uterus: Hysterectomy Fibroids or Cancer • Cervical Cancer • Tonsillectomy • Other:

Staff Initials/Date_____

DERMATOLOGY HISTORY:

(circle and date)

- Acne_____
- Actinic Keratoses (Pre-Cancers)_____
- Blistering Sunburns_____
- Dry Skin_____
- Eczema_____
- Flaking or Itchy Scalp_____
- Hay Fever / Allergies_____
- Atypical moles with treatment dates: _____
- Psoriasis_____
- Rosacea_____

Do you wear sunscreen? NO / YES SPF_____

Tanning Bed history: NO / YES # Years_____

Family History of Serious Skin Cancer: NO / YES
(Basal / Squamous Cell Carcinoma / Melanoma)
FAMILY MEMBER (Type of Skin Cancer)
1. Mother/Father _____

2. Sister/Brother _____

3. Daughter/Son _____

4. Grandmother/Grandfather _____
Other distant family members and type:
1. _____

SOCIAL HISTORY:

Illicit/IV or Recreational Drugs: NO / YES / PAST
Type: _____

Alcohol: NO or
less than 1 drink a day / 1-2 a day / more than 3 a day

Smoker: NO / YES / PAST
Yrs Smoked____Pack(s) Per Day____Year Quit_____

Married / Single / Widow / Divorced / Domestic Partner

Exercise: NO or Daily Weekly Monthly

Caffeine: NO or Daily Weekly Monthly

Occupation: _____

Retired (former occupation): _____

Hobbies: _____

Where did you live as a child and adult? _____

_____

SKIN CANCER HISTORY:

(list date, site, and treatment)
Basal Cell Carcinoma:

1._____

2._____
Squamous Cell Carcinoma:

1._____

2._____
Melanoma:

1._____

2._____

MEDICATION/SUPPLEMENT LIST:

(or attach a printed list)
1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

9._____

10._____

11._____

12._____

MEDICATION ALLERGIES / REACTIONS:

1._____

2._____

3._____

Latex Allergy? NO / YES Reaction:_____

Staff Initials/Date_____

Patient name: _____Date of birth: ___/___/____

(Please print) MRN- _____

Please answer the questions below as it pertains to you.

1. Are you a current smoker? ϒ YES ϒ NO

   If yes, would you like information on how to stop? ϒ YES ϒ NO

2. Have you received an influenza vaccine since October 1st, 2021? ϒ YES ϒ NO

3. For patients **65 years** of age and older,

   Have you ever received a pneumonia vaccine? ϒ YES ϒ NO

   Do you have an advanced care directive **legally documented**? ϒ YES ϒ NO

   If yes, which statement(s) best reflect your wishes on advanced care recommendations?

   ϒ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

   ϒ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.

   ϒ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

   ϒ I have a healthcare proxy. The person's name and contact info are:

   _____

4. If you would like access to our patient portal, please print your email address below. Watch for an email invitation to set your password (you may need to check your junk mail folder).

   My email address: _____