



OLYMPIC DERMATOLOGY & Laser Clinic

Today's Date ____/____/____

Title Mr. Mrs. Ms. Miss

Patient Name _____ Jr. Sr. Prefer to be called _____
Last First Middle

Mailing Address _____ Apt _____ City _____ State _____ Zip _____

Physical Address (if different from above) _____

Home Phone (____) _____ Cell (____) _____ Date of Birth ____/____/____ Age _____ Gender __M__F

Please circle the best phone number to reach you at. Home Cell Work

SS# ____/____/____ Marital Status _____ E-mail (we will not share your information) _____
(or copy of drivers license) To be notified of upcoming specials and newsletters

Employer _____ Work Phone (____) _____ Occupation _____
(If Self employed, name of Business)

Spouses Name _____ Employer _____ Work Phone(____) _____

Spouses Date of Birth ____/____/____ Spouses SS# ____/____/____

Primary Care Physician _____ Phone (____) _____
(If not local, please indicate City, State)

Referred to us by _____ Phone (____) _____

In case of emergency, contact _____ Phone (____) _____
(relationship to patient)

Legal Guardian or Parent Name if patient is under age of 18

Name _____ Sex _____ SS# ____/____/____
Last First M.I. (or copy of Drivers License)

Address _____ City _____ State _____ Zip _____ Birthdate ____/____/____

Home Phone (____) _____ Cell Phone (____) _____ Employer _____ Work Phone _____

INSURANCE INFORMATION (Please complete this section even if you have already presented your insurance card(s) to the office)

I have no insurance I have single coverage I have double coverage

Primary Insurance Name _____

Secondary Insurance Name _____
(IF NO SECONDARY, PLEASE MARK "NONE")

Ins. Address _____

Ins. Address _____

Name of Subscriber _____

Name of Subscriber _____

Subscriber's Date of Birth ____/____/____

Subscriber's Date of Birth ____/____/____

Insured's ID# _____ Group# _____

Insured's ID# _____ Group# _____

Employer Name _____

Employer Name _____

Employer Address _____

Employer Address _____

Employer Phone (____) _____

Employer Phone (____) _____

Relationship of patient to the Insured _____

Relationship of patient to the Insured _____

Please continue on back side, Thank you

Do we have your permission to:

Leave a medical message on your answering machine at home? _____ Yes _____ No
Leave a medical message at your place of employment? _____ Yes _____ No
Discuss your medical condition with any member of your household? _____ Yes _____ No

If yes, whom _____ Relationship _____
And, _____ Relationship _____

To the best of my knowledge, the information on both sides of this form is current and accurate. I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. I understand my portion of the fees are expected at the time of service. Effective January 1, 2008, any balances that aren't paid within 30 days of the 1st statement are subject to 1% per month interest (12% APR). In the event of default of payment and/or failure to pay, I agree to pay the costs of collection including court costs and reasonable attorney fees to be determined by a court of law. (I realize I will be discharged from the practice.) Any unresolved claims will be pursued in Thurston County court system.

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

Printed name if signed on behalf of the patient

Relationship (parent, guardian, personal Rep.)

Office Policies

Olympic Dermatology and Laser Clinic keeps a record of the health care services we provide you. You may ask to see and receive a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information. If you would like a complete copy of the privacy practices please inquire at the front desk.

Our office attempts to remind you of your appointments, but it is strictly a courtesy call.

If medical appointments are missed without cancellation or without 24 hours notice in advance, you may be charged a **\$45.00** fee that will not be billed to insurance. Two occurrences risk the chance of being discharged from the practice.

We understand there **may** be a time when you are unable to keep your cosmetic appointment, but we ask you the courtesy of a phone call for cancellation. Because of the value of your appointment, **you will be charged a \$100.00 fee if you fail to call us within 24 hours of your scheduled cosmetic appointment time.** Extenuating circumstances will be considered if you call the day of your appointment to reschedule.

***Thermage treatments, Laser Resurfacing, Blephoroplasty, Liposuction and Sculptra require full payment at pre-op appointment and is non-refundable.** (Extenuating circumstances may be considered.) All cosmetic procedures require a \$100.00 deposit in order to schedule the appointment.

By my signature below I acknowledge understanding of the Notice of Privacy Practices (if you desire a full copy of the privacy practices please inquire at the front desk) and understand the policies as stated above for Olympic Dermatology and Laser Clinic.

Patient or legally authorized individual signature

Date

Printed name if signed on behalf of the patient

Relationship (parent, guardian, personal Rep.)