Office Policy and Financial Agreement

In the interest of good health care practice, it is desirable to establish an office policy and financial agreement to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that end.

You will be asked to provide our office with your health insurance card (if applicable). If you do not have insurance, you are expected to pay the balance in full at the time of service.

- Insurances will be billed by Oregon Melanoma Center. It is the responsibility of the patient to verify that the office has their correct insurance information and/or to inform the office if there are any changes with their insurance provider, including changes in policy/group number. Remember, an insurance policy is a contract between the patient, the patient's employer or the insurance carrier. ***Ultimately the PATIENT is responsible for the timely payment of their account. All applicable co-pays are due at the time of service.***

- Although we will attempt to call you before your scheduled appointment, this call is only a friendly reminder and patients who schedule their appointment will be expected to keep their appointment whether or not they received a courtesy call by our office. We are happy to reschedule your appointment, if needed; just call our office. However, we *will charge a $50.00 fee for missed appointments and for appointments not canceled within 24 hours.*

I have read this *Office Policy and Financial Agreement* and understand that regardless of any insurance coverage I may have, I am responsible for payment on my account. I agree to pay a $12.00 monthly late fee on patient balances over 90 days. I also understand that delinquent accounts may be assigned to a credit reporting collection service and I will be charged a $50.00 collection fee. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment. There is a $1.00 fee for payments processed via credit card.

I authorize payment directly to Oregon Melanoma Center, PC by the insurance carrier, group or personal benefits or any other insurance otherwise payable to me for medical services rendered by Oregon Melanoma Center. I authorize Oregon Melanoma Center to release any medical information that may be necessary to request claim reimbursement from insurance companies or other payers to whom claims have been submitted, and to release credit information to appropriate information gathering services.

I understand if I do not have insurance, or do not notify the office of insurance in a timely manner, I am responsible for the balance of all charges incurred with Oregon Melanoma Center.

I agree whether I sign as patient or responsible party, which in consideration of the medical services rendered to the patient, I hereby individually obligate myself to pay the account of Oregon Melanoma Center, PC.

Patient Name (Print) Last: _____ First_____ DOB_____

Patient Signature:_____ Date:_____

Patient Name (Print) Last: _____ First_____ DOB_____

OREGON MELANOMA CENTER
(541) 302-6469
ACKNOWLEGEMENT OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received and understand the *Notice of Privacy Practices* that outlines that *Oregon Melanoma Center, PC* may:

- Disclose my information for *treatment purposes and to coordinate my medical care.*
- Disclose my information *to ensure that I receive insurance benefits*
- Disclose my information internally *to enhance the operation of its practice.* This includes Oregon Melanoma Center's commitment to reviewing the quality of care that is provided.
- Disclose my information *to comply with a limited number of legal requirements,* as outlined in the *Notice of Privacy Practices.*

I understand that additional information regarding each of the above disclosures is provided in the full *Notice of Privacy Practices* that has been provided to me on this date, and that only the minimum amount of information necessary will be disclosed for the purpose it was requested.

I understand that I have the right to request a secure copy of my medical records electronically.

_____ _____
Patient Signature **Date**

2. Emergency Contact Name_____Number_____Relationship:_____
☐ Appointment information ☐ Medical and treatment information ☐ Financial information

3. Name_____ Relationship_____
☐Appointment information ☐ Medical and treatment information ☐ Financial information

4. Name_____ Relationship_____
☐Appointment information ☐ Medical and treatment information ☐ Financial information

5. Name_____ Relationship_____
☐Appointment information ☐ Medical and treatment information ☐ Financial information

_____ _____
Patient Signature **Date**

Patient Name (Print) Last:_____ First_____ DOB_____

***Gender:** ☐ Male ☐ Female

Medical History

Last Name	MI	First Name	*DOB	Age	Today's Date
_____			_____	_____	_____

Physical Address:_____ **City/Zip Code**_____

Mailing Address (if different): _____ **City/Zip Code**_____

Referring Provider_____ City/State**:**_____
(please note MD, PA, or DO)

Primary Care Provider_____ City/State**:**_____
(please note MD, PA, or DO)

Pharmacy/Location:_____

Employer Name & Ph Number_____

Why are you here today? (Chief Complaint)

How long has the skin lesion been present? _____

Any similar lesions elsewhere? ☐ Yes ☐ No Has it been changing? ☐Yes ☐No

How long has the change been going on? _____

What symptoms (itching, pain, bleeding, oozing) do you have? _____

Do you have any lumps or bumps elsewhere? ☐ Yes ☐ No

Is your Breathing comfortable? ☐ Yes ☐ No Is your appetite ok? ☐ Yes ☐ No

Any brand new aches or pains? ☐ Yes ☐ No If yes, where?_____

Does your abdomen feel ok?☐ Yes ☐ No Any weight loss of recent? ☐ Yes☐ No

Please list any medical illnesses (ie, Diabetes, Asthma, Heart Problems) _____

_____

Any family history of cancer? If yes, who and what type? _____

_____

***Have you been a smoker?** ☐ Yes ☐ No **If yes, when?** _____

***Alcohol**? _____ **Drinks per day?**_____ **Per week?**_____

Surgery	Reason for Surgery	Year

Do you take any herbal supplements? ☐ Yes ☐ No **If so, what type**?

_____

Are you allergic to iodine? ☐ Yes ☐ No **Are you Claustrophobic?** ☐ Yes ☐ No

***List allergies to any medications**?

_____

Medications

If you have a medication list from your primary care provider, please bring that with you to your appointment. Otherwise, please list the medications (both prescription and over-the-counter) that you are currently taking. Please include strength (ie: "mg") and dosage (ie: "2 tablets twice a day")

MEDICATION	REASON FOR TAKING MEDICATION