

BAKER ALLERGY, ASTHMA & DERMATOLOGY

Be sure to complete both sides

ACCOUNT _____ DATE _____ NEW / UPDATED _____
PATIENT'S FULL NAME _____ BIRTHDATE: _____ SEX: M / F
STREET ADDRESS _____ SOC SEC # _____
CITY/STATE/ZIP _____ DRIVER'S LIC. # _____
OCCUPATION _____ HOME PHONE _____ CELL PHONE _____
EMPLOYER _____ WORK PHONE _____ EXTENSION _____
EMAIL ADDRESS _____ FAX NUMBER _____

SPOUSE/RESPONSIBLE PARTY _____ RELATIONSHIP _____
STREET ADDRESS _____ SOC SEC# _____
CITY/STATE/ZIP _____ HOME PHONE _____
OCCUPATION _____ CELL PHONE _____
EMPLOYER _____ WORK PHONE _____

NEAREST (LOCAL) RELATIVE/FRIEND (NOT LIVING WITH YOU) TO CALL IF WE CANNOT REACH YOU
NAME _____ RELATIONSHIP _____ HM PHONE _____ WK PHONE _____

IMPORTANT: PLEASE COMPLETE ALL INSURANCE INFORMATION AND PROVIDE A COPY OF INSURANCE CARD
PRIMARY INS CO _____ SECONDARY INS CO _____
SUBSCRIBER'S NAME _____ SUBSCRIBER'S NAME _____
SUBSCRIBER'S DATE OF BIRTH _____ SUBSCRIBER'S DATE OF BIRTH _____
ID# / SOC SEC # _____ ID# / SOC SEC # _____
GROUP # _____ EFFECTIVE DATE _____ GROUP # _____ EFFECTIVE DATE _____
SUBSCRIBER'S EMPLOYER _____ SUBSCRIBER'S EMPLOYER _____
As a service to our patients, we will gladly bill your primary and secondary insurance for you with a copy of your insurance card.

PRIMARY CARE DOCTOR _____ PHONE # _____
STREET ADDRESS _____ CITY/STATE/ZIP _____
Does this provider request a report to be sent to him / her? Y / N
HEALTHCARE SPECIALIST _____ PHONE # _____
STREET ADDRESS _____ CITY/STATE/ZIP _____
Does this provider request a report to be sent to him / her? Y / N
How did you hear about us? Yellow pages Sign Insurance Newspaper Website PCP Other
Have you or any of your family members been seen at our clinic? _____ Names _____

CONTACT AUTHORIZATION: I hereby authorize Baker Allergy, Asthma & Dermatology to leave a voicemail regarding visits, and any results needing communicated at the phone number provided below.
Phone: _____
CONTACT AUTHORIZATION: I hereby authorize Baker Allergy, Asthma & Dermatology to send an email regarding visits, and any results needing communicated at the email address provided below.
Email: _____
Signature authorizing the above statement(s): _____
(if patient is a minor, signed by parent or legal guardian)

Updated Information:
Date/Initial _____ Date/Initial _____ Date/Initial _____
Date/Initial _____ Date/Initial _____ Date/Initial _____

Office Use ONLY:
COPAY _____ CLINIC _____ INITIALS _____

BAKER ALLERGY, ASTHMA & DERMATOLOGY

James W. Baker, MD
Diane R. Baker, MD
Amy M. Nolfo, ANP

Mercantile Village - Dermatology
3975 SW Mercantile Dr. Suite 165
Lake Oswego, OR 97035
503-534-2622

Mercantile Village - Allergy & Asthma
3975 SW Mercantile Dr. Suite 158
Lake Oswego, OR 97035
503-636-9011

PATIENTS RESPONSIBILITY FOR PAYMENT

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Baker Allergy, Asthma & Dermatology will submit charges for medical treatment to the patient's insurance company and where applicable, to Medicare. However, the patient is primarily responsible for paying any and all medical expenses incurred at the clinic. **Dr. Diane Baker has opted out of Medicare. This means that our office may not bill Medicare for any services provided by Dr Diane Baker and that you, as a Medicare beneficiary, also agree not to bill Medicare for any services provided by Dr Diane Baker. As a Medicare beneficiary, if you wish to receive dermatological care from Dr Diane Baker you will need to sign a "contract for Medicare beneficiaries" in order for us to provide dermatologic care by Dr Diane Baker.**

Baker Allergy, Asthma & Dermatology does not verify in advance the patients insurance. Patients should contact their insurance companies directly for any coverage questions they may have. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of the account balance. Likewise, if the patient has not met his or her deductible under a given insurance plan, the patient will be responsible for the amount of the deductible and whatever amounts the insurance company does not pay.

If the patient participates in an Oregon Health Plan program, the patient will be responsible for payment of services related to conditions that are not covered by the Plan. If the patient participates in Washington DSHS, the patient will be responsible for all services. Baker Allergy, Asthma & Dermatology does not accept Washington DSHS.

Baker Allergy, Asthma & Dermatology does not treat worker's compensation injuries or illnesses. If the patient is involved in a motor vehicle or liability accident, the patient is responsible for paying all medical costs even if there is a pending lawsuit.

If the patient participates in an HMO or PPO that requires co-payment, the patient must pay the co-payment at the time of the appointment.

Contractual Agreement to Pay Medical Expenses

I understand that I am personally responsible for all medical expenses incurred at Baker Allergy, Asthma & Dermatology for medical care and treatment. I agree to pay all medical expenses within 90 days of the date those expenses were incurred.

Patient Responsibility (Disclaimer)

I understand that my insurance plan _____ can require a referral from my Primary Care Physician in order to cover the visits to a Specialty Physician. If Baker Allergy, Asthma & Dermatology at this time has not received verification that a referral was obtained for services, and, if my insurance company denies payment, I agree that I will be financially responsible for any and all charges incurred (including lab and x-ray).

I hereby assign to Baker Allergy, Asthma & Dermatology any and all insurance benefits due me to the fullest extent of my financial obligation. I authorize them and the physician to release to the insurance company any information acquired in the course of my examination and treatment.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Baker Allergy, Asthma & Dermatology and the above physician to release to the insurance company named above any information acquired in the course of my examination or treatment	ASSIGNMENT OF INSURANCE BENEFITS: I hereby agree to full responsibility for all expenses incurred by or on account of this patient and hereby assign to Baker Allergy, Asthma & Dermatology any and all insurance benefits due me to the fullest extent of my financial obligation to said office.
SIGNED _____ (if patient is a minor, signed by parent or guardian)	SIGNED _____ (if patient is a minor, signed by parent or guardian)

Patient Signature (Parent or Guardian if patient is a minor)

Date

Patient Printed Name

Diane R. Baker, MD
Baker Allergy, Asthma and Dermatology
3975 SW Mercantile Drive, Suite 165
Lake Oswego, OR 97035

NOTICE: PATIENT PRIVACY

We are committed to preserving the privacy of your personal health information. We are required by law to protect the privacy of your medical information and to provide you with notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION

We may use or disclose to others your medical information for the purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

By: _____	Date: _____
(patient)	
OR	
By: _____	Date: _____
(patient representative)	
Description of Representative's Authority: _____	

Diane R. Baker, MD
Baker Allergy, Asthma and Dermatology
3975 SW Mercantile Drive, Ste 165
Lake Oswego, OR 97035

Dr Diane Baker has opted out of Medicare. "Opting out" is not the same as "non-participating". "Opting out" of Medicare means that it is considered fraudulent for patients to seek reimbursement from Medicare for medical services provided by a physician, such as Dr Baker, who has opted out, and it is fraudulent for Dr Baker to bill Medicare for such services.

Medicare beneficiaries seeking medical care from Dr Baker that ordinarily would be covered by Medicare will need to sign the attached payment agreement form for medical services supplied by Dr. Baker.

Cosmetic services are ordinarily not covered by Medicare.

Patients who are receiving cosmetic services are asked to pay on the date of the service. Initial office evaluation for cosmetic procedures is \$250.00. Further charges may apply if procedures are performed on the same day as the initial visit.

I understand the above and agree that payment for services at this office is my responsibility.

Signature _____ Date _____

Print Name _____



Medical History

Date _____ Name _____ DOB _____ Chart _____

1. What skin problems are you here for today?

Past Treatments:

3. What medications are you now taking? (Both prescription and over-the-counter)

Medication	Dose	For what condition	Approx. start date
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

4. What medications are you allergic to?

What other allergies do you have?

5. List any medical conditions

Is there any family history of:

Yes No Specify

Skin Cancer?
 Skin Disease?
 Hypertension?
 Heart Disease?

6. List any surgeries you've had:

Surgery	Date
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_____	_____
_____	_____
_____	_____

7. List any skin cancers you've had:

Skin Cancer(s)	Date(s)	Body Location(s)
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_____	_____	_____
_____	_____	_____
_____	_____	_____

Diane R. Baker, MD
Baker Allergy, Asthma and Dermatology
3975 SW Mercantile Drive, Suite 165
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Skin Care Regime

AM

PM

FACIAL CLEANSER

MOISTURIZER

TREATMENT PRODUCTS
PRESCRIPTIONS (like Retin A)

SUNSCREEN

Acne Surgery:

Informed Consent and Patient Responsibility for Payment

As a part of your acne treatment plan a procedure called acne surgery or comedone extraction has been recommended. This procedure, done in the office during your regularly scheduled appointments, consists of manual removal of acne blackheads or whiteheads (the medical term is “comedones”) and can dramatically shorten the time that it takes to get acne under control.

Our office will bill your health insurance company for this procedure but you should be aware that some insurance policies do not allow for coverage for acne surgery. In that case or if you do not have health insurance you will be responsible for the cost of the procedure (usually \$ 180 per procedure).

It is your responsibility to understand the terms of your insurance prior to the procedure. Any pre-authorizations needed by your insurance company for this procedure must be done, prior to the day of the procedure. For insurance purposes you may need to know the procedure code for acne surgery (CPT Code 10040) and the diagnosis code for acne (ICD-9 706.1).

By signing this form, you give your consent (or consent as a legal representative) for acne surgery and the associated costs.

Signature of Patient

Date

Signature of Legal Representative

Date

CONSENT FORM
STARLUX 1440/1540 FRACTIONATED NON ABLATIVE LASER RESURFACING

1. I understand that fractional non-ablative laser resurfacing is an elective, cosmetic treatment, the purpose of which is to provide a cosmetic skin treatment to improve photo aging skin changes (dyspigmentation, roughness, fine lines or wrinkles) acne scarring or other forms of pigmentation. I understand that the results vary with each individual and that multiple treatments may be necessary.
2. The StarLux fractional laser system delivers precise fractionated pulses of energy that is absorbed by the skin causing a thermal reaction. All personnel in the treatment room, including me, will wear protective eyewear to prevent eye damage.
3. The sensation of the laser is sometimes uncomfortable and may feel like a moderate pinprick or flash of heat.
4. Following the procedure the area may be red and swollen for 2-24 hours. Cold packs may help reduce this swelling.
5. Serious complications are rare, but possible. I understand that expected side effects include: temporary redness and "sunburn" like effects that may last a few hours to 3 days or longer. Other potential side effects include areas of irritation, crusting, blistering, itching, pain, scaling, flaking, bruising, burns, infection, longer-lasting swelling, hives, rash, inflammation, ingrown hairs, and failure to achieve the desired result. I understand that sun or tanning lamp exposure, and not adhering to the after treatment instructions provided to me may increase my chance of complications.
6. I understand there is a rare chance of a skin allergic reaction to the topical numbing anesthetic that may be applied to the skin before treatment. Allergic reaction may cause temporary swelling, itching, rash or hives.
7. I understand that any post-operative follow-up and/or questions should be directed to Dr. Diane Baker or her staff.
8. No photographs or digital images revealing my identity will be used without my written consent. If my identity is not revealed, these photographs and digital images may be used, shared, and displayed for teaching purposes without my permission.
9. Before and after treatment instructions have been discussed with me. The procedure, potential benefits and risks, and alternative treatment options have been explained to my satisfaction. I have read and understood all information presented to me before consenting to StarLux treatment. I have also been given the opportunity to ask questions, I freely consent to the proposed treatment.

Signature: _____ Date: _____

Print Name: _____

Witness Signature: _____ Date: _____