Diane L. Baird, MD P.C./Cheryl Bourgault, MHS, PA-C
360 S Garden Way, Suite 210
Eugene, OR 97401

PLEASE PRINT

MEDICAL HISTORY

Name: _____ DOB: _____ AGE: _____

Reason for today's visit: _____ Primary Care Physician: _____

Have you had problems with the following (**Please circle**)

Skin Cancer:
- **Basal Cell Carcinoma** ☐
- **Squamous Cell Carcinoma** ☐
- **Melanoma** ☐
- **Actinic Keratosis** ☐

Acne ☐
Atypical Moles ☐
Eczema ☐
Psoriasis ☐
High Blood Pressure ☐

Allergies ☐
Asthma ☐
Blood Clots ☐
Depression ☐
Diabetes ☐

Liver Disease ☐
Kidney Disease ☐
HIV ☐
GERD ☐
Heart Disease ☐

Other skin or medical disease: _____

Family History: (List Relationship Maternal/Paternal)

Skin Cancer: _____ Atypical Moles: _____ Diabetes: _____
Melanoma: _____ Psoriasis: _____ Eczema: _____

Current Prescribed Medications including over the counter: _____

_____

List Allergies to Medications: _____

Are you current on you immunization? ☐Yes ☐No

Do you have artificial joint or prosthetic (artificial) heart valves? ☐Yes ☐No

Do you have a pacemaker or implanted defibrillator (AICD)? ☐Yes ☐No

Have you had an organ transplant? Please specify: _____ ☐Yes ☐No

Do you wear sunscreen daily? ☐Yes ☐No

Females: Are you pregnant? ☐Yes ☐No Are you planning on becoming pregnant? ☐Yes ☐No

Have you been told to take antibiotics every time you have dental work or other procedure? ☐Yes ☐No

Do you use Tobacco? ☐Yes ☐No (if yes please specify) Cigarettes ☐ Cigars ☐ Chewing tobacco ☐

Quit Tobacco ☐ (how long ago) _____

Do you drink alcohol? ☐Yes ☐No (if yes # of drinks daily) _____

Do you use recreational drugs? ☐Yes ☐No (if yes, type and frequency) _____

Do you use assistance when walking? ☐Yes ☐No (if yes, type of assistance) _____

Occupation: _____ Who do you live with? _____

Signature: _____ **Date:** _____

Patient/Guardian

Patient Registration (PLEASE PRINT LEGIBLY & COMPLETE ENTIRELY)

Diane Baird, MD, P.C./ Cheryl Bourgault, PA-C Dermatology

Birth Gender: Male/Female **(please circle)** **Gender Identity**: Male/Female **(please circle)**

First Name _____ **Last Name** _____ **Middle Initial** _____

Date of Birth_____ **Social Security #**_____ **Nick Name**_____

Home Address_____ **City**_____ **State**_____ **Zip**_____

Preferred Phone #_____**Home/Mobile** **Secondary #** _____**Home/Mobile**

Primary Care Physician_____ **Referring Provider**_____

Pharmacy Preference & Location_____

Email Address_____ **May we contact you via email?** _____

Patient Portal: Yes/No **(please circle)**

Currently Employed Yes☐ **No**☐ **Retired**☐ **Occupation:** _____

Employer's Name_____ **Work Phone #** _____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Domestic Partner**

Primary Language_____ **Ethnicity: Hispanic or Latino**_____ **Not Hispanic or Latino** _____

Race- (Please check) Caucasian_____ African American_____ Asian_____ Native American/Pacific Islander _____
Native Hawaiian/Pacific Islander_____ Unknown/Undefined_____ Other_____

Emergency Contact: _____ **Phone #** _____ **Relationship** _____

Primary Insurance: _____ **Effective Date:** _____

Medical Claims Address (On Back of card) _____

Member ID# _____ **Group#**_____

Policy Holder Name & Address_____ **D.O.B:** _____

Secondary Insurance: _____

Medical Claims Address (On Back of card) _____

Member ID# _____ **Group#**_____

Policy Holder Name & Address_____ **D.O.B:** _____

THE COPAYMENT IS DUE AT THE DATE OF SERVICE

Assignments of Benefits and Information release: I hereby assign all medical and/or surgical benefits, to which I am entitled to DIANE BAIRD MD, P.C. This assignment remains in effect until revoked by me in writing. A facsimile or photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information necessary to secure payment. I consent to release of information by DIANE BAIRD MD, P.C. and my health insurance and/or payor to DIANE BAIRD MD, P.C., and its employees/representatives to facilitate peer review and of my treatment including utilization and quality management. I understand that DIANE BAIRD MD, P.C. will maintain the confidentiality of this information at all times. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that my medical insurance is a contract between myself and the insurance company and/or my employer. DIANE BAIRD MD, P.C. is not party to said contract. I understand that I am responsible for legal and/or collection fees necessary to settle my account, should it be delinquent.

Signature_____ Date_____

Patient/Guardian

CONSENT TO USE OR DISCLOSE MEDICAL INFORMATION

I authorize the office of Diane Baird, M.D., P.C. to use and disclose the health and medical information of _____ for the purpose of **Treatment, Payment and HealthCare Operations.** (Name of patient)

- **Treatment** (includes activities performed by a physician, nurse, office staff, and other types of health care professionals providing care to you, coordinating or managing your care with third parties, and consultations with and between other health care providers. This consent includes treatment provided by any physician who covers my/our practice by telephone as the on-call physician).

- **Payment** (includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization).

- **Health Care Operations** (includes the necessary administrative and business functions of our office).

You may review the Diane Baird, MD, PC ***"Notice of Privacy Practices"*** for additional information about the uses and disclosures of information described in this CONSENT prior to signing this CONSENT. Please verify that you have been offered a copy of our ***Notice*** by placing your initials here:_____.

(copy available at the front desk)

Because we have reserved the right to change our privacy practices in accordance with the law, the terms contained in the ***Notice*** may change also. A summary of the ***Notice*** will be posted in the lobby of our office indicating the effective date of the ***Notice*** in the right hand corner. We will offer you a copy of the ***Notice*** on your first visit to us after the effective date of the then current ***Notice.*** We will also provide you with a copy of the ***Notice*** upon your request.

As more fully explained in the ***Notice***, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. ***We are not required to agree to your request.*** If we do agree, we are required to comply with your request unless the information is needed to provide you emergency treatment. Other physicians who provide call coverage for our office are required to use and disclose your protected health information consistent with the ***Notice.***

I understand that I have the right to revoke this CONSENT provided that I do so <u>In writing</u>, except to the extent that the office of Diane Baird, M.D., P.C. has already used or disclosed the Information in reliance on this CONSENT.

_____ (or)

(Date) (Signature of patient)

_____

(Date) (Signature of person authorized by law)

Diane Baird MD, P.C./ Cheryl Bourgault, MHS, PA-C

360 S Garden Way, Suite 210

Eugene, OR 97401

Financial Policy

Payment for service is due at the time of service unless other arrangements were made. Should you have any questions, please contact our business office at 541-868-0648. ****** If your insurance requires a referral we do ask that you help us obtain this prior to service or you may be asked to sign a waiver of responsibility and pay in full at time of service.******

Medicare Patients: We participate with Medicare, which means we accept assignment and bill you for the 20% coinsurance, deductible and non-covered charges. We will also bill your secondary or supplement insurance carrier for you. All copayments are due at the time of service provided with your Medicare Replacement insurance(s).

Medical Patients: We will bill LIPA and Oregon Health Plan, however you may be asked to sign a waiver if medical necessity does not meet your insurance criteria and will be asked for payment at the time of service.

Surgery Fees: All copays, deductible and cost-shares are due at the time of service for your surgical procedure unless prior arrangements were made. Please check with your insurance company for your deductible and limitations, **it is your responsibility to know and understand your insurance policies and limitations. Prior authorization may be required.**

Noncovered Services: Any care not paid for by your insurance coverage will require payment in full at the time of service or upon notice of insurance denial.

Yearly Skin Exam Screenings: Periodic preventive skin screening may or may not be covered under your health plan's policy, **please check with your insurance**; however they may be required by your physician.

Past Due Balances: If your insurance does not pay your account in full within 45 days of service, you will be responsible for the balance. If you do not abide by this payment agreement and your balance becomes delinquents, you understand that your account may be forwarded to a collection agency. You agree to pay any collection cost, including attorney fees. You may be charged a late fee of $15 for balances over 90 days unless arrangements have been made with our business office. If you cannot meet this obligation, you agree to pay 25% of the total balance each month unless other payment arrangements have been made with our business office. Payments are due within 10 days of the statement date. Balances on your account maybe requested at your next appointment date unless prior arrangements have been made with our office.

Assignement of Insurance Benefits: I assign medical benefits paid by my insurance carrier(s) to Diane L Baird MD, P.C. for application to my bill. I acknowledge that I will be billed for charges not coverd under my insurance policy.

Release of information: I HEREBY authorize Diane L Baird MD, P.C. to furnish the insurance company(s), employer, other payor(s) or their representatives, of either myself or the subscriber, or to the referring physician, any and all information required to process my claim.

PATIENT NAME:_____ **Date:**_____

Signature of Patient/Responsible party/Guardian: _____

DIANE L. BAIRD, M.D., P.C.
BOARD CERTIFIED IN DERMATOLOGY
CHERYL BOURGAULT, MHS, PA-C
DERMATOLOGY

CHASE GARDEN MEDICAL CENTER
360 S. GARDEN WAY, SUITE 210
EUGENE, OR 97401

Dear Patient,

We have seen a greater number of people not show up for their initial appointments without notifying us of this in advance. Due to these actions, Diane Baird, MD and Cheryl Bourgault, PA-C have put this policy in place:

Any patient who misses his/her initial appointment will need to provide a $75 deposit before another appointment can be scheduled. This deposit is the responsibility of each patient and is not covered by medical insurance. The deposit will be refunded after the patient attends the next scheduled appointment and any outstanding balance is satisfied. However, if a patient provides the deposit and fails to arrive for the appointment; the deposit will not be refunded and the patient will be unable to schedule any more appointments with Diane Baird, MD and Cheryl Bourgault, PA-C.

Diane Baird, MD, Dermatology and Cheryl Bourgault, PA-C

_____ _____

Signature Date

541-683-3202
TOLL FREE: 866-807-4969
FAX: 541-868-1063

Dr. Diane Baird & Cheryl Bourgault PA-C Dermatology
360 S. Garden Way, Suite 210, Eugene, OR 97401
(541) 683-3202 Fax: (541) 868-1063

Family/Friend Information Form
(Verbal Release only)

I, _____ _____
(Print Patient Name) (Patient's Date of Birth)

Hereby authorize Dr. Diane Baird & Cheryl Bourgault PA-C to inform and/or involve the following family members and friends in my care planning. I understand that their participation may include giving information to staff at Dr. Diane Baird & Cheryl Bourgault PA-C regarding my condtion. I also understand that Dr. Diane Baird & Cheryl Bourgault PA-C staff may be sharing verbal information with the family and/or friends listed below about my care plans.

Family and friends:

1. _____ _____ _____
(Relation) (Address/Street) (Phone/Home)

_____ _____
(City/State/Zip) (Phone/Work)

2. _____ _____ _____
(Relation) (Address/Street) (Phone/Home)

_____ _____
(City/State/Zip) (Phone/Work)

3. _____ _____ _____
(Relation) (Address/Street) (Phone/Home)

_____ _____
(City/State/Zip) (Phone/Work)

This consent is good until revoked in writing by the patient.

I understand that information specific to drug and alcohol treatment, psychiatric treatment, AIDS/HIV test information can be release with this consent. I can cancel this at any time, and I understand that the cancellation will not affect any information that was already release before the cancellation.

I understand what this agreement means and I am satisfied with any explanations I may have requested and received.

_____ _____
(Patient Signature) (Date)

_____ _____
(Person authorized to sign) (Relationship) (Date)