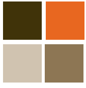


CENTRAL WASHINGTON DERMATOLOGY & COSMETICS, PS
SKIN CARE • SKIN CONCERNS • SKIN DISEASES • COSMETICS

Dear Patient,

You have an appointment scheduled with Jason Berreman, DCNP,
Jenatte Clark, ARNP, Kari Knight, ARNP or Amy Root, ARNP on __________________________ at __________________________. **PLEASE CHECK IN 10 MINUTES PRIOR TO APPOINTMENT.**

We would like to thank you for choosing our clinic for your skin care needs. It is very important to us that your visit be a positive one from start to finish. Enclosed you will find a patient registration packet. ***Please complete and bring it with you to your appointment***. We will also need to make a photocopy of your insurance card and photo ID upon check-in at the clinic.

If you have an insurance company that requires a referral, we request that the referral is in place prior to your visit. Please feel free to contact us if you need assistance with the referral process.

We do ask that all co-pays be made at the time of your visit. We will be happy to bill both your primary and secondary insurance for you. If you are a cash paying patient we request that the balance be paid at the time of your appointment. However, if this will present you with an undue hardship, please contact our office prior to your appointment to set up alternative payment options.

Please note that if the patient is a minor (under the age of 18) a parent or guardian must accompany the patient on the initial visit. At that time, an authorization for continued care will be offered for signature by the parent or guardian.

If the patient is living in an assisted living or requires assistance, they must be accompanied by a nurse or a family member.

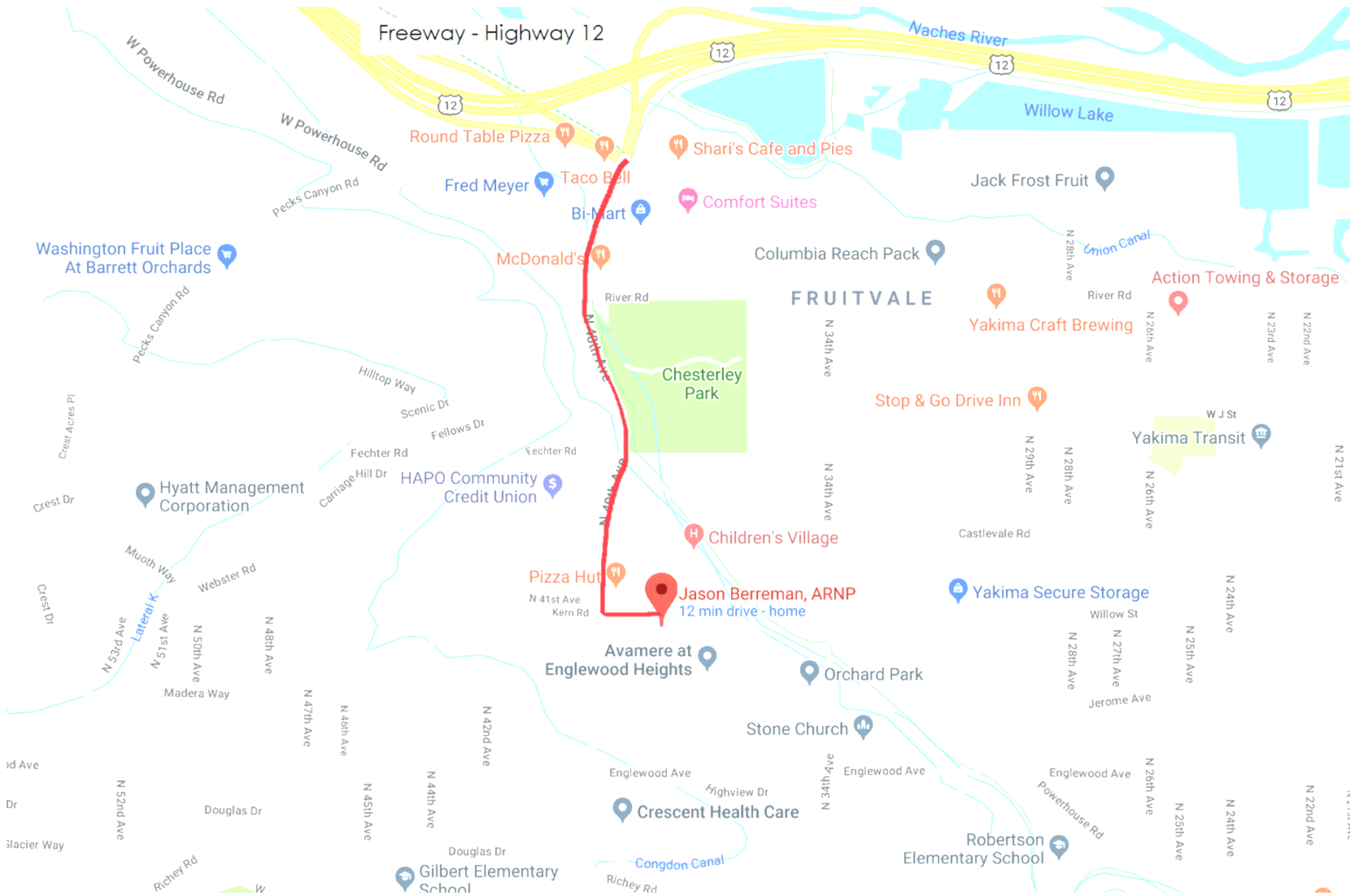
Our clinic is conveniently located off 40th Avenue on Kern Road. For your convenience, a map and directions are included in this welcome packet.

Again, thank you for choosing Central Washington Dermatology & Cosmetics, PS *(formerly known as Jason Berreman, ARNP, PS)* for your skin care needs. Should you have any questions, concerns or need for assistance please contact our office at 509.248.4303. We look forward to meeting you!

3810 Kern Rd. Suite D
Yakima, WA 98902
P 509.248.4303
F 509.469.2441
cwderm.com

DIRECTIONS TO CENTRAL WASHINGTON DERMATOLOGY & COSMETICS, PS

3810 Kern Rd, Suite D, Yakima, WA 98902

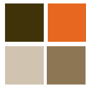


From I-82

Go East on I-82 / US-12 East
Take exit 31 (US-12 West) towards Naches / White Pass
Take the North 40th Avenue Exit
Continue 1.3 miles up 40th Avenue
Turn left on Kern Rd – clinic is the 2nd building on the right

From I-90

Take exit 110 (1-82 East)
Take exit 31 (US-12 West) towards Naches / White Pass
Take the North 40th Avenue exit
Continue 1.3 miles up 40th Avenue
Turn left on Kern Rd – clinic is the 2nd building on the right



CENTRAL WASHINGTON DERMATOLOGY & COSMETICS, PS

SKIN CARE • SKIN CONCERNS • SKIN DISEASES • COSMETICS

PATIENT INFORMATION

Name: ____
Last First MI

Date of Birth: ____ / ____ / ____ Age: ________ Sex: ❐ Male ❐ Female

Last 4 digits of your SSN#: ________

Mailing Address: ____
City State Zip Code

Preferred Phone: ( ) ____________________ OK to leave a message? ❐ yes ❐ no

OK to receive text reminders? ❐ yes ❐ no

Email: ____________________________ OK to receive email reminders? ❐ yes ❐ no

*text and email are only used for appointment reminders, not for provider / patient communication

RESPONSIBLE PARTY *(IF DIFFERENT FROM PATIENT)*

Name: ____
Last First MI

Date of Birth: ____ / ____ / ____

Mailing Address: ____
City State Zip Code

Preferred Phone: ( ) ____________________

If patient is minor, relationship to patient: ❐ mother ❐ father ❐ other

PRIMARY INSURANCE COVERAGE

Insurance Company Name: ____________________ ID #: ____________

Name of policy holder (insured): ______________________________

Policy holder (insured) date of birth: ____ / ____ / ____

Employer: ____________________ Group#: ____________

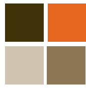
SECONDARY INSURANCE COVERAGE *IF APPLICABLE*

Insurance Company Name: ____________________ ID #: ____________

Name of policy holder (insured): ______________________________

Policy holder (insured) date of birth: ____ / ____ / ____

Employer: ____________________ Group#: ____________



CENTRAL WASHINGTON DERMATOLOGY & COSMETICS, PS

SKIN CARE • SKIN CONCERNS • SKIN DISEASES • COSMETICS

EMERGENCY CONTACT INFORMATION

In case of emergency, who should be notified? ______________________________

Relationship: ______________________ Phone: (   ) ______________________

Primary Care Provider: ____

PERMISSION TO DISCUSS TREATMENT

Who do you give our office permission to discuss your medical information with? Please provide their names and phone numbers below.

Name: ______________________ Phone: (   ) ______________________

Name: ______________________ Phone: (   ) ______________________

Name: ______________________ Phone: (   ) ______________________

RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have received and / or reviewed a copy of this clinic's Notice of Uses and Disclosures of Protected Medical information (Notice of Privacy Practices).

Patient or Responsible Party Signature: ______________________ Date _____ /_____ /_____

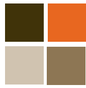
PAYMENT POLICY

Signature below acknowledges you will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier. Signature below authorizes Central Washington Dermatology & Cosmetics, PS and its agent to use all available phone numbers including cell phone to contact the patient and / or guardian.

I authorize Central Washington Dermatology & Cosmetics, PS to release demographic including cell phone numbers, medical or other information about me to the insurance policy that has been given to Central Washington Dermatology & Cosmetics, PS., its intermediaries, or any carrier information needed for this or related insurance claim, including Medicare. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance to be paid to Central Washington Dermatology & Cosmetics, PS.

Patient or Responsible Party Signature: ______________________ Date _____ /_____ /_____

If patient is minor, relationship to patient: ❒ mother ❒ father ❒ other



CENTRAL WASHINGTON DERMATOLOGY & COSMETICS, PS

SKIN CARE • SKIN CONCERNS • SKIN DISEASES • COSMETICS

PERSONAL HEALTH HISTORY

Patient Name: ______________________________ Date: ______________________

Preferred pharmacy: ____

Reason for today's visit: ____

____

MEDICAL HISTORY

Allergies to medications – **check box if no known allergies ❒**

Name of the drug	Reaction you had

Current medications, including over-the-counter drugs, vitamins and supplements

Check box if you are not taking any medications ❒

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

___________________________________ ___________________________________

Any medical problems that other doctors have diagnosed

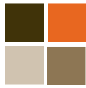
___________________________________ ___________________________________

___________________________________ ___________________________________

Have you ever had any of the following?

	Yes	No	If yes, please explain
Bleeding Problems	❒	❒	
Transplant	❒	❒	
Diabetes	❒	❒	
Heart Disease	❒	❒	
Hepatitis/Liver Disease	❒	❒	
High Blood Pressure	❒	❒	
HIV	❒	❒	
Kidney Disease	❒	❒	

Patient Initials__________



PERSONAL HEALTH HISTORY *CONTINUED*

Have you ever had any of the following? *continued*

	Yes	No	If yes, please explain
Pacemaker	❒	❒	______________________
Artificial Joints	❒	❒	______________________
Skin Cancer	❒	❒	______________________
Thyroid Problems	❒	❒	______________________

Surgeries

Year	Reason
__________	______________________________
__________	______________________________

FAMILY HISTORY

Has anyone in your family ever had:

	Yes	No	Relationship	
Skin Cancer	❒	❒	__________	Type of cancer __________
Psoriasis	❒	❒	______________________	
Other serious medical problems	❒	❒	__________	Description __________

HEALTH HABITS

What is your occupation? ______________________________

	Yes	No	
Do you use a tanning bed?	❒	❒	If yes, how many times per week? __________
Do you smoke?	❒	❒	If yes, how many packs per week? __________
Do you drink alcohol?	❒	❒	If yes, how many drinks per week? __________
Do you use recreational drugs?	❒	❒	

FEMALE PATIENTS ONLY

	Yes	No		Yes	No
Are you pregnant?	❒	❒	Using contraceptives?	❒	❒
Breastfeeding?	❒	❒	Trying to get pregnant	❒	❒

COSMETIC CONCERNS *OPTIONAL*

Some of our patients have concerns about the appearance of their skin. If you would like to discuss any of the following with your provider, please check below.

Lines and wrinkles	❒	BOTOX® / Dysport®	❒
Sun damage	❒	Discoloration	❒
Age spots	❒	Clear & Brilliant Laser®	❒
Juvederm® / Restylane®	❒	CoolSculpting®	❒

Other: ____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in our medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.
Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after, authorizing a use or disclosure of you information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information the occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send your appointment reminders. These will include recall letters to notify you of the need to schedule an appointment, telephone calls to remind you of an appointment.

Individual Rights

You have certain rights under the federal privacy standard. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Central Washington Dermatology and Cosmetics, PS Duties

We are required by law to maintain the privacy of your personal health information and to provide you with this notice of privacy practices.
We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contracting our *Medical Records Clerk* or *Clinic Manager*. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Clinic Manager
Central Washington Dermatology and Cosmetics, PS
3810 Kern Road, Suite D
Yakima, WA 98902

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you may contact for further information concerning our privacy practice is:

Clinic Manager
Central Washington Dermatology and Cosmetics, PS
3810 Kern Road, Suite D
Yakima, WA 98902

Effective Date
This notice is effective on or after August 1, 2019