



JAMES L. BRAZIL, M.D.

Olympic Dermatology & Laser Clinic, P.S.

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360.459.1700 - voice 360.459.0537 - facsimile

PATIENT INFORMATION (Please Print & Complete ALL areas)

Today's Date ____/____/____

Name _____ Prefer to be called _____
Last First M.I.>

Mailing Address _____

Home Phone (____) _____ Cell Phone (____) _____ SS# ____/____/____ Marital Status _____
CITY STATE ZIP

Date of Birth ____/____/____ Age ____ Sex ____ Employer _____ Work Phone (____) _____

If Student ____ full time ____ part time Name of School _____

Primary Care Physician _____ Phone (____) _____

Referred to us by _____ Phone (____) _____

In the event of an emergency, please contact _____ Phone (____) _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____ Sex ____ SS# ____/____/____
Last First M.I.

Address _____ Birthdate ____/____/____
City State Zip

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

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

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 _____

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 _____

To the best of my knowledge, the above information 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. 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. 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.)

OVER→

Office Policies

Olympic Dermatology and Laser Clinic keeps a record of the health care services we provide you. You may ask to see and copy 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. You may see your record or get more information about it by contacting the Office Manager.

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. We are happy to provide you with a complete copy if you desire.

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

We understand there *may* be a time when you are unable to keep your 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 and Sculptra require full payment within one week of appointment and is non-refundable.** (Extenuating circumstances may be considered.) All cosmetic procedures require a \$100.00 deposit in order to schedule the appointment.

If two medical appointments are missed without cancellation or without 24 hours notice in advance, you will be charged a **\$45.00** fee that will not be billed to insurance.

By my signature below I acknowledge having been offered a copy of the Notice of Privacy Practices 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.)

(Notation, if any, by staff)