Skin & Allergy Center

Ben Hayes, MD Chris Robb, MD Ryan Sullivan, MD
Kelly Taylor, NP Brenda Sanchez, NP Sheri Chapman, NP Amanda Amick, PA-C Angela Higgins, PA-C

FINANCIAL POLICY

Your Signature below forms a binding agreement between Spring Hill Dermatology, PLC (provider of medical services) and the Patient who is receiving medical services, or the Responsible Party for minor patients (those under 18 years old). Responsible Party is the individual who is financially responsible for payment of medical bills.

All charges of services rendered are due and payable at the time of service.

The person signing on behalf of the patient as the Responsible Party must:

- Inform Spring Hill Dermatology, PLC of the current address and phone number for the patient and the responsible party.
- Present all current insurance cards prior to each office visit.
- Verity at each visit that the information is current upon check in for appointment.
- Pay any required co-pay at the time of visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When Spring Hill Dermatology, PLC receives an explanation of benefits (EOB) from your insurance company, any amounts that you need to pay will be billed to you.)

All specimens are either sent to our in-house lab with Dermatopathologist, Benjamin B. Hayes, MD PhD or sent for pathology testing to an outside laboratory such as PCA Southeast or Pathology Associates of Saint Thomas, LLC. Neither of these groups are affiliated with Spring Hill Dermatology, PLC and you may receive a separate bill.

Return Check Policy:
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NSF), Account Closed (AC), or Refer to Maker (RTM), the Patient or patient's Responsible Party will be responsible for the original check amount in addition to a $25.00 service charge. Once notice is received of the returned check, Spring Hill Dermatology, PLC will send a new statement reflecting the returned check and service charge. If a response is not made within 15 days from the letter date by the Patient or Responsible Party, the account may be turned over to our collection agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 returned check service charge.

Non-Payment on Account:
Should collection proceedings or other legal actions become necessary to collect an overdue account, the Patient or patient's Responsible Party, understands that Spring Hill Dermatology, PLC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for services rendered. The Patient, or patient's Responsible Party, understands that they are responsible for all cost of collections including, but not limited to, court cost and Attorney fees, and a collection fee will be added to the outstanding balance.

By signing below, you agree to accept full financial responsibility as a Patient who is receiving medical services, or as the Responsible Party for minor patients. Your signature verifies that you have read the above disclosure statement, understand your responsibilities, and agree to these terms.

Patient Name (Please Print): _____

Patient Signature: _____ **Date:** _____

Responsible Party Name (Please Print): _____

Responsible Party Signature: _____ **Date:** _____

Skin & Allergy Center: New allergy patient form

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Name: _____ Chart #: _____ Date: _____

Location of allergies: Nose { } Eyes { } Skin { } Throat { }

Are you currently experiencing any of the following symptoms?

	Yes	No
Abdominal pain		
Coughing		
Diarrhea		
Drainage down the throat		
Headaches		
Itchy Eyes		
Nasal Congestion		
Nasal Drainage		
Runny Nose		
Shortness of breath		
Skin rash		
Sneezing		
Snoring		
Vomiting		
Watery Eyes		
Wheezing		
Other:		

When do these symptoms occur? Spring { } Summer { } Fall { } Winter { } All the time { }

What best describes your symptoms? Coming and going { } Constant { } Worse at night { }

Symptoms are made worse by:

Cats		Food	
Cigarette smoke		Hot Weather	
Cleaning		Infections	
Cold weather		Mowing grass	
Colds		Perfumes	
Damp areas		Weather Changes	
Dogs		Windy days	
Dusting		Other:	

How severe are your symptoms?

Mild { } Moderate { } Severe { }

How long have you had allergy symptoms? _____

Current Exposures:

Air Cleaners		Down comforters	
Air conditioning		Feather Pillows	
Baseboard heat		Forced air heat	
Birds		House Plants	
Carpeting		Humidifiers	
Cats		Mold Growth	
Cigarette smoke		Other pets	
Damp baseboards		Roaches	
Dogs		Other:	

Do you have a history of any of the following?

Asthma	
Bee sting reactions	
Frequent ear infections	
Frequent sinus infections	
Pneumonia	
Previous allergy test	
Previous allergy shots	

Previous allergy or asthma medications (including OTC):

_____ Helped { } No help { } Drowsy { } Jittery { }

_____ Helped { } No help { } Drowsy { } Jittery { }

_____ Helped { } No help { } Drowsy { } Jittery { }

_____ Helped { } No help { } Drowsy { } Jittery { }

_____ Helped { } No help { } Drowsy { } Jittery { }

SKIN & ALLERGY CENTER

CHART #_____

Name, Last:_____ First :_____MI: ____ DOB:_____SSN:_____

Address:_____ City:_____ ST: _____ Zip:_____

Sex: M / F Race/Ethnicity: _____ Primary Language Spoken:_____

Referring Physician: _____ Employer/Occupation:_____

Phone Numbers	YES	NO	
Home:_____	□	□	Please put an "X" in the box to let us know if our office
Work:_____	□	□	may leave message with personal information, such as
Cell:_____	□	□	biopsy or lab results.

Local Pharmacy Information: Name: _____ City: _____ Phone: _____

To activate your secure, HIPAA compliant electronic patient portal, we need your E-mail: _____

Interested in our electronic newsletter for specials/upcoming events: □ Yes □ No How did you hear about us?_____

Consent to disclose health information: I have been shown and have read Skin & Allergy Center's "Notice of Privacy Practices." I hereby authorize the office of Skin & Allergy Center to report any related health information to my insurance carriers and referring/consulting doctors. Furthermore, I give permission to discuss lab results or medical conditions with those listed below. _____ **Initials**

Family/Friend with whom we are allowed to discuss **Medical results**: _____ **Billing information**: _____

Responsible Party:

Name, Last _____ First _____ DOB_____ SSN# _____

Address _____ City _____ ST _____ Zip _____ Best Phone: _____

Emergency Contact Information

Name: _____ Relationship:_____ Phone:_____

Primary Insurance Company Name: _____

Policy Holder: _____ Relationship to Policy Holder: _____

Policy Holder's Employer: _____ DOB: _____ SSN: _____

Claims Address: _____ COPAY: $_____ (if known)

Group No:_____ ID / Policy No: _____ Circle: PPO HMO POS EPO

Secondary Insurance Company Name: _____

Policy Holder: _____ Relationship to Policy Holder: _____

Policy Holder's Employer: _____ DOB: _____ SSN: _____

Claims Address: _____ COPAY: $_____ (if known)

Group No:_____ ID / Policy No: _____ Circle: PPO HMO POS EPO

Assignment of Benefits: *I hereby assign all medical and/or surgical benefits, to which I am entitled, from private insurance or any other health plans to Skin & Allergy Center. Co-pays as mandated by your insurance or full payment (self-pay) are required at the time service is provided. HMO patients are responsible for obtaining the necessary referrals prior to appointments. Unauthorized services will be the responsibility of the patient. Should your insurance carrier require you to use a specific ancillary facility, you must inform the front desk or nursing staff prior to being seen by a provider. Failure to do so may result in charges billed directly to you. We file insurance claims for related care with your insurance carrier. A copy of your insurance card and signed authorization is required. Any remaining balance after insurance payment is your responsibility. I authorize the release of any medical information necessary to process an insurance claim. I agree to be responsible for payment of services not covered by insurance. I authorize payment of medical benefits to the physician or supplier of services.*

Patient/Guardian Printed Name: _____

Patient/Guardian Signature: _____ **Date**:_____