



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 patient form

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Name: _____

Chart #: _____

Past Medical History: (Circle all that apply)

- | | | |
|-----------------------------|-------------------------|----------------------|
| Anxiety | Coronary Artery Disease | Hyperthyroidism |
| Arthritis | Depression | Hypothyroidism |
| Artificial Joints | Diabetes | Leukemia |
| Asthma | End Stage Renal Disease | Lung Cancer |
| Atrial Fibrillation | GERD (reflux disease) | Lymphoma |
| Benign Prostate Hypertrophy | Hearing Loss | Prostate Cancer |
| Bone Marrow Transplant | Hepatitis | Radiation Treatments |
| Breast Cancer | HIV/AIDS | Seizures |
| Colon Cancer | High Blood Pressure | None |
| COPD | High Cholesterol | |

Other: _____

Past Surgical History: (Circle all that apply)

- | | |
|--|--|
| Appendix Removed | Kidney Biopsy |
| Bladder Removed | Kidney Removed (Right, Left) |
| Mastectomy (Right, Left, Bilateral) | Kidney Stone Removal |
| Lumpectomy (Right, Left, Bilateral) | Kidney Transplant |
| Breast Biopsy (Right, Left, Bilateral) | Ovaries Removed: Endometriosis |
| Breast Reduction | Ovaries Removed: Cyst |
| Breast Implants | Ovaries Removed: Ovarian Cancer |
| Colectomy: Colon Cancer Resection | Prostate Removed: Prostate Cancer |
| Colectomy: Diverticulitis | Prostate Biopsy |
| Colectomy: IBD | Transurethral resection of the Prostate |
| Gallbladder Removed | Skin Biopsy |
| Coronary Artery Bypass | Basal Cell Cancer Surgery |
| Angioplasty (PTCA) | Squamous Cell Cancer Surgery |
| Mechanical Valve Replacement | Melanoma Surgery |
| Biological Valve Replacement | Spleen Removed |
| Heart Transplant | Testicles Removed (Right, Left, Bilateral) |
| Joint Replacement, Knee (Right, Left, Bilateral) | Hysterectomy: Fibroids |
| Joint Replacement, Hip (Right, Left, Bilateral) | Hysterectomy: Uterine Cancer |
| Joint Replacement within last 2 years | None |

Other: _____

Skin Disease History: (Circle all that apply)

- | | | |
|------------------------|------------------------|---------------------------|
| Acne | Eczema | Precancerous Moles |
| Actinic Keratosis | Flaking or itchy scalp | Psoriasis |
| Basal Cell Skin Cancer | Hay Fever / Allergies | Squamous Cell Skin Cancer |
| Blistering Sunburns | Melanoma | None |
| Dry Skin | Poison Ivy | |

Other: _____

1229 Reserve Blvd, Ste 200

100 Blythewood Dr, Ste A

1970 Medical Center Pkwy, Ste K

Spring Hill, TN 37174

Columbia, TN 38401

Murfreesboro, TN 37129

phone 615-302-5000

phone 931-381-1920

phone 615-624-5050

fax 615-302-5006

fax 931-381-4294

fax 615-624-5056

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 officeWork: _____ may leave message with personal information, such asCell: _____ 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:** _____