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.
- Verify at each visit that the information is current upon check in for appointment.
- Pay any required co-pay at the time of the visit.
- Pay any additional amount owing within 30 days of receiving a statement from our office. (When Spring Hill Dermatology, PLC receives and 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 return check, Spring Hill Dermatology, PLC will send a new statement with a new 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 collections agency and a collection fee will be added to the outstanding balance – in addition to the $25.00 Check Service Charge.

Non-Payment on Account:
Should collection proceedings or other legal actions become necessary to collect an overdue account, the patient or the 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 the 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: ______________

Columbia
100 Blythewood Drive
Columbia TN 38401
931-381-1920
Fax: 931-381-4294

Murfreesboro
1970 Medical Center Pkwy
Murfreesboro TN 37129
615-624-5050
Fax: 615-624-5056

Spring Hill
3098 Campbell Station Pkwy
Spring Hill TN 37174
615-302-5000
Fax: 615-302-5006
Skin & Allergy Center: New patient form

Name: ____________________________________________  Chart# ________________

Past Medical History: (Circle all that apply)

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

Other: ____________________________________________

Past Surgical History: (Circle all that apply)

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

Other: ____________________________________________

Skin Disease History: (Circle all that apply)

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

Other: ____________________________________________
Do you wear sunscreen?  Yes  No  If yes, what SPF?____
Do you tan in the tanning salon?  Yes  No
Do you have a family history of Melanoma?  Yes  No  If yes, who?________________

**Medications:** (please list all of your medications)
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

**Medication allergies** (please list all medication allergies)
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

**Social History:** (please circle all that apply)

<table>
<thead>
<tr>
<th>Alcohol Use</th>
<th>If yes how often?______________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Currently smokes</td>
<td>Has smoked in the past?</td>
</tr>
<tr>
<td>Do you exercise?</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Caffeine intake</td>
<td>Yes  No</td>
</tr>
<tr>
<td>Occupation</td>
<td>_______________________________</td>
</tr>
</tbody>
</table>

Are you currently experiencing any of the following?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problems with bleeding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problems with healing</td>
<td></td>
<td></td>
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<tr>
<td>Problems with scarring</td>
<td></td>
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<tr>
<td>Rash</td>
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<tr>
<td>Allergy to adhesive</td>
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<tr>
<td>Allergy to lidocaine</td>
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<tr>
<td>Allergy to topical antibiotic ointments</td>
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<tr>
<td>Artificial heart valve</td>
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<td>Artificial joints within the past two years</td>
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<tr>
<td>Blood thinners</td>
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<tr>
<td>Defibrillator</td>
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<td>MRSA</td>
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<tr>
<td>Pacemaker</td>
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<tr>
<td>Premedication to procedures</td>
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<tr>
<td>Rapid heartbeat with epinephrine</td>
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<td></td>
</tr>
<tr>
<td>Pregnancy or planning a pregnancy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Name, Last: ________________  First: ______________ MI: __ DOB: ___________ SSN: ____________

Address: __________________________  City: __________________________  ST: __________ Zip: __________

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

Referring Physician: __________________________  Employer/Occupation: __________________________

Phone Numbers

Home: __________________________  □   □  Please put an "X" in the box to let us know if our office may leave message with personal information, such as biopsy or lab results.

Work: __________________________  □   □

Cell: __________________________  □   □

Local Pharmacy Information:

Name: __________________________  City: __________________________  Phone: __________

To activate your secure, HIPPA 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.

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

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 Signature: __________________________  Date: __________________________