Skin & Allergy Center

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

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 in 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, PL:C 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:** ____________

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
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)
Alcohol Use If yes how often?_________________________________

Currently smokes Has smoked in the past? Drug Use

Do you exercise? Yes No If yes, how often?____________

Caffeine intake Yes No If yes, how much?____________

Occupation____

Are you currently experiencing any of the following?

	Yes	**No**
Problems with bleeding		
Problems with healing		
Problems with scarring		
Rash		
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointments		
Artificial heart valve		
Artificial joints within the past two years		
Blood thinners		
Defribillator		
MRSA		
Pacemaker		
Premedication to procedures		
Rapid heartbeat with epinephrine		
Pregnancy or planning a pregnancy		

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, 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**:_____________________