Skin & Allergy Center
Ben Hayes, MD Chris Robb, MD Ryan Sullivan, MD Tammie Campanali, 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.

MEDICAL INSURANCE: We have contracts with many insurance companies, and we bill them as a service to you. **As the responsible party, you are responsible if any insurance company declines to pay for any reason.**

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 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 a Dermatopathologist, Benjamin Hayes, MD 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.

Returned Check Policy:
If a payment is made on an account by check, and the check is returned as Non-Sufficient Funds (NFS), 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 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 action 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 costs of collection including, but not limited to, court costs 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:** _____

Spring Hill
3098 Campbell Station Parkway
Suite 201
Spring Hill TN 37174
Phone (615) 302-5000
Fax (615) 302-5006

Murfreesboro
1970 Medical Center Parkway
Suite K
Murfreesboro TN 37129
Phone (615) 624-5050
Fax (615) 624-5056

Columbia
854 West James Campbell Boulevard
Suite 404
Columbia, TN 38401
Phone (931) 381-1920
Fax (931) 381-4294

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 Discharge		
Runny Nose		
Shortness of Breath		
Skin Rash		
Sneezing		
Snoring		
Vomiting		
Watery Eyes		
Wheezing		
Other		
Does not Apply		

See reverse side ——>

WHEN DO THESE SYMPTOMS OCCUR:

Spring [ ] Summer [ ] Fall [ ] Winter [ ] All the time [ ]

WHAT BEST DESCRIBES YOUR SYMPTOMS?

[ ] coming and going
[ ] constant
[ ] worse at night
[ ] other

SYMPTOMS ARE MADE WORSE BY:

[ ] Cats
[ ] Cigarette smoke
[ ] Cleaning
[ ] Cold weather
[ ] Colds
[ ] Damp areas
[ ] Dogs
[ ] Dusting
[ ] Food
[ ] Hot weather
[ ] Infections
[ ] Mowing grass
[ ] Perfumes
[ ] Weather changes
[ ] Windy days

HOW SEVERE ARE YOUR SYMPTOMS?

[ ] mild [ ] moderate [ ] severe

HOW LONG HAVE YOU HAD ALLERGIES?

_____

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?

Yes	No	
[ ]	[ ]	Asthma
[ ]	[ ]	Bee sting reactions
[ ]	[ ]	Frequent ear infections
[ ]	[ ]	Frequent sinus infections
[ ]	[ ]	Pneumonia
[ ]	[ ]	Previous allergy shots
[ ]	[ ]	Previous allergy testing

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

Personal Information: DOB: ___ /___ /___

Last Name: _____ First: _____ MI: _____ SSN: _____-_____-____

Address: _____City: _____ ST: ____ Zip: _____

Sex: M / F Race//Ethnicity:_____ Language: _____ Employer/Occupation: _____

Referring Physician: _____ How did you hear about us? _____

Phone Numbers:	**YES**	**NO**
Home: _____	☐	☐
Work: _____	☐	☐
Cell: _____	☐	☐

Please put an "X" in the box to let us know if our office may leave messages with personal information, such as lab results.

Would you like to receive our e-mail newsletter or special offers? E-mail: _____

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): _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone: _____

Primary Insurance Company: _____

Policy Holder: _____ Relationship to Policy Holder: _____

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

Claims Address: _____

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

Secondary Insurance Company: _____

Policy Holder: _____ Relationship to Policy Holder: _____

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

Claims Address: _____

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

Pharmacy Information: Name: _____City: _____ Phone: _____

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. Payments or co-pays are required at the time of service is provided. HMO participants 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 specific ancillary facilities, you must inform your nurse. Failure to do so may result in charges 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 for services not covered by insurance. I authorize payment of medical benefits to the physician or supplier of service.

Patient/Guardian Signature: _____ Date: _____