Patient Information
for
SPRINGHILL DERMATOLOGY CLINIC, P.C.

ADULT FORM

PLEASE PRINT

A. Patient's Name _____ Date of Birth _____ Sex _____
(Last) (First) (Middle Initial)

Address _____
(Street) (City) (State) (Zip Code)

If Living in an Apartment: Name _____ Apt. # _____

If Using a Post Office Box: Do you have a street address @ residence: If so, please identify: _____

Marital Status _____ Home Phone # _____ Cell Phone # _____ Social Sec. # _____

Employed by _____ Business Phone # _____

Address _____ Occupation _____

Name of Insurance Carrier _____ Contract Number _____

Secondary Insurance _____ Contract Number _____

B. Spouse's Name _____ Date of Birth _____
(Last) (First) (Middle Initial)

Social Sec. Number _____

Employed by _____ Business Phone # _____

Address _____ Occupation _____

Name of Insurance Carrier _____ Contract Number _____

C. Patient's Nearest Relative and Address (Nearest Relative Not Living At Same Address As Patient) _____

Name of Primary Physician _____

Name of Referring Physician _____ City _____

ALLERGIES: Are you allergic to any medication? _____ Yes _____ No. If yes, list medication and the reaction you had to them: _____

MEDICATIONS: List all medications that you take on a regular or every-once-in-a-while schedule (include aspirin, headache remedies, laxatives, birth control pills and all prescription medicines).

REASON FOR SEEING DOCTOR TODAY? _____ Age _____

Has your lesion (skin cancer) been treated before? _____

AUTHORIZATION OF BENEFITS

"I hereby authorize any payment due on my claim to be paid directly to Springhill Dermatology Clinic, P.C."

Legal Signature Date

(Please complete other side)

FAMILY HISTORY

Do any disorders, diseases, or health problems run in your family?

_____ Yes _____ No

If yes, what: _____

_____

Are you pregnant? _____ Yes _____ No

Do you have any of the following:

_____ Asthma/Hayfever _____ Diabetes

_____ Melanoma/Skin Cancer _____Hepatitis

_____ Multiple Allergies _____ Dry, Sensitive Skin

_____ Infantile eczema _____ Severe acne

_____ Sinus trouble _____ Tuberculosis

OPERATIONS: List and indicate year: _____

_____

_____

_____

_____

HEART PROBLEMS: _____

_____

any other health problems: _____

_____

_____

_____

_____

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Springhill Dermatology Clinic, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Springhill Dermatology Clinic, P.C. Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Springhill Dermatology Clinic, P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Springhill Dermatology Clinic, P.C., Privacy Officer at, 4300 Old Shell Road, Mobile, Alabama 36608.

With my consent, Springhill Dermatology Clinic, P.C., its employees, and its computerized calling service may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such an appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Springhill Dermatology Clinic, P.C. may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and healthcare operations (TPO), such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Springhill Dermatology Clinic, P.C.'s use and disclosure of my protected health information (PHI) to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, Springhill Dermatology Clinic, P.C. may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

Springhill Dermatology Clinic, P.C.

Authorization for Release of Medical Information, Assignment of Benefits, Patient Financial Responsibility, Signature on File

Patient's Names: (Print)_____

Release of Information:

I Hereby authorize the release of all medical information necessary to process my insurance claims, insurance applications and Prescriptions. I authorize the release of my medical information to my primary care and/or referring physician and to consultants if needed.

Assignment of Benefits:

I Hereby authorize payment of medical benefits to Springhill Dermatology Clinic, P.C. under all insurance otherwise payable to me, but not exceed the physician's regular charges for the periods of treatment. A copy of this signature is as valid as the original one.

Payment Policy:

HMO, PPO and participating insurance plans:

If Springhill Dermatology Clinic, P.C. is a participating provider for your insurance plan, you are responsible for your deductible, co-payment, and charges for non-covered and cosmetic services at the time of service.

Non-participating Commercial Insurance:

If you are covered by an insurance in which Springhill Dermatology Clinic, P.C. *is not a participating provider, you are responsible for the entire balance regardless of the benefits and payment policies of your carrier: In the event of major procedures or hospitalization,* this office may file "assigned" claims for the purpose of having benefits paid directly to Springhill Dermatology Clinic, P.C.. You will be required to pay a deposit at the time your surgery/procedure is scheduled.

Medicare:

Springhill Dermatology Clinic, P.C. is a participating Medicare provider. Our office will accept assignment and file your claim with Medicare. As a Medicare Beneficiary, you are responsible for paying your annual $140.00 deductible, 20% co-payment, non-covered and cosmetic services, If you have Medicare secondary/supplemental insurance, we will file with one of your secondary/supplemental carriers. However, you are responsible for paying your annual $140.00 deductible and your 20% co-payment, if your supplemental carrier has not paid within 60 days.

Agreement To Pay:

I, the undersigned, accept the fee charges as a legal and lawful debt and agree to pay said fee, including any/all cost of collection, (33.33%), attorney fees and/or court costs if necessary. I waive now and forever may right of exemption under the laws of the constitution of the State of Alabama and any other State.

Express Prior To Contact Consumer By Cell Phone:

I, the undersigned, give Springhill Dermatology Clinic P.C., its employees and/or agents 'express prior consent' to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance or payment.

Your signature below signifies your understanding and willingness to comply with this policy.

X Patient or Responsible Signature: _____ Date_____

I, _____, have received a copy of SPRINGHILL DERMATOLOGY CLINIC, P. C.'s NOTICE OF PRIVACY PRACTICES.

X Signature of Patient _____ Date _____

Medicare Patients

Medicare Authorization:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Springhill Dermatology Clinic, P.C. for any services furnished to me by Springhill Dermatology Clinic, P.C. I authorize any holder of medical or other information about me to release to the Health Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. Regulations pertaining to Medicare assignment of benefits apply, I permit a copy of this authorization to be used in place of the original.

X Beneficiary Signature: _____ Date _____

MEDIGAP Patients:

X MEDIGAP Carrier: _____ Policy # _____

I request authorized MEDIGAP benefits payments be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable to related services.

PATIENT RESPONSIBILITY ACKNOWLEDGEMENT

Thank you for choosing Springhill Dermatology Clinic for your dermatology treatment. We understand that by your coming to our practice you consent to the treatment of your dermatology needs by the physicians and staff of our center.
To meet the needs of our patients, we participate in many insurance programs. Each insurance company has its own specific rules regarding the level of care, the amount of reimbursement and the physician practice where you may obtain dermatologic care. While we will work with you to provide your care within the guidelines of your plan, our main concern is providing you with quality health care. It is your responsibility to inform us of your plans guidelines for dermatology coverage. You are financially responsible for all charges for health care services that you receive at our center unless you are insured for such services. If you have full insurance coverage and/or our center is one of your network providers, you are responsible for paying annual deductibles, co-payments, co-insurance and all charges for noncovered services at the time that the services are rendered, and we will bill your insurance plan for your charges. If your insurance plan considers our center an out-of-network provider, you are also responsible for all charges for non-covered services rendered for each office visit or procedure. Most insurance companies apply to the out-of-network deductible, any services that are rendered by an out-of-network provider This amount will be adjusted if we learn that your plan covers more, or less, of your services.] We will file your insurance (up to two submissions) and then you will be billed directly for any unpaid balances after 45 days.

Please be sure to tell us when any of the following occur:
- You change insurance companies.
- You change plans within the same insurance company.
- Your plan has special rules for services such as lab work, ultrasounds, surgery, etc.
- You receive any notice of a change in your infertility benefits.

Payment for all services is your financial responsibility. We will have to bill you directly if you do not inform us of the above information and your coverage for care at our center is denied. If your plan requires you to have a referral to be seen at our center, you must bring or send the referral to us before you begin treatment. You may choose to receive services without the proper referral forms, however, you will be financially responsible for these services. We will assist you when we can so that you receive all of the insurance benefits to which you are entitled, and our staff and billing service are available to answer your questions. Thank you for your cooperation in this process.
I HAVE READ AND UNDERSTAND THE POLICY STATED ABOVE.

I CONSENT TO MEDICAL TREATMENT BY SPRINGHILL DERMATOLOGY CLINIC AND TO THE DISCLOSURE OF MY HEALTH INFORMATION AS NEEDED FOR MY TREATMENT.

I ACCEPT THE FINANCIAL RESPONSIBILITY AS EXPLAINED TO ME ABOVE.

I AUTHORIZE PAYMENT OF INSURANCE BENEFITS FOR CLAIMS SUBMITTED ON MY BEHALF, AND I EXPRESSLY AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS SUCH CLAIMS.

Patient Signature _____
Date _____