5243 Little Debbie Pkwy, STE 111
Ooltewah, TN 37363
P: (423) 206-2777 F: (423) 206-2772

PATIENT INFORMATION SHEET

Last Name_____First Name_____

Middle Name_____Maiden Name_____

Home Address_____City_____State_____Zip_____

Mailing Address_____City_____ State_____Zip_____

SSN_____Birthdate_____ Marital Status S M D W (circle one)

Home Phone_____Cell Phone_____Work Phone_____Ext____

Employer_____Email_____

Emergency Contact_____ Phone Number _____

Primary Insurance Company _____ ID# _____

Secondary Insurance Company _____ ID# _____

COMPLETE THE FOLLOWING FOR (please check one):

☐ **GUARDIAN OF MINOR** ☐ **SPOUSE (IF SPOUSE IS INSURANCE POLICY HOLDER)**

Last Name_____First Name_____MI____Relationship_____
Home Address_____City_____State_____Zip_____
Mailing Address_____City_____State_____Zip_____
Home Phone_____Cell Phone_____Work Phone_____Ext_____
SSN_____Birthdate_____Employer_____

The above information is true to the best of my knowledge.

_____ _____
Signature (Patient/Guarantor) **Date**

REQUEST TO APPLY BENEFITS TO PHYSICIAN: I hereby request payment be made directly to the attending physician for the medical services, if any, otherwise payable to me for the services as described.

_____ _____
Signature (Patient/Guarantor) **Date**

REQUEST TO RELEASE INFORMATION: I hereby request the attending physician and/or collaborating medical professionals to release any information to my insurance company required in the course of my examination or treatment.

_____ _____
Signature (Patient/Guarantor) **Date**

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HEALTH INFORMATION PRIVACY FORM

In compliance with federal law, it is the policy of Uderm, PLLC to **NOT** release confidential, and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, e-mail, cellular telephone, pager and/or fax. **WE WILL NOT LEAVE A MESSAGE ON YOUR ANSWERING MACHINE IF YOUR NAME IS NOT ON THE RECORDED MESSAGE TO IDENTIFY THE RESIDENCE.** Information will not be left with an unauthorized person who may answer your telephone.

By listing your own telephone number(s) below, you authorize Uderm to use the phone numbers listed below to contact you and assume responsibility to notify Uderm whenever this information changes:

Home Telephone:_____
Working Telephone:_____
Cellular Telephone:_____

☐ Please check this box if you would like to authorize Uderm to leave detailed medical information pertaining to your care on your voicemail or answering machine.

If you would like to have your medical information released to someone other than yourself, please list the names and telephone numbers of individuals whom you authorize us to speak with regarding your medical information:

	Name	Telephone Number
Spouse/Significant Other	_____	_____
Parent	_____	_____
Brother/Sister	_____	_____
Son/Daughter	_____	_____
Friend	_____	_____

Authorization and Privacy Practice Acknowledgement

I authorize Uderm, PLLC to contact me and/or any of the people I have listed above at the numbers listed above. I authorize Uderm to leave medical information pertaining to my care by the methods listed above, and I assume responsibility to notify Uderm whenever this information changes. I acknowledge I have had available to me a copy of Uderm, PLLC's Notice of Privacy Practices. I understand that a copy of this policy may be given to me upon my request.

_____ _____
Patient Printed Name Date

_____ _____
Patient/Guardian Signature Guardian Printed Name (if applicable)

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MEDICAL HISTORY

Name _____ Date of Birth _____

The following are "Yes" – "No" questions. Please check the box if "Yes" and leave blank if "No".

Past Medical History

- ☐ Anxiety/Depression
- ☐ Bleeding problems
- ☐ Cancer (non-skin)_____
- ☐ Diabetes
- ☐ Healing problems (keloids, hypertrophic scars, other)
- ☐ Heart disease, murmur
- ☐ High blood pressure
- ☐ Infectious disease (HIV, Hep B, Hep C, other)
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Lung disease (COPD, asthma, other)
- ☐ Stroke
- ☐ Dementia
- ☐ Seizure disorder

Past Surgical History

- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Organ transplant_____
- ☐ Pacemaker/defibrillator
- ☐ Other _____

Past Dermatologic History

- ☐ Atypical moles
- ☐ Actinic keratoses
- ☐ Skin cancer
  - ☐ Basal cell carcinoma
  - ☐ Squamous cell carcinoma
  - ☐ Melanoma
  - ☐ Other _____
- ☐ Family history of skin cancer or melanoma
- ☐ Eczema
- ☐ Other rashes _____
- ☐ Acne
- ☐ Blistering sunburns
- ☐ Tanning bed use
- ☐ Sunscreen use (SPF___)

Medications (include dosing)

- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

Allergies

- ☐ _____
- ☐ _____

Social History

- ☐ Occupation _____
- ☐ Exercise
- ☐ Smoking (circle): current or former
- ☐ Alcohol (circle): daily or occasionally

Quality Measures

- ☐ Influenza vaccine current
- ☐ Pneumonia vaccine current
- ☐ Women only: pregnant or breastfeeding
- ☐ Any other history you would like us to know?

  _____

  _____
- ☐ We strive for whole-person care: would you like prayer for anything in particular today?

  _____

Pharmacy: _____

Patient Signature: _____ Date: _____

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CONSENT FOR TREATMENT & PATIENT FINANCIAL POLICY

1. **CONSENT FOR TREATMENT:** I consent to treatment necessary or desirable to the care of the patient first mentioned above, including but not restricted to, whatever drugs, medicine, performance of operations and conduct of laboratory, x-ray or other studies that may be used by the attending doctor, his nurse or qualified designate.
2. **CONSENT FOR PHOTOS**: I hereby give permission to Uderm, PLLC to take photographs and/or videos for diagnostic purposes and to enhance the medical record. I agree that these photographs and/or videos will remain the company's property. I further authorize the company to use such photographs and/or videos for coordination of care, teaching purposes, medical research, or to illustrate scientific papers, websites, books, or lectures, in print and/or digital form. I understand that I will not be entitled to any payment or other form of remuneration as a result of any use of the photographs and/or videos.
3. **PROOF OF INSURANCE:** All patients must verify their insurance information before seeing the physician. Uderm, PLLC participates with a large variety of insurance plans, including Medicare. Please confirm with our staff that we participate with your specific insurance plan. If you are not insured by a plan that we participate with, we will be happy to file your claim for you. It is your responsibility to ensure that we have your correct information and an up-to-date copy of your insurance card.
4. **UPDATED CHANGE OF INFORMATION & COVERAGE:** We will ask you to update this whenever you have a change in address, employment, insurance, etc., and annually. However, it is your responsibility to make us aware of these changes and if you fail to provide us with the correct updated information, you will be responsible for the entire cost of the services rendered and immediate payment will be expected.
5. **CO-PAYMENTS, DEDUCTIBLES & CO-INSURANCE:** All co-payments, deductibles & co-insurance must be paid at the time of service. Payment of your copayments, deductibles and co-insurance is part of your contract agreement with your insurance plan. Our failure to collect payment may be a violation of billing compliance and may be considered as an act of fraud by your insurance plan.
6. **NON-COVERED SERVICES:** Please be aware that some or perhaps all of the services you receive may not be covered or considered reasonable or necessary by your insurance plan. If you elect to have these services, you will be asked to sign a waiver and payment in full at the time of service will be expected.
7. **REFERRALS:** Some insurance plans require a referral from a primary care physician to obtain services of a specialist, such as a dermatologist. These health plans will not pay for services rendered without a referral. It is **'YOUR'** responsibility to obtain a referral prior to treatment. If you have not obtained the necessary referral, you may either reschedule your appointment or, if allowed by your insurance company, sign a waiver agreeing to pay for the service at the time it is rendered.
8. **AUTHORIZATIONS:** Obtaining a prior authorization for services is not a guarantee of payment of benefits. A prior authorization means that the information given at that time meets the medical necessity for the services; not a guarantee of payment. Your insurance plan will confirm to you that even though the services may be authorized, the services may not be covered under your plan and a decision for payment will not be rendered until a claim is submitted.
9. **CLAIMS SUBMISSION:** We will submit your claims and assist you in any way we can to help get your claims paid. Your insurance plan may request information directly from you. Your failure to timely respond to your insurance plan's request may result in your claim denial and if so, will result in our seeking full reimbursement from you for services rendered; even if we are a participating provider with

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your plan. Your insurance benefit is a contract between you and your insurance plan. You also authorize this office to appeal any denials made by yourself on your behalf.

10. **SELF-PAY**: If you do not have valid health care coverage, you will be considered as self-pay. Payment in full is due at the time of service.
11. **NON-PAYMENT:** If your account is over 60 days past due, you will receive a statement indicating that you have 30 days to pay your account in full. Partial payments will not be accepted unless you have contacted our office and otherwise negotiated. Please be aware that if a balance remains unpaid, we will turn your account over to a collection agency after the 90th day past due.
12. **PAYMENT METHODS:** We accept cash, personal checks, money orders, MasterCard, Visa, Discover, American Express, and CareCredit as payment for services rendered.
13. **RETURNED CHECKS:** A returned check fee of $30 will be added to your account for every check returned for insufficient funds, stopped payment, or closed accounts. After the second occurrence, only cash, money orders, cashier's check or credit card payments will be accepted.
14. **NO SHOW POLICY:** If you miss 3 or more visits without canceling or rescheduling 24 hours in advance you may be dismissed from our practice.
15. **OUTSIDE LABORATORY CHARGES:** Any outside laboratory testing will be billed by the separate laboratories to you and/or your insurance company.

*****Knowing your insurance benefits is your responsibility. Please contact your insurance plan with questions you may have regarding your coverage*****

This is an agreement between Uderm, PLLC and the patient/responsible party signed below. By executing this agreement, you are agreeing to pay for all services that are received.
I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES.

_____ _____
Patient Printed Name Date

_____
Patient/Guardian Signature

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CORONAVIRUS ACKNOWLEDGEMENT, CONSENT, AND WAIVER

The undersigned Patient acknowledges that the procedure(s), test(s), and/or healthcare services (the "Services") to be provided at Uderm, PLLC by its healthcare professionals and other personnel (the "Staff") are determined necessary by me in consultation with my medical professional. Patient acknowledges that there may be additional risks associated with the provision of the Services in light of the current healthcare environment and the outbreak of the global COVID-19 novel coronavirus pandemic. In spite of these and other risks, whether known or unknown, Patient elects and consents to proceed with such Services. In taking advantage of the Services, Patient agrees to hereby release, discharge and forever holds Uderm, PLLC harmless along with its owners, officers, directors, agents, employees, volunteers, affiliates, parent, subsidiaries and the Staff (collectively, the "Released Parties"), from and against any and all claims, demands, suits, penalties, costs, including attorney fees and court cost, charges and any and all other liability, including without limitation bodily harm, infection, illness or injury, in connection with, related to, or arising out of any action or inaction of the Released Parties and the provision of the Services by the Released Parties which could be in any way related to this pandemic.

_____ _____
Patient Printed Name Date

_____ _____
Patient/Guardian Signature Guardian Printed Name (if applicable)