TULLAHOMA DERMATOLOGY

1330 Cedar Lane, Suite 700
Tullahoma, Tn 37388
Ph. 931-455-7400
F: 931-455-6344

Please initial and sign after you have read the consent below.

INITIAL HERE _____ **FINANCIAL RESPONSIBILITY**

I understand that Tullahoma Dermatology PC will collect my copayment at the time of service and will attempt to verify my insurance coverage. If my insurance fails to reimburse despite all efforts, I will be responsible to pay the balance in full. Co-pays, deductibles, and procedures not covered by my insurance are my responsibility. Partial payments will not be accepted unless prior arrangements have been made. My insurance company may require me to supply certain information directly to them. I understand it is my responsibility to comply with their request in a timely manner. Any charges that incur from failure to comply will be solely my responsibility. I will inform Tullahoma Dermatology PC of any changes in my insurance plan immediately. A $30.00 returned check fee will be charged for checks returned due to insufficient funds. **All copayment and past due balances are due and payable at the time of service. If a biopsy is performed, depending on my health coverage for this facility, I may receive a separate pathology bill from the lab.**

INITIAL HERE _____ **GENERAL POLICY**

Prescriptions: Prescriptions are issued during office hours only due to HIPAA guidelines and to protect my confidentiality. Tullahoma Dermatology, PC will not refill medications by phone or fax. If I have medication(s) for a chronic condition, I am required to see the physician on a regular basis. It is my responsibility to plan ahead so that I do not run out of my medication(s).

Medical Records: As a professional courtesy, Tullahoma Dermatology, PC will fax, mail or electronically send copies of my Medical Records to other physicians with a signed authorization to release health information form. Medical records requested by insurance companies or attorneys must be requested by those entities.

Cosmetic or Non-Covered Procedures: I will be asked to sign a Waiver of Liability Form in the event that a service is provided with Tullahoma Dermatology, PC and is known not to be covered by insurance. In the event that Tullahoma Dermatology, PC is not aware of a charge that is not covered by my plan, I will be billed for the balance after the clinic obtains a denial from my insurance carrier.

Referrals: If my insurance has designated a primary care physician (PCP), I am required to have a prior authorization from my PCP and/or my insurance prior to my clinic visit. If this authorization is not provided, I will be asked to either reschedule my appointment or self-pay for my visit at the time service.

INITIAL HERE _____ **PRIVACY POLICY** I have received a copy of my Privacy Policy Notice.

INITIAL HERE _____ **AUTHORIZATION FOR DERMATOLOGY PHOTOGRAPHY**

For my medical record, Tullahoma Dermatology, PC uses an electronic medical records system and requires my photograph to be taken. I hereby authorize the appropriate personnel of the office of Dr. Isaac Bryan, Dermatologist and/or Tullahoma Dermatology, PC personnel to take photographic and digital pictures of my skin condition. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. This photograph will not be used or released for any other purpose. If I wish to withdraw my consent in the future, I may do so with a written request.

INITIAL HERE _____ **RELEASE OF INFORMATION**

Patients frequently request that their medical treatment be discussed with family members or other parties. If there is anyone whom you would like to authorize the doctor to discuss your treatment, please indicate that person's name, date of birth and relationship.

Name:_____ DOB: _____ Relationship:_____

Name:_____ DOB: _____ Relationship:_____

Patient Signature: _____

Patients name (please print): _____ Date:_____/_____/_____