Financial Policy & HIPAA Authorization

SOUTHEASTERN
DERMATOLOGY
MEDICAL · SURGICAL · COSMETIC

Main Office: 1930 Pinnacle Pointe Way, Knoxville TN 37922 Phone: (865) 474-8800
Satellite Office: Tennova South, 7323 Chapman Hwy., Suite 100, Knoxville, TN 37920

OUR FINANCIAL POLICY: Please read and sign below.

Thank you for choosing Southeastern Dermatology as your healthcare provider. We are committed to your treatment being successful, and your health is our greatest concern. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment so that you understand your responsibility regarding the charges for services rendered by this office.

All patients must complete and sign our registration form in full before seeing the physician. If you have insurance which will pay our physician directly, and which we can verify, we still require that all co-payments, deductibles, co-insurances and charges for non-covered/cosmetic services be paid for at the time service is rendered. We will file both your primary and secondary insurance. If you have Medicare as well as a secondary coverage that is not a Medigap, we will file a claim to your secondary carrier. If you are a member of an HMO or PPO which requires a referral form from your primary care physician, you are responsible for having the referral in our office prior to your appointment.

Payment is due at the time of service. We accept cash, checks and credit cards. If needed, a payment plan can be established with prior approval from the practice manager.

If you are unable to keep your appointment, kindly give a 24-hour notice. Please help us to serve you better by keeping scheduled appointments. If you are more than 15 (fifteen) minutes late for your appointment, you may be asked to reschedule for another date.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy and understand that I am responsible for all charges incurred by me. I agree to pay any monies due to Southeastern Dermatology.

____ ______ /______ /______
Signature of Responsible Party Date

HIPAA AUTHORIZATION: Please check yes or no to all of the following.

I, ______________________________, authorize Southeastern Dermatology and its employees the following:

Call to remind me of my appointment	❑ YES ❑ NO	Text appointment reminders to my cell phone	❑ YES ❑ NO
Contact me on my cell phone	❑ YES ❑ NO	Leave a message at my home phone number	❑ YES ❑ NO
Leave a message on my cell phone	❑ YES ❑ NO	Call me at work and/or leave a message	❑ YES ❑ NO
Leave test/pathology results on my answering machine	❑ YES ❑ NO	Release info and/or test results to my physician	❑ YES ❑ NO
Contact me via email *(disclose here)*			❑ YES ❑ NO

Give test/pathology results and/or discuss my care with:

______________________________ ______________________________
Name Relationship

______________________________ ______________________________
Name Relationship

This authorization will remain in effect until I provide written instructions otherwise.

____ ______ /______ /______
Patient Signature (if minor, guardian signature) Date